Virginia Department of Health

Office of Emergency Medical Services

Quarterly Report to the

State EMS Advisory Board

Wednesday, November 5, 2014

Executive Management, Administration & Finance

Office of Emergency Medical Services
Report to The
State EMS Advisory Board
November 5, 2014

MISSION STATEMENT:

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

I. Executive Management, Administration & Finance

a) Action Items before the State EMS Advisory for November 5, 2014

1. In accordance with the State Emergency Medical Services Advisory Board Bylaws, Section C 1 Nominating Committee; and on behalf of Mr. Passmore, Chair of the Nominating Committee, the following slate of nominations was disseminated to all members of the Sate EMS Advisory Board on Friday, September 19, 2014. The Bylaws state that *"the committee shall present a slate of nominations to the Board thirty (30) day's prior to the election."* Election of Officers, Chairs and Coordinators will be held on the next regularly scheduled meeting of the Board on Wednesday, November 5, 2014. Please refer to **Appendix A.**

2. The TSO&MC moves that the EMS Advisory Board approve the 2015 Trauma Center Designation Manual. See **Appendix F.**

b) Comprehensive EMS Code Clean Up Workgroup – HB581/SB355

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

were also introduced to separate Fire and EMS in the code in an attempt to develop legal and operational clarity.

Because of the compressed time frame during any legislative session, there was not sufficient time for key stakeholder groups and other interested parties to review the changes proposed in multiple sections of the Code. HB 581 was carried over to the Health, Welfare and Institutions Committee until the 2015 session of the Virginia General Assembly. SB 355 was carried over until 2015 with a request for the state EMS Advisory Board to review and make recommended changes to the existing bills. By not acting on these bills, the legislature gave key stakeholder groups and other interested parties addition time to comment on the proposed code language changes. The EMS community will be in a better position to understand the proposed changes to the Code if they have had an opportunity to participate in drafting the language changes.

At the direction of the state EMS Advisory Board Chairman, Mr. Gary Critzer, a workgroup of the Legislation and Planning committee was formed to review the existing code and with input from key stakeholder groups and other interested parties, make recommendations for technical changes to the Code in order to reduce the ambiguity and confusion over the use of definitions and terms related to EMS. The workgroup included representation from OEMS, VDFP, VFCA, VPFF, Virginia Firefighters' Association, VAA, VAVRS, VAGEMSA, regional EMS Councils, and the Division of Legislative Services.

The workgroup held meetings at OEMS in Glen Allen, VA on March 14 and April 18, May 30 and August 1. The guiding principles of the workgroup were to: 1) make technical changes to update language in the code to be consistent with the EMS Regulations (12VAC5-31), 2) avoid making any substantive changes resulting in a change in policy or procedure, 3) remove citations in code to Fire/EMS used in Title 27 and move all references to EMS to Title 32 of the Health section of the Code in an effort to develop legal and operational clarity between Fire and EMS. Individuals and organizations interested in providing public comments related to the latest version of the draft bill language were encouraged to submit their remarks on-line using the template provided on the OEMS Web site. A summary of the recommended changes made by the workgroup, is available on the OEMS Web site at click here. Public comments on the proposed draft comprehensive EMS bill language were received until 5 PM on Friday, Oct. 3.

The Office of EMS received several remarks during the public comment period. The comments received related to clarification of definitions and the use of certain terms used in the proposed code language. Each individual providing comment was received verbal and/or written clarification in response to their question(s). In each case, there was no need to make any further changes to the proposed draft bill language.
In addition, each member of the state EMS Advisory Board received an Email from Irene Hamilton, Executive Secretary to the Board on September 10, 2014 with a link to the latest version of the draft bill language and a request for public comment on the proposed technical amendments in Code to clarify the use of terms and definitions related to EMS. No comments were received.

The Legislation and Planning Committee of the State EMS Advisory Board will request action by the Board on November 5, 2014 regarding the final proposed draft of the bill language. If

approved by the Board, the draft bill language will be submitted to the Division of Legislative Services in order to draft the bill language and assign a bill number for introduction in the 2015 session of the Virginia General Assembly that begins on January 14.
If you have questions or require additional information, please contact Mr. Scott Winston, Asst. Director, VA OEMS at scott.winston@vdh.virginia.gov or at 804-888-9135 or toll free in VA, 1-800-523-6019.

c) **EMS Voluntary Event Notification Tool (E.V.E.N.T.)**

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

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

Appendix B contains an aggregate report of **patient safety events** reported to E.V.E.N.T. in the second quarter of 2014 (April through June 2014).

Appendix C contains an aggregate report of the **provider violence events** reported to E.V.E.N.T. for the second quarter of 2014 (April through June 2014).

There were not enough **Near Miss** to report this quarter.

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

d) Model Interstate Compact for EMS Personnel Licensure Project Is Complete Otherwise known as Recognition of EMS Personnel Licensure CompAct (REPLICA)

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

The Model Interstate Compact will benefit EMS personnel who my work in cross border environments, EMS employers, state EMS offices and ultimately the patients served by EMS

personnel and organizations working in more than one state. One of the important features of the compact addresses EMS personnel practicing medicine in a state in which they are not technically licensed. According to Dia Gainer, NASEMSO Executive Director, "EMS is at the leading edge of a growing wave of medical disciplines' leadership who have discovered that interstate compacts are a novel yet time tested way to solve the pervasive dilemma of providing appropriately credentialed individuals from other states the legal ability to practice under specified conditions, introduce unprecedented accountability related to those personnel, and create means of information sharing among states that have never existed before."

NASEMSO received legal and technical assistance, and process guidance from the Council of State Governments (CSG) through its National Center for Interstate Compacts (NCIC). At its annual meeting last month, the CSG passed a resolution supporting the establishment of REPLICA and encouraging its member jurisdictions to consider adoption as an "innovative policy solution". You may view a copy of the resolution as **Appendix D** of this report.

The project was closely coordinated with the National Governors Association, National Council of State Legislatures, Federal Interagency Committee on EMS (FICEMS), the National EMS Advisory Council (NEMSAC), and all federal agencies that employ EMS personnel.

Key Provisions of the Compact

A home state's license authorizes an individual to practice in a remote state under the privilege to practice only if the home state:

1) Currently requires the use of the NREMT examination as a condition of issuing initial licenses at the EMT and paramedic levels;
2) Has a mechanism in place for receiving and investigating complaints about individuals;
3) Notifies the Commission, in compliance with the terms of the Compact, of any adverse action or significant investigatory information regarding and individual;
4) No later than five (5) years after activation of the Compact, requires a criminal background check of all applicants for initial licensure, including the use of the results of fingerprint or other biometric data checks compliant with the requirements of the FBI;
5) Complies with the rules of the Commission.

Compact Privilege to Practice

In order to exercise the privilege to practice under the terms and provisions of the compact, an individual must:

1) Be at least 18 years of age;
2) Possess a current unrestricted license in a member state as an EMT, AEMT, paramedic, or state recognized and licensed level with a scope of practice and authority between EMT and paramedic; and
3) Practice under the supervision of an EMS medical director.

An individual providing patient care in a remote state under the privilege to practice shall function within the scope of practice authorized by the home state unless and until modified by an appropriate authority in the remote state as may be defined in the rules of the commission.

An individual practicing in a remote state will be subject to the remote states' authority and laws.

A remote state may, in accordance with due process and the state's laws, restrict or revoke an individual's privilege to practice in the remote state and may take any other necessary actions to protect the health and safety of its citizens. If a remote state takes action it shall promptly notify the home state and the Commission.

Additional information about REPLICA is available on the NASEMSO Web site at: http://www.nasemso.org/Projects/InterstateCompacts/index.asp.

You may also view the final draft of the Interstate Compact for EMS Personnel Licensure as **Appendix E** to this report.

In order for Virginia to become a member of the compact, the REPLICA model legislation will be introduced during the 2015 session of the General Assembly. The model legislation must be enacted without any substantial changes, and the Governor must sign it into law.

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

- **EMS – Grant Information Funding Tool (E-GIFT)**

The OEMS Grants Unit and VDH Office of Information Management (OIM) has implemented a web-based grant program to replace the Consolidated Grant Application Program (CGAP) for RSAF. The program has several phases, all which will be complete by Spring 2015:

- Phase I – Grant Application – implemented and required for the 12/14 RSAF grant cycle.
- Phase II – Grant Review – implemented and required for the 12/14 RSAF grant review.
- Phase III – Meeting Program – being developed and will be required for the 12/14 RSAF grant awards meeting.
- Phase IV – Reports – being developed and will be completed by Spring 2015.

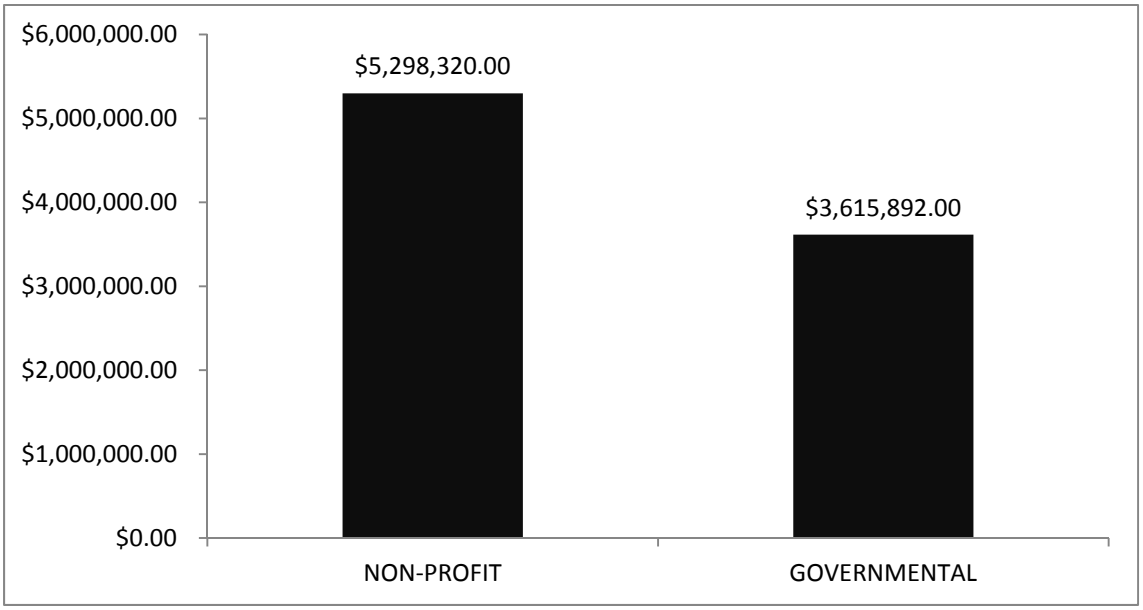
OEMS created user groups to assist with the development of the various phases and recruited volunteers to beta test the applications prior to production. The program has been highly successful and has been a major improvement to the RSAF grant program.

The RSAF grant deadline for the December 2014 grant cycle was September 15, 2014, OEMS received 125 grant applications requesting $8,914,211.00 in funding. This is the first cycle that the EMS Grant Information Funding Tool (E-GIFT) web-based application was required by all applicants.

Funding amounts are being requested in the following agency categories:

- 84 Non-Profit Agencies requesting $5,298,320.00
- 41 Government Agencies requesting $3,615,892.00

Figure 1: Agency Category by Amount Requested

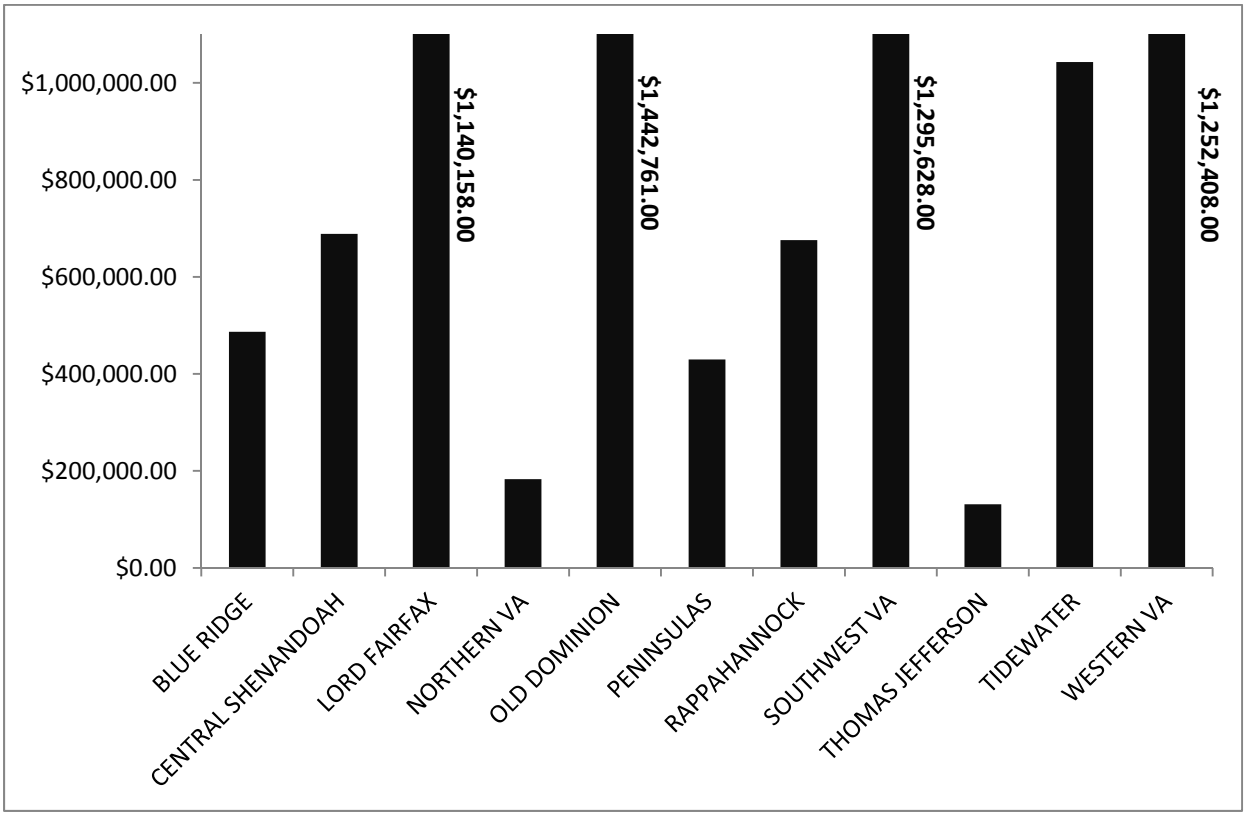


Funding amounts are being requested in the following regional areas:

- Blue Ridge – Requesting funding of $486,939.00
- Central Shenandoah – Requesting funding of $688,766.00
- Lord Fairfax – Requesting funding of $1,140,158.00
- Northern Virginia – Requesting funding of $182,833.00
- Old Dominion – Requesting funding of $1,442,761.00.00
- Peninsulas – Requesting funding of $429,690.00.00
- Rappahannock – Requesting funding of $675,705.00
- Southwestern Virginia – Requesting funding of $1,295,628.00

- Thomas Jefferson – Requesting funding of $131,144.00
- Tidewater – Requesting funding of $1,042,841.00.00
- Western Virginia – Requesting funding of $1,252,408.00

Figure 2: Regional Area by Amount Requested



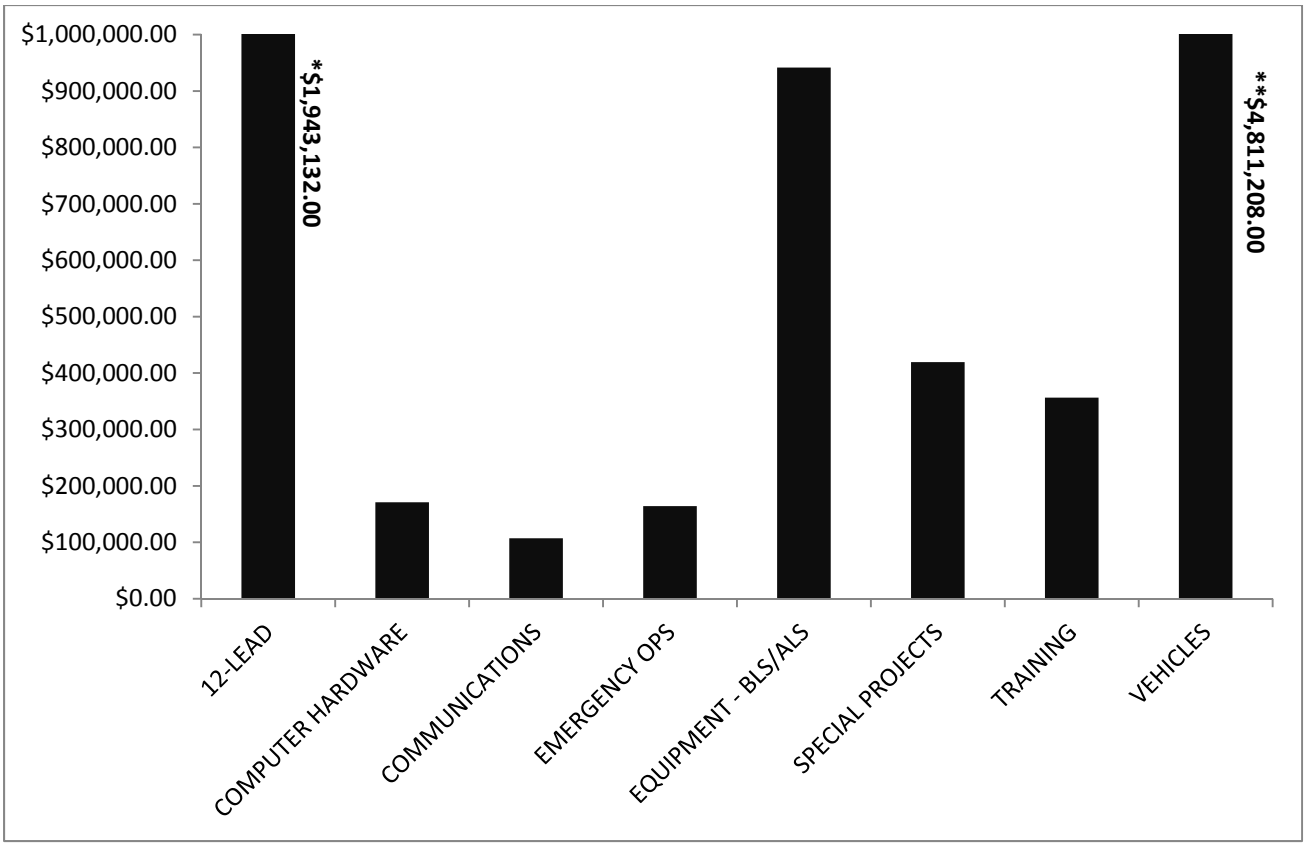
NOTE: Figure 2 has been altered to display regional areas requesting $1,100,000.00 or less to graphically represent a clearer graph of funds requested. Non-affiliated requests have not been displayed because they represent a state-wide organization. Non-affiliated organizations requested $145,338.00 in funding.

Funding amounts are being requested for the following items:

- 12 –Lead – $1,943,132.00
  - Includes all 12-Lead Defibrillators.
- Computer Hardware - $ 170,926.00

    - Includes projectors, computer hardware/software, toughbooks, and other audio visual equipment.
- Communications - $ 107,120.00
    - Includes items for mobile/portable radios, pagers, towers, repeaters and other communications system technology.
- Emergency Operations - $ 164,265.00
    - Includes items such as Mass Casualty Incident (MCI), extrication equipment and personal protection equipment (PPE). The Emergency Operations category also includes any other equipment or items needed in order to rapidly mobilize and dispatch help in emergency situations.
- Equipment - Basic and Advanced Life Support Equipment - $ 941,687.00
    - Includes any medical care equipment for sustaining life, airway management, and supplies, not including 12-Lead Defibrillators.
- Special Projects - $ 419,450.00
    - Includes projects such as Recruitment and Retention, Special Events Material, Emergency Medical Dispatch (EMD), Virginia Pre-Hospital Information Bridge (VPHIB) projects and other innovative programs.
- Training - $ 356,423.00
    - 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 - $4,811,208.00
    - This category includes all vehicles such as ambulances, re-chassis, re-mounts and quick response vehicles.

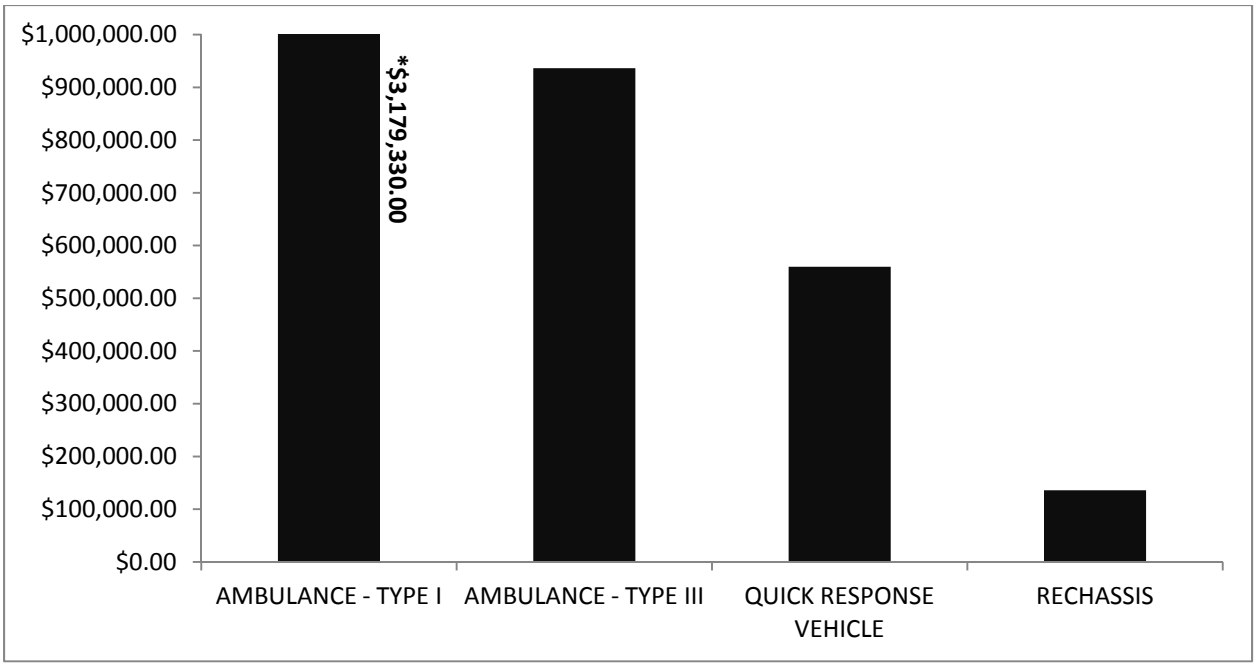
Figure 3: Item Requested by Amount Requested



***NOTE**: The 12-LEAD monitors category request amount was $1,943,132.00, the graph only represents items requested up to $1,000,000.00 to visually display other items requested.

****NOTE**: The AMBULANCES category request amount was $4,811,208.00, the graph only represents items requested up to $1,000,000.00 to visually display other items requested.

Figure 4: Vehicle Category by Amount Requested



***NOTE**: The AMBULANCE category request amount was $4,811,208.00, the graph only represents items requested up to $1,000,000.00 to visually display other items requested.

The RSAF Awards Meeting will be held on December 5, 2014 and the Financial Assistance and Review Committee (FARC) will make recommendations to the Commissioner of Health. The grant awards will be announced on January 1, 2015. The next RSAF grant cycle will open on February 1, 2015 and the deadline will be March 16, 2015.

EMS on the National Scene

II. EMS On the National Scene

a) NASEMSO Participates in Update to BLS Data on EMS Professions

The Joint National EMS Leadership Forum (JNEMSLF), a group of national EMS organizations including NASEMSO has submitted suggested changes to the Standard Occupational Classification Policy Committee, U.S. Bureau of Labor Statistics, regarding the broad group of emergency medical technicians (EMTs) and Paramedics (29-2040) and creation of new detailed occupations under the broad group of EMTs and Paramedics (29-2040) to replace the existing detailed occupation EMTs and Paramedics (29-2041). The JNEMSLF has identified concerns about the current data collecting structure, which results in serious under reporting of critical EMS-related work place data. The JNEMSLF, which supports and represents professionals and agencies responsible for the EMS delivery in the United States, works collaboratively on issues of national importance impacting the provision of EMS at the community level and as part of U.S. disaster preparedness and response activities.

b) NASEMSO Posts New "Need to Know" Resource for Paramedic Students on Program Accreditation

NEW from NASEMSO!! *Is Your Paramedic Program Accredited?* is a one-page guide for candidates thinking about a career in paramedicine. CAAHEP accreditation is the gold standard in paramedic education that ensures career mobility and enhances opportunities for licensure reciprocity among the states. Find out what you need to know when considering, applying for, or enrolled in a paramedic program. Please go to: http://nasemso.org/EMSEducationImplementationPlanning/documents/Is-Your-Program-Accredited-Aug2014.pdf.

c) FAA Corrects Air Ambulance Requirements

The Federal Aviation Administration (FAA) is correcting a final rule published on February 21, 2014. In that rule, the FAA amended its regulations to revise the helicopter air ambulance, commercial helicopter, and general aviation helicopter operating requirements. This document corrects errors in the codified text of that document, Helicopter Air Ambulance, Commercial Helicopter, and Part 91 Helicopter Operations. For more information got to: http://www.gpo.gov/fdsys/pkg/FR-2014-07-15/pdf/2014-16523.pdf.

d) Official Date for ICD-10 Implementation Announced

The U.S. Department of Health and Human Services (HHS) has issued a rule finalizing Oct. 1, 2015 as the new compliance date for healthcare providers, health plans, and healthcare clearinghouses to transition to ICD-10, the tenth revision of the International Classification of Diseases. This deadline allows providers, insurance companies, and others in the healthcare industry time to ramp up their operations to ensure their systems and business processes are ready to go on Oct. 1, 2015. Go to: https://s3.amazonaws.com/public-inspection.federalregister.gov/2014-18347.pdf.

e) NHTSA OEMS Research Notes Break Down National EMS Assessment

When the Federal Interagency Committee on EMS (FICEMS) sponsored the first nationwide assessment of emergency medical systems across the country, researchers analyzed data from four principle data sources to describe EMS Systems, EMS preparedness and 911 systems at both the State and national levels. The 2011 National EMS Assessment report contains a tremendous amount of information about the nation's EMS systems, but the 500-page report can be overwhelming. NHTSA has worked to summarize the information in a way that will be more accessible to EMS leaders. NHTSA's Office of EMS has created its first National EMS Assessment EMS Research to provide a condensed snapshot of the data in a 7-page summary of a topic of particular interest. This first EMS Research Note focuses on EMS Systems Demographics, addressing:

- Number of licensed local EMS agencies nationwide
- Types of EMS agencies licensed by states
- Percentages of agencies that are fire-based or rely on volunteer service

You can review the Research Note at: http://www.ems.gov/pdf/812041-Natl_EMS_Assessment_2011.pdf.

You can download the complete National EMS Assessment report at: http://www.ems.gov/pdf/2011/National_EMS_Assessment_Final_Draft_12202011.pdf.

f) BREAKING NEWS!! CSG Passes Resolution in Support of REPLICA!!

During its recent annual meeting, the Council of State Governments (CSG) passed a resolution in support of the Recognition of the EMS Personnel Licensure Compact (REPLICA). CSG is the nation’s only organization that fosters the exchange of insights and ideas to help state officials

shape public policy. Its Governing Board is comprised of the 56 member jurisdictions whose delegates include each state's Governor, state legislative representatives, and each state's highest ranking judicial official. Through the National Center for Interstate Compacts in partnership with NASEMSO, the CSG encourages member jurisdictions to consider the new interstate agreement that would facilitate the movement of EMS agency personnel across state borders. For more information go to:

http://knowledgecenter.csg.org/kc/system/files/CSG_Resolution%20in%20Support%20of%20the%20Recognition%20of%20EMS%20Personnel%20Licensure%20Compact%20%28REPLICA%29.pdf.

g) NASEMSO Issue Brief: The Use of Naloxone in Out-of-Hospital Settings

NASEMSO has released an issue brief on The Use of Naloxone in Out-of-Hospital Settings. This resource is intended as an informational guide on the use of naloxone in out-of-hospital settings and the rationale for including mandatory education and medical oversight for the use of naloxone by non-medical personnel. The National Association of State EMS Officials believes that the increase of substance abuse in the United States is a significant public health and public safety concern that warrants consideration of several related issues. For more information go to: http://www.nasemso.org/Advocacy/PositionsResolutions/documents/NASEMSO-Issue-Brief-Naloxone-14Aug2014.pdf.

h) NASEMSO Provides Comments on Model Uniform Core Criteria for Mass Casualty Triage

NASEMSO recently provided comments to the National Center for Disaster Medicine and Public Health on the proposed addendum for the Instructional guidelines on the Model Uniform Core Criteria for Mass Casualty Triage (MUCC). NASEMSO supports the proposed concept of implementing MUCC to ensure a coordinated approach to triage by EMS and its response partners. For details, download the letter to National Center for Disaster Medicine and Public Health from NASEMSO President James DeTienne at: http://www.nasemso.org/Projects/DomesticPreparedness/documents/MUCC_comments_NASEMSO_08-25-2014.pdf.

i) NEMA Offers New Primer on History of EMAC

The Emergency Management Assistance Compact (EMAC) is a state-led effort that provides a legal mechanism and framework for sharing resources across state lines during a governor-declared disaster. Currently, all 50 states, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands are members of EMAC. Initiated more than 20 years ago, EMAC has grown

in prominence with its proven effectiveness in numerous disasters. Today, EMAC has become a cornerstone for emergency response and recovery efforts in large-scale disasters.

The National Emergency Management Association (NEMA), which administers EMAC, produced this report to preserve knowledge and lessons learned from EMAC's evolution. Specifically, the report's objectives are to:

- Provide a detailed history of EMAC, analyzing changes in policies and operations from its beginnings to the present day; and

- Explore how EMAC has affected mutual aid policies and response and recovery operations.

j) FEMA Releases National Preparedness Report

The Federal Emergency Management Agency (FEMA) and its partners has released the 2014 National Preparedness Report. Developed to meet the requirements of Presidential Policy Directive 8/PPD-8, the report provides a status update on the nation's progress toward reaching the national preparedness goal of a secure and resilient nation. The report notes that state and local law enforcement are better trained to address active shooter incidents; states have improved Enhanced 9-1-1 capabilities, though diligence is needed as technology improvements continue; and public health and medical services fared well in trainings and exercises, though fears continue about long-term gains due to budget uncertainties. Areas identified for improvement include cybersecurity, temporary housing, and aging infrastructures. For more information go to: http://www.fema.gov/national-preparedness-report.

k) NEMSAC Offers Revisions to EMS Education Agenda

The National EMS Advisory Council (NEMSAC) recently requested community input to the suggested revisions for the EMS Education Agenda for the Future. You can view the draft at: http://ems.gov/nemsac/DraftRevisionsEducationAgenda-PublicComment-Aug2014.pdf.

A second opportunity for input will take place later this Fall, and the formal recommendation vote will take place at the December 3-4, 2014 NEMSAC meeting.

Educational Development

III. Educational Development

Committees

A. **The Training and Certification Committee** (TCC): The Training and Certification Committee meeting was postponed to Wednesday, October 22nd. Any action items will be forwarded to the Board prior to the Quarterly meeting.

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

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

B. **The Medical Direction Committee (MDC)** The Medical Direction Committee meeting met on Thursday, October 9, 2014. The White Paper, OMD Response to HB1010 was unanimously approved and is presented for informational purposes only. There are no action items for consideration.

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

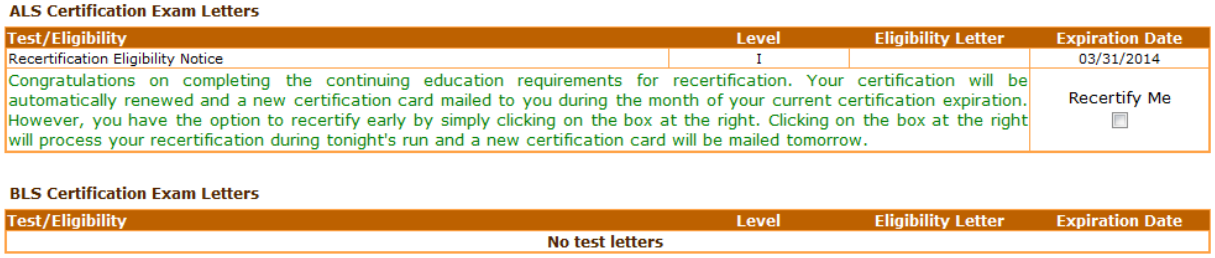
New EMS Certification Process effective March 1, 2014

As of March1, 2014, the recertification process in Virginia changed. Any provider, regardless of affiliation status, who receives recertification eligibility prior to their certification expiration, will automatically be recertified during the month of their certification expiration. If the last continuing education (CE) is received in the month of their expiration, the process will automatically recertify the provider. There is no action required by the provider for this to occur, other than to assure their continuing education is received by the office prior to their certification expiration. Submission of a "blue" form with an OMD test waiver signature is no longer be required.

ALS –Coordinators and Emergency Operations Instructors will continue to recertify through their normal process.

The new process allows the provider to recertify early, should they choose to do so.

Once a provider has complied with all recertification criteria prior to their certification expiration date, instead of an eligibility letter, the following will appear in their EMS portal:



ALS Certification Exam Letters

Test/Eligibility	Level	Eligibility Letter	Expiration Date
Recertification Eligibility Notice	I		03/31/2014
Congratulations on completing the continuing education requirements for recertification. Your certification will be automatically renewed and a new certification card mailed to you during the month of your current certification expiration. However, you have the option to recertify early by simply clicking on the box at the right. Clicking on the box at the right will process your recertification during tonight's run and a new certification card will be mailed tomorrow.			Recertify Me ☐

BLS Certification Exam Letters

Test/Eligibility	Level	Eligibility Letter	Expiration Date
No test letters			

By checking this box, the provider's certification will be processed in that night's batch process and a new certification card will be issued the next day. This allows providers who wish to forfeit any remaining time on their current certification to do so and to recertify early. We primarily see this as an option for those who wish to keep both their Virginia certification and their National Registry certification continuing education on the same rotation. Remember, as indicated in the first paragraph, this is optional. Regardless of whether or not you check the box, you will automatically be recertified during you certification expiration month if you are eligible.

(Hint – all Virginia providers whose National Registry certification is up for renewal March 2014, are encouraged to manually recertify in March if you want to synchronize your two certifications.)

Important Note:

This change does not affect re-entry. If a provider's CE is not received in the office prior to the certification expiration date, regardless of when the class was taken, the provider reverts to re-entry status. There is no grace period for the submission of CE. Upon receiving eligibility to recertify while in re-entry status, the provider will need to pass the certification examination. The new recertification process does not apply. A BLS provider will be required to pass both the Virginia psychomotor exam and the National Registry cognitive examination at their expense. ALS providers will be required to pass the National Registry cognitive assessment examination at their expense.

Providers, who obtained certification by legal recognition or are in the process of challenging Virginia EMT, must successfully complete the Virginia psychomotor exam and the National Registry cognitive examination at their expense after receiving an eligibility notice. The new recertification process does not apply if this is the first Virginia recertification for the provider who obtained their current certification through legal recognition; however, subsequent recertifications will follow the described "new" process.

As with any new program, there may be some unforeseen or untested situations. For those providers who are eligible for recertification and have not been recertified by the middle of the month of certification expiration, please contact the office.

Contact OEMS training staff with any questions.

Advanced Life Support Program

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

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

Basic Life Support Program

A. Education Coordinator Institute

1. The Office held an Education Coordinator (EC) Psychomotor Exam on August 9, 2014. Fifteen (15) Candidates attended and passed the exam.
2. Since the June Institute was canceled due to low number of candidates, the EC Institute was held September 20-24th in Oilville VA. Twenty-four (24) EC Candidates completed the process. We would like to thank VAVRS for the use of their building.
3. The deadline to pass the EC Cognitive exam in order to be eligible for the next Institute is November 16, 2014. The next EC Psychomotor Exam is scheduled for December 13, 2014 in the Richmond Area.
4. The Next EC Institute is scheduled for January at we are planning to hold it in the Tidewater Region.
5. EMS Providers interested in becoming an Education Coordinator please contact Greg Neiman, BLS Training Specialist by e-mail at Gregory.Neiman@vdh.virginia.gov
6. Schedule of the various deadlines and EC Institutes can be found on our website: http://www.vdh.virginia.gov/OEMS/Training/BLS_InstructorSchedule.htm

B. EMS Educator Updates:

1. For 2014, the Division of Educational Development continued to provide in-person Educator Updates.
2. Since the last advisory board meeting, the Office conducted in-person EMS Instructor Updates on September 20th in the ODEMSA Region, September 27th in conjunction with the VAVRS Conference in Virginia Beach and October 11th in the Southwest Council area.

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

EMS Training Funds

FY13

	Commit $	*Payment $*	*Balance $*
Emergency Ops Funding	$1,460.00	$755.00	$705.00
BLS Initial Course Funding	$729,348.00	$357,424.83	$371,923.17
BLS CE Course Funding	$125,160.00	$49,936.21	$75,223.79
ALS CE Course Funding	$297,360.00	$78,102.50	$219,257.50
BLS Auxiliary Program	$80,000.00	$18,280.00	$61,720.00
ALS Auxiliary Program	$350,000.00	$161,005.00	$188,995.00
ALS Initial Course Funding	$1,102,668.00	$585,777.45	$516,890.55
Totals	**$2,685,996.00**	**$1,251,280.99**	**$1,434,715.01**

FY14

	Commit $	*Payment $*	*Balance $*
Emergency Ops Funding	$1,120.00	$280.00	$840.00
BLS Initial Course Funding	$780,912.00	$366,410.86	$414,501.14
BLS CE Course Funding	$94,010.00	$36,578.02	$57,431.98
ALS CE Course Funding	$223,270.00	$79,100.00	$144,170.00
BLS Auxiliary Program	$130,000.00	$59,060.00	$70,940.00
ALS Auxiliary Program	$304,000.00	$168,690.00	$135,310.00
ALS Initial Course Funding	$1,188,504.00	$509,217.51	$679,286.49
Totals	**$2,721,816.00**	**$1,220,176.39**	**$1,501,639.61**

FY15

	Commit $	*Payment $*	*Balance $*
Emergency Ops Funding	$2,300.00	$0.00	$2,300.00
BLS Initial Course Funding	$387,204.00	$35,343.00	$351,861.00
BLS CE Course Funding	$38,401.50	$2,212.00	$36,189.50
ALS CE Course Funding	$82,582.50	$1,032.50	$81,550.00
BLS Auxiliary Program	$57,360.00	$0.00	$57,360.00
ALS Auxiliary Program	$293,120.00	$0.00	$293,120.00
ALS Initial Course Funding	$614,464.00	$2,142.00	$612,322.00
Totals	**$1,475,432.00**	**$40,729.50**	**$1,434,702.50**

EMS Education Program Accreditation

A. EMS accreditation program.

1. Emergency Medical Technician (EMT)
   a) Navy Region and the City of Virginia Beach Fire/EMS are now fully accredited for their initial five-year accreditation cycle.
   b) Frederick County Fire and Rescue has submitted their self-study and it has been reviewed by the site team. A site visit will be conducted in the near future.
   c) Harrisonburg Rescue Squad has submitted their self-study. It is currently under review by the office before being assigned to a site visit team.
   d) Chesterfield Fire/EMS has submitted their self-study. It is currently under review by the office before being assigned to a site visit team.
2. Advanced Emergency Medical Technician (AEMT)
   a) Frederick County Fire and Rescue has submitted their self-study and it has been reviewed by the site team. A site visit will be conducted in the near future.
3. Intermediate – Reaccreditation
   a) Roanoke Valley Regional Fire/EMS Training Center reaccreditation is under review by a site team and will be scheduled for their reaccreditation visit in the near future.

4. Intermediate – Initial
   a) Southwest Virginia EMS Council site visit has been conducted. Their report has been received and is under final revision in the office.
   b) Paul D. Camp Community College has submitted their initial self study. It has been evaluated in the office and has been assigned to a site review team.
5. Paramedic – Initial
   a) Patrick Henry Community College had their CoAEMSP initial accreditation visit in April and is awaiting their report of findings.
   b) Lord Fairfax Community College has been granted full accreditation from CAAHEP.
6. Paramedic – Reaccreditation
   a) Central Virginia Community College is scheduled for a CoAEMSP reaccreditation visit on November 19 & 20, 2014.
   b) J. Sargeant Reynold Community College is schedule for a CoAEMSP reaccreditation visit on November 13 & 14, 2014.
   c) VCU Paramedic program is scheduled for a CoAEMSP reaccreditation visit on November 20 & 21, 2014.

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

C. Beginning January 1, 2013, students must enroll in a nationally accredited paramedic program to qualify for National Registry certification. National accreditation is offered through the *Committee on Accreditation of Educational Programs for the EMS Professions* (CoAEMSP – www.coaemsp.org).
   1. Virginia paramedic training programs in the Commonwealth have met the requirements making their students eligible to test NREMT as of January 1, 2013.

   2. The following programs still need to obtain national accreditation through CoAEMSP/CAAHEP.
      a) Rappahannock EMS Council Paramedic Program
         (1) Has received their Letter of Review from CoAEMSP and are completing their first cohort class. They will then be required to submit their ISSR within the next six months after which their initial site visit will be scheduled.
      b) Prince William County Paramedic Program
         (1) Has received their Letter of Review from CoAEMSP and have completed their first cohort class. They have submitted their ISSR and are awaiting further information from CoAEMSP.

On Line EMS Continuing Education

Distributive Continuing Education

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

EMSAT

A. EMSAT programs for the next three months include:

1. Dec. 17, Responding to Opiate Abuse
   Cat. 1 ALS, Area 76, Cat. 1 BLS, Area 05

   Jan. 21, Ebola! Enterovirus! What next?

   Cat. 1, ALS, Area 89, Cat. 1 BLS, Area 06

   Feb. 18, Advances in Prehospital CPR
   Cat. 1 ALS, Area 72, Cat. 1 BLS, Area 05

The EMS Portal

The office has released the OMD portal this past spring. This component provides unprecedented access to EMS physicians. EMS physicians now have access to their agencies, providers, courses, education coordinator endorsements, educational program statistics and the status of their re-endorsement status. All current EMS physicians should have received an email providing access documentation. Any concerns or issues gaining access can be directed to Warren Short or Mike Berg.

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

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

Please be sure to keep your email up to date and assure it is listed correctly in the portal.

CTS

A. There have been 25- CTS, 1- EMT accredited course and 4- ALS psychomotor test sites conducted since your last meeting on August 8, 2014 and through October 7, 2014.

B. New examiners Josh Wilkinson, Cody Jackson, Christopher Christensen, Ksenia Stace are progressing well in their job training. Interviews for a new examiner in Northern Virginia will begin soon.

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

D. The following are the only written examinations that will be offered at Consolidated Test Sites as of October 31, 2014:
   a. Education Coordinator Pretest
   b. EMT Enhanced retest

Other Activities

- The division continues working closely with OIM, OEMS Administration, and the EMS Symposium Program Committee to develop a new web-based program.

- Warren continues participating with the NASEMSO's Education and Professional Standards Committee's (EPSC) Monthly conference calls and was fortunate to receive approval to attend the NASEMSO's annual conference in Cleveland, Ohio.

- Warren participated in a meeting of the Atlantic EMS Councils EPSC committee August 4 through August 6.

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

- Debbie Akers served as the assistant program director and volunteer coordinator for the National Association of EMS Educators annual symposium held in Reno, Nevada.

- The Office of EMS, working with FISDAP, will be hosting a free workshop on October 24 & 25, 2014 on item writing. Offered to all accredited program directors in Virginia, this workshop will facilitate experience in item writing and collaboration amongst the programs.

- The Division filled the EM005 vacancy overseeing EMSTF, Web and portal activity, and educational technology with Adam Harrell. Adam comes to us from Regulation and Compliance. Adam brings with him a wealth of knowledge. Please welcome Adam to the Division.

- Warren is participating on the workgroup reviewing CoAEMSP draft accreditation standards.

Emergency Operations

IV. Emergency Operations

Operations

- **Virginia 1 DMAT**

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

- **National Preparedness Month Activities**

Winnie Pennington, Emergency Planner, developed and sent messages to OEMS employees throughout September for National Preparedness Month to help employees prepare for emergencies and disasters.

- **Ebola Preparedness**

The Division of Emergency Operations developed and distributed messaging for information to EMS agencies, providers, and PSAPs pertaining to the worldwide Ebola outbreak throughout the months of August through October. Information is being shared through outreach using email and social media in concert with the VDH Office of Epidemiology. Special thanks are due to Winnie Pennington, Emergency Planner, for her hard work on this effort.

Winnie Pennington, Emergency Planner, attended the VDH Ebola Planning Briefing via teleconference on October 9, 2014. Karen Owens, Emergency Operations Manager attended various meetings regarding Ebola planning and preparedness in Virginia, including the VERT staff briefing and the Health and Human Resources Subpanel of the Secure Commonwealth Committee

Committees/Meetings

- **EMS Communications Committee**

The EMS Communications Committee met August 8, 2014. New members Lewis Cassada (VITA) and Melissa Wood (Fredericksburg 9-1-1) attended. Discussion included an update of the Va. EMS Communications Directory. The committee agreed to changes in the OEMS PSAP Accreditation Program including 1) extending the length of accreditation from two to three years, 2) that 100% of call takers tasked with receiving EMS calls are to be certified as emergency medical dispatchers (as defined in section "A" of the accreditation process), and 3) PSAP compliance scores must be 85% or higher for the center, yearly. PSAP's which had expired

Accreditations due to failure of OEMS to follow up on accreditation were granted two (02) year extensions and will be advised of changes in the accreditation process and guidelines.

- **EMS Emergency Management Committee**

Karen Owens, Division Manager and Connie Green, Assistant Manager, attended the EMS Emergency Management Committee meeting on August 7, 2014. The committee discussed Mutual Aid Net, an emergency management tool, which is being piloted in Virginia, and reviewed the updated triage tag specifications. The role of EMS in Tactical Medicine was also brought up for further consideration at a future meeting.

- **Traffic Incident Management (TIM)**

The HMERT Coordinator continues to work with the TIM program. He held a meeting of the Best Practices Workgroup of which he is chair. From this meeting he was able to report on several topics at the meeting of the Statewide TIM Committee of which he is a member. He also attended a meeting of the SHRP 2 Training Oversight Committee of the TIM Committee.

- **Strategic Highway Safety Plan Steering Committee**

Frank Cheatham attended the update meeting of the Strategic Highway Safety Plan Steering Committee of which he is a member. This meeting is held to review the Plan and make adjustments and plan for other needs such as education and best ways to get the message of the plan out. EMS is an integral part of the planning process.

- **Lane Reversal Coordination**

Frank Cheatham continued to attend meetings in regards to Lane Reversal. He also met with a representative from the Virginia National Guard to discuss the use of guard medical assets to support EMS operations during lane reversal.

- **Task Force Meetings**

The HMERT Coordinator conducted a Task Force interest meeting in Roanoke to discuss HMERT capabilities with various jurisdictions in that immediate area. The meeting was held at the Western Virginia EMS Council.

Frank Cheatham, HMERT Coordinator met with a Massage Therapy group in Lynchburg to discuss and investigate the possible development of a Massage Therapy Team.

- **Hurricane Evacuation Coordination Workgroup**

Karen Owens, Division Manager, Connie Green, Assistant Manager, and Frank Cheatham, HMERT Coordinator, attended Hurricane Evacuation Planning meetings throughout August with VDEM and other state and local partners. The HMERT Coordinator continues to attend these meetings which continue to look at the various aspects of evacuation and the effects on jurisdictions.

- **ASTHO Meeting**

Winnie Pennington, Emergency Planner, attended the Association of State and Territorial Health Officials (ASTHO) Meeting on September 24-26, 2014. Discussion surrounded the development of a CONOPS to effectively distribute and administer anti-neutropenics in a post-IND (improvised nuclear device) environment.

- **VDH Patient Tracking Workgroup**

Winnie Pennington, Emergency Planner, attended the VDH Patient Tracking Workgroup meeting on October 16, 2014.

- **EMS Advisory Board Orientation**

Connie Green, Assistant Manager briefed the new members of the EMS Advisory Board on the Emergency Operations Division as part of the new member orientation on August 7, 2014.

- **VAVRS Convention**

Ken Crumpler, Communications Coordinator represented OEMS at the VAVRS Convention in September.

Training

- **Mass Casualty**

Karen Owens, Division Manager, Connie Green, Assistant Manager and Frank Cheatham, HMERT Coordinator, conducted an MCIM I and II class in Northern Virginia in August. The class, which was attended by 15 individuals, also included a train-the-trainer lecutre.

Karen Owens, Division Manager, and Connie Green, Assistant Manager, conducted an MCIM Train the Trainer Class in the Peninsula Region in August.

- **OEMS COOP Exercise**

The Emergency Operations Division developed and coordinated the annual OEMS Continuity of Operations (COOP) Exercise, which was held on September 16, 2014. Winnie Pennington, Emergency Planner, developed the exercise framework and documents for the COOP exercise, led the exercise activities, and compiled the After Action Report.

- **OEMS Earthquake Drill**

The Emergency Operations Division developed and coordinated the annual OEMS Office Earthquake Drill, which was held on October 16, 2014. Winnie Pennington, Emergency Planner, developed the framework and documents for the drill, led the drill activities, and compiled the After Action Report.

- **National Protection Framework**

Karen Owens, Division Manager, Connie Green, Assistant Manager and Winnie Pennington, Emergency Planner, attended the National Protection Framework Webinar on August 26, 2014.

- **HAN Training**

Karen Owens, Division Manager, Frank Cheatham, HMERT Coordinator and Winnie Pennington, Emergency Planner, attended the HAN video conference update on September 18, 2014.

- **Education Coordinator Certification**

Connie Green, Assistant Manager, completed the required training to receive her Education Coordinator Certification in September.

- **Symposium**

Frank Cheatham, HMERT Coordinator, focused a large portion of his attention on the Symposium planning as part of his role as Logistics Section Chief. He participated in multiple meetings with other agencies as well as internal meetings to cover all aspects of logistics needs.

- **Vehicle Rescue Program**

The Division of Emergency Operations sponsored a Vehicle Rescue Class in Prospect, Va. September 13-14, 2014. The course, which was attended by 20 students, prepares first responders

Communications

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

PSAP Accreditation for City of Virginia Beach 911 was approved by the EMS Advisory Board on August 8, 2014.

- **Patrick County Presentation**

A presentation was given to the Patrick Co. 9-1-1 on August 20, 2014 on the deployment and implementation of emergency medical dispatch protocols. This was at the invite of Patrick Co. 9-1-1.

- **APCO/NENA/Interoperability Fall Conference**

Ken Crumpler, Communications Coordinator represented OEMS at the APCO/NENA/Interoperability Fall Conference in October.

Critical Incident Stress Management (CISM)

- **CISM Regional Council Reports**

During this reporting quarter Regional Council CISM teams reported 22 events, including education sessions, training classes, and debriefings (both group and one-on-one).

Planning and Regional Coordination

V. Planning and Regional Coordination

Regional EMS Councils

Regional EMS Councils

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

The EMS Systems Planner attended the Southwest Virginia EMS Council award program, and the board meetings of the Central Shenandoah, Peninsulas, and Tidewater councils during the quarter.

Medevac Program

The Medevac Committee is scheduled to meet on November 5, 2014. The minutes of the August 7, 2014 meeting are available on the OEMS website.

The Medevac Helicopter EMS application (formerly known as WeatherSafe continues to grow in the amount of data submitted. In terms of weather turndowns, there were 615 entries into the Helicopter EMS system in the third quarter of 2014. 70% of those entries (436 entries) were for interfacility transports, which is a slight increase from previous quarters. The total number of turndowns is an increase from 597 entries in the third quarter of 2013.

To date, there have been 1,680 total entries into the system in 2014, a decrease from 1,814 entries for the same timeframe in 2013. This data continues to show dedication to the program itself, but also to maintaining safety of medevac personnel and equipment. Additionally, the EMS Systems Planner has been working with the Helicopter EMS programmers to add pictures of landing zones of 60 hospitals across Virginia.

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

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

The EMS Systems Planner made a site visit to VCU LifeEvac during the quarter.

State EMS Plan

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

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

Public Information and Education

VI. Public Information and Education

Public Relations

Promotions

Via Constant Contact E-mail Listserv (July – September)

- **July 28** - 2014 Symposium Registration Now Open
- **July 29 –** E-Gift Announcement
- **August 8 –** Four-for-Life Return to Locality Funds
- **August 26 –** Symposium Registration Reminder
- **September 9 -** Virginia Fire and Rescue Conference
- **September 25** – Symposium Registration Reminder
- **September 30** – Final Symposium Registration email

Via Social Media Outlets

We continue to keep OEMS' Twitter and Facebook pages active, educational and relevant by posting daily and/or weekly updates that provide important announcements and health-related topics to increase awareness and promote the mission of OEMS and VDH. Also regained access to the OEMS YouTube site in March, and posted new training videos courtesy of the Division of Educational Development. Some of the subjects that were featured from July - September are as follows:

- **July –** Hurricane preparedness, office closures, food safety, fireworks safety, swim safety, 911 operators article, KKK-A822F Ambulance Specifications change order 6, criminal history checks and Virginia EMS Symposium registration opening.

- **August –** Guidelines for the Four-For-Life Return to Locality Funds, E-Gift Grant Webinar Training, WHO officially declares Ebola a public health emergency and rip currents/swim safety.

- **September –** National Preparedness Month, World Suicide Prevention Day, emerging infections update on Enterovirus D68, 9/11 remembrance, Public Safety Equity & Diversity Conference, RSAF grant cycle closes, Child Passenger Safety Week, Symposium registration reminder and CDC Health Advisory: Acute Neurological Illness with Limb Weakness of Unknown Cause in Children.

Customer Service Feedback Form (Ongoing)

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

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

Training

- In July, PR assistant attended training to become the OEMS' CommonHealth coordinator for the CommonHealth program. This new task requires regular updates supplied to OEMS staff with information (CommonHealth Wellnotes) regarding the program's benefits.

- In August, PR assistant presented PowerPoint presentation regarding Public Information and Education for an office orientation to new members of the State EMS Advisory Board.

- On September 16, PR coordinator and PR assistant participated in a Continuity of Operation Planning Exercise at the Office of EMS.

Social Media and Website Statistics

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

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

***As of October 20, 2014, the OEMS Facebook page had 3,976 likes, which is an increase of 208 new likes since July 24, 2014. As of October 20, 2014, the OEMS Twitter page had 2,888 followers, which is an increase of 150 followers since July 24, 2014.**

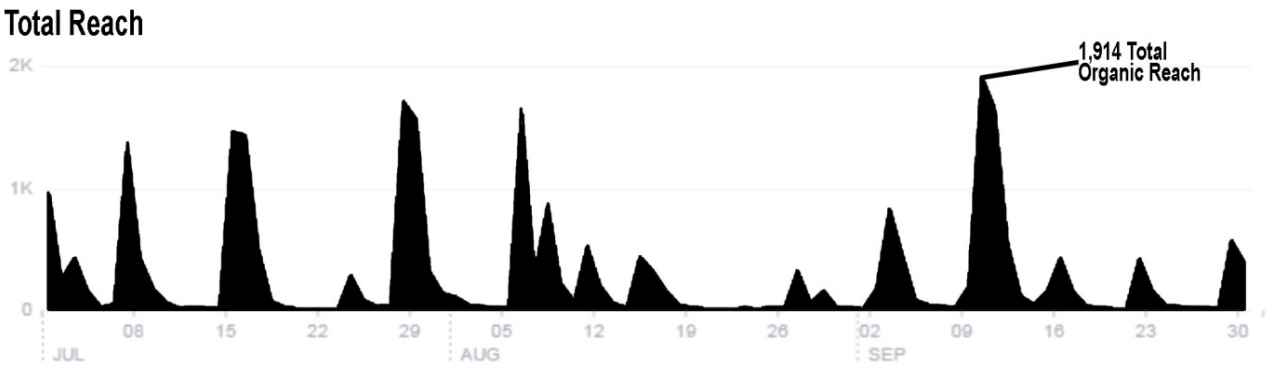


Figure 2: This table represents the top five downloaded items on the OEMS website from July – September.

July	1. 2014 Virginia EMS Symposium Catalog (79,849) 2. 2010 Symposium Presentation LMGT-732 (40,613) 3. EMSAT Centrelearn Instructions (14,623) 4. 2013 Symposium Presentation OPE-4003 (10,664) 5. 2013Symposium Presentation AIR-202 (8,583)
August	1. 2014 Virginia EMS Symposium Catalog (122,862) 2. 2010 Symposium Presentation LMGT-732.pdf (26,462) 3. EMSAT Centrelearn Instructions (17,940) 4. 2012 Symposium Presentation OPE-4006 (10,327) 5. 2010 Presentations CAR-205 (7,567)
September	1. 2014 Virginia EMS Symposium Catalog (58,344) 2. 2010 Symposium Presentation LMGT-732 (24,244) 3. EMSAT Centrelearn Instructions (14,035) 4. Training Course Enrollment – Student Guide (11,637) 5. 2012 EMS Regulations (6,401)

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

	Visitors	Average Hits Per Day	Average Visit Length (Minutes)
July	76,091	2,454	15:11
August	84,568	2,728	14:42
September	78,226	2,607	15:07

EMS Symposium

- PR coordinator finished final catalog and promo guide design. Posted catalog online in July, it was the top downloaded item on the OEMS website each month, July – September.

- PR assistant coordinated the mailing of the Symposium promo guide and catalog to EMS agencies and providers in the month of July.

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

- PR coordinator updated Symposium webpage general event info, sponsors, etc.

- PR coordinator began coordinating Symposium sponsors and event sponsors.

- PR coordinator began planning Flu Shot Clinic with Norfolk HD.

- PR coordinator promoted the Symposium through social media outlets.

- PR assistant sent promotional emails regarding symposium registration through the email listserv.

Governor's EMS Awards Program

- PR assistant completed and submitted press releases that covered the Regional EMS Award ceremonies in July - September. These press releases were posted on the VDH Regional Press Releases webpage.

- PR assistant prepared regional submissions for the Governor's EMS Awards nomination packets and mailed them out to committee members for review. Also organized the Governor's EMS Awards Nomination Committee meeting.

- August 22, PR coordinator and PR assistant provided assistance and support at the Governor's EMS Awards nomination committee meeting.

- PR assistant ordered Governor's EMS Award pyramids.

- PR coordinator submitted award winner's info to the Governor's Office for consideration. Submitted requests to the Governor's office for signed award certificates and an invite for the Governor to attend the ceremony.

- PR coordinator prepared decision memo request inviting the Governor to the annual awards ceremony.

Media Coverage

The PR coordinator was responsible for fielding the following OEMS media inquiries July - September:

- **July 1** – Received an inquiry from the Farmville Herald about compliance and accreditation data for Buckingham Co. Rescue Squad, Glenmore Vol. Rescue Squad and Arvonia Rescue Squad.

- **July 11** – Received an inquiry from the News & Advance about the Governor's EMS Advisory Board, and if they received stipends, salary or financial benefit.

- **July 28 –** Received an inquiry from the Daily Progress regarding EMS agencies that bill for services.

- **August 11**- Received an inquiry from the Bloomberg Press for a request for Trauma Center Variances, Jan. 2012 to date and Trauma Committee Minutes.

- **August 13** - Received an inquiry from The Roanoke Times regarding reporting requirements that measure compliance with emergency/ambulance response times.

- **August 15 –** Received an inquiry from Scripps' Washington Bureau regarding Trauma Center funding, site team reviews and correction plans.

- **August 15** – Received inquiry from the Bristol Herald Carrier regarding County EMS officials discussing refining emergency response plan.

- **September 19** – Received inquiry from the Daily Press regarding Va. Trauma Centers' designation, specialist requirements, minimum requirements for an emergency room, transportation between different facilities, Trauma Center Fund, the use of helicopter, the different levels of heart attack/stroke care and surgeon qualifications.

- **September 23 –** Received a follow-up inquiry from the Daily Press regarding the State Trauma Registry.

VDH Communications

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

- **July** – Responsible for the VDH in the News task for the month of July. Collected news stories that mentioned VDH personnel or programs and emailed them to key staff every morning.

- **August** – Responsible for coordinating and editing stories for the weekly commissioner's email during the month of August.

    - **August 29 –** The PR coordinator participated in a two-day RFP review panel for Adult Immunization. Reviewed contracts and supplied grades and feedback for each. On the second day, provided feedback for negation points review.

- **September** – Responsible for Team Editor task during the month of September, which involved editing various press releases, the Commissioner's Weekly email and other documents for the PR team.

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

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

September 2 - OEMS Launches New Symposium Program
After nine months of planning and programming, the Office of EMS (OEMS) launched its new Virginia EMS Symposium registration program July 28. This comprehensive project consists of four main modules: a presentations system that allows instructors to submit class proposals; a symposium program database that includes course track assignments, committee review, selection and scheduling; contract modules; and symposium registration. This program also moved from a Lotus Notes system to an entirely Web-based format, eliminating numerous manual processes and providing one integrated product to manage all activities related to the annual symposium. Since launching, more than 900 people have successfully registered for this year's symposium. The project would not have been possible without the hard work, dedication and collaboration of the Office of Information Management and OEMS: **Debbie Condrey**, chief information officer, **Diana Malik**, software development manager, **Dheeraj Katangur**, technical project manager, **Manoj Madhavan**, technical lead, **Monika Tolliver**, business analyst/user liaison, **Sarada Das**, oracle developer, **Sreevidya Tekula**, oracle developer, **Gary Brown**, OEMS director, **Scott Winston**, assistant director, **Warren Short**, training manager, **Irene Hamilton**, senior executive secretary, **Marian Hunter**, public relations coordinator, and **Tristen Graves**, public relations assistant.

Regulation and Compliance

VII. Regulation and Compliance

Agency/Provider Compliance

The EMS Program Representatives continue to complete ongoing investigations pertaining to EMS agencies and providers. These investigations relate to issues concerning failure to submit prehospital patient care data and/or quality (VPHIB), violation of EMS vehicle equipment and supply requirements, failure to secure drugs and drug kits, failure to meet minimum staffing requirements for EMS vehicles and individuals with criminal convictions. The following is a summary of the Division's activities for 2014:

Compliance

Enforcement	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	YTD
Citations	**12**	**20**	**6**		**38**
Agency	5	12	3		20
Provider	7	8	3		18
Verbal Warning		**14**	**7**		**21**
Agency		5	6		11
Provider		9	1		10
Correction Order		**46**	**13**		**59**
Agency		46	13		59
Provider		0	0		0
Temp. Suspension	**8**	**8**	**4**		**20**
Agency		0	0		

Provider		8	4		
Suspension	**5**	**3**	**0**		**8**
Agency		0	0		
Provider		3	0		
Revocation	**1**	**3**	**1**		**5**
Agency		0	0		
Provider		1	1		
Compliance Cases	**30**	**109**	**48**		**187**
Opened	14	87	30		131
Closed	16	22	18		56
Drug Diversions	**4**	**10**	**4**		**18**
Variances	**6**	**5**	**8**		**19**
Approved	3	4	5		12

Hearings

July 8, 2014 – Hollowell

July 8, 2014 – Hitt

July 22, 2104 – Salyer

July 31, 2014 – Perry

Sept. 30, 2014 – Biondi

Licensure

Licensure	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	YTD
Agency	680	674	673		
New	3	1	4		8
Vehicles	4,400	4,455	4,439		
Inspection					
Agency	72	85	68		225
Vehicles	701	463	712		1,876
Spot	127	120	106		353

Background Unit

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

Background Checks		1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	YTD
Processed			248	1,387		2,440
Eligible			243	1,132		1,375
Non-Eligible			4	11		15
Outstanding			1	240		

We are excited to welcome Mrs. Regina Garcia to the Division effective October 15, 2014. Her responsibilities will focus on the processing of all background checks received by the Office. She can be reached by her email account, regina.garcia@vdh.virginia.gov or contacting the Office main number.

Regulatory

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

- The Fast Track Regulatory Packet for changes to the Financial Assistance to EMS agencies (FARC) is within the regulatory process and currently is at the Office of the Attorney General for their review and actions (http://townhall.virginia.gov/L/viewstage.cfm?stageid=6969)
- The Fast Track Regulatory Packet for changes to "eliminate the required signature of the medical care practioner on patient care report" has been published by the State Registrar for final public comment with expected implementation on November 6, 2014. (http://townhall.virginia.gov/L/viewstage.cfm?stageid=6819).
- A Fast Track regulatory package to include the terminology of "affiliation" in the language of 12VAC-5-31-910 is within the regulatory process and currently is at the Office of the Attorney General for their review and actions (http://townhall.virginia.gov/L/viewstage.cfm?stageid=7067)

EMS Physician Endorsement

Endorsed EMS Physicians: As of October 18, 2014: 213

Staff is working with the state Medical Director to coordinate and schedule the next series of "Currents" sessions beginning with the upcoming EMS Symposium November 6, 2014. The PEMS/TEMS combined OMD meeting will be December 11, 2015. The Medical Direction Committee has formed a workgroup to review the re-endorsement process to explore the expansion of acceptable course programs to meet the intent of the re-endorsement process in light of several EMS Physicians whose endorsement have expired. Any changes will need to be submitted as part of a regulatory packet.

Additional Division Work Activity

The Regulation and Compliance staff held their quarterly staff meeting on September 2-4, 2014.

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

August 14, 2014 – Washington County Board of Supervisors

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

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

CAAS GVS 2015:

July 14-15, 2014

August 11, 2014

NFPA 1917

August 26-27, 2014

Additional Personnel Matters

Mr. Adam Harrell has accepted a position within the Division of Educational Development and as such the Northern Virginia Program Representative position is in the active interview process. Ms. S. Heather Phillips will be assuming the service area in addition to her service area until a candidate can be selected for the position. Interviews are scheduled for October 19, 2014.

Mr. Romney Smith has submitted his resignation effective October 31, 2014. The Office received approval to recruit for the position and in this process with a close date of October 22, 2014. Current field staff will work with Ms. Philips to provide coverage until such time we can secure a successful candidate for the service area held by Mr. Smith. We wish Mr. Smith success in his future endeavors!

Technical Assistance

VIII. Technical Assistance

EMS Workforce Development Committee

The EMS Workforce Development Committee last met on August 7, 2014. The committee's primary goal is to complete the EMS Officer and Standards of Excellence (SoE) programs.

EMS Officer Sub-Committee

The EMS Officer Sub-committee has met several times since the last State EMS Advisory Board meeting. The sub-committee has been working on developing an EMS Officer I course similar to the Fire Officer I course material in the Jones and Bartlett Fire Officer Principles and Practice (Third Edition). This course will require the student to do reading, home work assignments and projects prior to each class. The course will involve approximately 24 hours of actual class time and an equivalent amount of time working on assignments and projects.

Once completed, training materials, reading assignments, homework and projects for the EMS Officer I class will be available on TrainVA. All EMS Officer course content will be stored on the Cloud – and be iOS and Android compatible.

The EMS Officer I course is a blended learning experience and delivered in a "flipped classroom" format. The key principles and educational objectives from reading assignments and homework assignments will be reinforced during classroom meeting s.

Topics covered in the EMS Officer I course include –

Communications , Safety and Risk Management, Understanding People – Management Concepts, Teaching and Coaching, Evaluation and Discipline, Working in the Community, Handling Problems, Conflicts and Mistakes, Pre-Incident Planning, Budgeting, Managing incidents, Crew Resource Management and Leading Change.

The EMS Officer I program will be ready in early 2015.

Candidate Pre-Requisites –

- Current Virginia EMT certification
- Minimum of 2 years field experience
- Basic computer skills

- High School diploma or GED
- MCI modules I and III
- IS 100, 200, 700
- No EMS corrective action against the candidate within 5 years

Standards of Excellence (SoE) Sub-Committee

The Standards of Excellence Assessment program uses a document that details optimal tasks, procedures and guidelines that are necessary to maintain the business of managing a successful EMS agency. The voluntary self-evaluation process for EMS agencies in Virginia is based on eight Areas of Excellence – or core measures of successful EMS agencies.

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

SoE Areas of Excellence

- General Information including EMS Agency Viability
- Leadership and Management
- Recruitment and Retention
- EMS Operational Readiness
- Life Safety
- Medical Direction
- Clinical Care Measures/Standards
- Community Involvement
- Emergency Medical Dispatch

Once the agency has completed their self-review they will be able to identify areas of strength and weakness - in each of the above listed areas, as well as an overall tally. EMS agency representatives will have the option of choosing two (2) different paths after completing their review:

1: An EMS agency demonstrating a weakness in a particular area, can request individual assistance. Assistance will be provided to address the specific weakness. This assistance will be provided by subject matter experts. These experts may share sample forms and/or documents, articles and other items to assist the agency in a non-threatening way.

2: EMS Agencies that have demonstrated competency in all eight of the SoE assessment areas - may submit their completed assessment forms to the Office of EMS to be considered for the Virginia EMS Standards of Excellence Recognition.

Once the completed EMS agency assessment document is submitted the agency will be contacted for a site review. Documents and other items attested to in the completed SoE assessment document will be reviewed during the EMS agency site review.

Once the site review team has completed their work and the agency information has been confirmed – the agency will be considered for the Standards of Excellence Assessment Certificate. EMS agencies reaching this level will receive special recognition at the annual EMS Symposium.

Virginia Recruitment and Retention Network

Unfortunately, the Virginia Recruitment and Retention Network has not met since February 2014. The next meeting will be held at EMS Symposium on Thursday – November 6, 2014 at 6:00 PM. A presentation will be made on using the Standards o Excellence (SoE) program to improve EMS Recruitment and Retention.

Trauma and Critical Care

IX. Trauma and Critical Care

Division of Trauma/Critical Care Staffing

We are very pleased to announce that the Division of Trauma/Critical Care (Div. TCC) has secured an additional FTE. This new position will serve as the Trauma Critical/Care Coordinator (TCCC) and assume responsibilities for managing the states trauma system. The TCCC will staff the Trauma System Oversight and Management Committee (TSO&MC) and manage the trauma designation program, trauma triage, and Trauma Center Fund. The TCCC will also represent the OEMS with other time-sensitive illness programs including stroke and STEMI.

Ms. Robin Pearce, RN, MSN, Trauma/Critical Care Coordinator began in this new position on October 25th. Robin comes with a strong clinical and nursing leadership background. Her nursing experience includes clinical practice and leadership in areas of nursing such as emergency nursing at both VCU/MCV and Inova Fairfax Hospital, pediatric intensive care, interventional radiology, oncology nursing, and patient access support.

Ms. Pearce's nursing leadership includes a wide variety of experience including professional development, clinical practice development, quality assurance, staff education, and more.

Adding this new position will decompress the current division manager and allow existing programs to be further developed and interact with other agency and state programs.

Trauma System

Trauma System Oversight and Management Committee (TSO&MC)

The most recent TSO&MC meeting was held on September 4, 2014. The final agenda and draft minutes to the meeting can be found on-line on the Virginia Regulatory Town Hall. The key agenda items were to finalize the voting composition of the committee and approving the draft 2015 Trauma Center Designation Manual.

It was determined at the June 2011 TSO&MC meeting to begin to perform a full review and revision of the Trauma Center Designation Manual. The work product of this effort was approved during the September 2014 TSO&MC and is being presented to the November 2014 EMS Advisory Board for approval. The motion form **Appexdix F** and draft 2015 Trauma Center Designation Manual can be found in **Appexdix G.**

Five subcommittees were established to review and make recommended changes to the Manual. The five areas of focus included operational, education/credentialing, performance improvement,

special needs, and administrative. After this process began additional emphasis was placed on pediatric trauma criteria and the ability for a stand-alone pediatric hospital to become a designated trauma center.

Several additional pediatric focused meetings were held with additional stakeholders from the pediatric community. The EMS for Children Committee also reviewed and provided input towards the draft Manual being presented. Based on the additional stakeholder input and comments submitted by the EMS for Children committee, pediatric designation was made to mimic level I designation.

There are still a few positions to be filled, but below is the TSO&MC composition as of 10/18/2014:

1. Dr. Ajai Malhotra – Lead until a Chair is appointed
2. Dr. Forest Calland - Level I
3. Dr. T.J. Novosel - Level I
4. Dr. Margaret Griffen - Level I
5. Ms. Andi Wright – Level I/TPM
6. Dr. Michael Feldman - Level I/Burn
7. Ms. Lou Ann Miller - Level II
8. Ms. Melissa Hall - Level II
9. Dr. Raymond Makhoul - Level III
10. Mr. Emory Altizer - Level III
11. Dr. Luis Eljaiek – Non-trauma Designated Hospital
12. Pending Trauma Survivor/Consumer
13. Vacant as of 10/13/2014 - Emergency Physician
14. Pending - EMS Provider (non-specific affiliation)
15. Dr. Safford - Pediatric Surgeon

State Trauma System Assessment

Div. TCC staff continues to work towards arranging an American College of Surgeons State Trauma System Consultative Visit. OEMS is awaiting approval to enter into a sole source contract from the Department of General Services. Approvals internal to VDH have been secured. Our goal is to have the consultative process begin in early 2015.

Through the TSEPC of the Committee on Trauma (COT), the American College of Surgeons (ACS) assesses and evaluates trauma systems and provides consultative guidance for future trauma system development.

Using the public health approach, the TSEPC offers expertise in the areas of regionalization of care, health care system development, and disaster preparedness through system enhancement. The ACS TSEPC has been conducting trauma system consultations for nearly 20 years.

Since the definitive care for trauma is often surgery, many trauma system leaders in any jurisdiction tend to be surgeons. The engagement of the ACS in the consultative process provides a level of expertise and credibility that can engage this important audience in dialogue that extends beyond their own operating rooms or trauma centers. Having completed more than 35 statewide and regional trauma system consultations, the ACS has the benefit of promoting promising practices from visits in other states of similar geography, demography, and health care resources.

The ACS is the only entity that has a structured statewide trauma system consultation process that can, through the selection of a multidisciplinary team with focused expertise, be tailored to meet the specific needs of a state regardless of the current status of the trauma system or health care assets. Areas of expertise include the following: Injury Epidemiology, Statutory Authority and Administrative Rules, System Leadership, Coalition Building and Community Support, Lead Agency and Human Resources within the Lead Agency, Trauma System Plan, System Integration, Financing, Prevention and Outreach, Emergency Medical Services, Definitive Care Facilities, System Coordination and Patient Flow, Rehabilitation, Disaster Preparedness, System wide Evaluation and Quality Assurance, Trauma Management Information Systems, and Research. The ACS trauma system consultation process has been promoted by governmental agencies, such as HRSA, and is specifically noted in the Institute of Medicine's Future of Emergency Care in the U.S. Health System series.

Trauma Center Fund

Figure 1 shows the Trauma Center Fund distributions since the last reporting period. Since the beginning in late 2006 OEMS has distributed over $74 million from the trauma fund to designated trauma centers.

Figure 1 Recent Trauma Center Fund disbursement

Trauma Center & Level	Percent Distribution	Previous Quarterly Distribution	June 2014	Total Funds Received Since FY06
I				
Roanoke Memorial Hospital	14.26%	$303,330.03	$550,209.89	$9,717,710.67
Inova Fairfax Hospital	17.89%	$374,723.59	$679,710.57	$14,829,087.03
Norfolk General Hospital	9.31%	$205,975.17	$373,618.05	$9,087,421.51
UVA Health System	13.13%	$281,105.59	$509,897.01	$10,159,334.72
VCU Health Systems	27.66%	$566,876.52	$1,028,256.48	$17,697,775.22
II				
Lynchburg General Hospital	1.88%	$59,844.54	$108,551.92	$1,901,908.95
Mary Washington Hospital	4.38%	$109,013.66	$197,739.72	$1,642,499.39
Riverside Regional Medical Ctr.	3.32%	$88,165.95	$159,924.09	$2,240,597.37
Winchester Medical Ctr.	4.09%	$103,310.04	$187,393.93	$2,856,047.82
III				
New River Valley Medical Ctr.	0.40%	$30,736.42	$55,752.74	$325,184.12
CJW Medical Ctr.	0.95%	$41,553.63	$75,374.06	$835,923.57
Montgomery Regional Hospital	0.17%	$26,212.86	$47,547.47	$320,445.87
Southside Regional Medical Ctr.	0.62%	$35,063.30	$63,601.27	$496,808.27
Virginia Beach Gen'l Hospital	1.94%	$61,024.60	$110,692.43	$2,384,716.07
Total		$2,286,935.90	$4,148,269.63	$74,495,460.58

Trauma Performance Improvement Committee (TPIC)

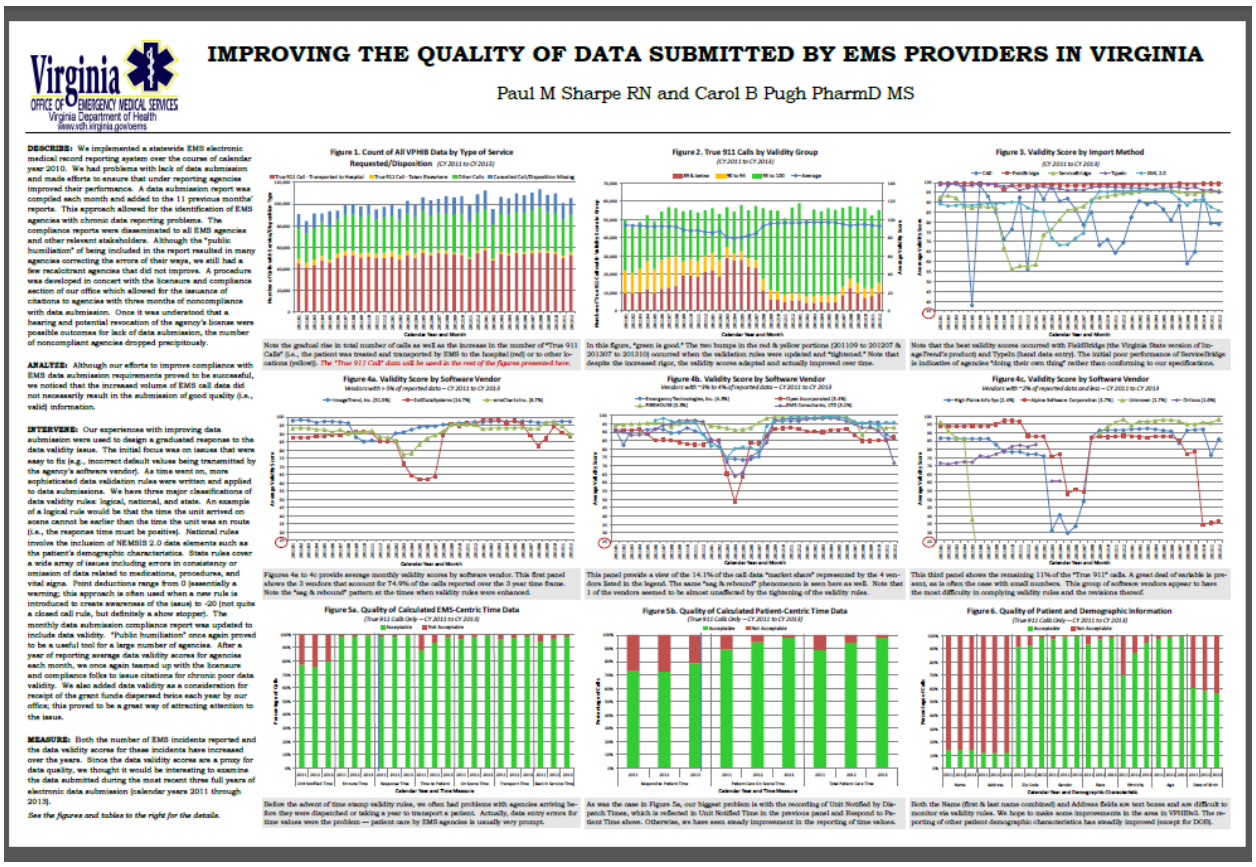
The trauma PI committee met on September 4, 2014 and continues to work toward providing state regional, and agency level reporting of potential missed-triages of trauma patients. Inter-facility transfer of trauma patients is also being developed. Step 1 of the Statewide Trauma Triage Plan, which are physiologically based, is being used to identify patients that should be transferred to designated trauma centers.

Patient Care Information System

Patient Care Information System (VPHIB & VSTR)

The Div. of TCC is pleased to share that it won 3rd place in a national poster competition at the recent National Association of State EMS Officials (NASEMSO) Annual Meeting. To review the poster, please go to http://oemssupport.kayako.com/Knowledgebase/List/Index/48/data-in-use or click on the figure below and open the PDF version.

Figure 2 Improving the quality of data submitted by EMS providers in Virginia poster



The Div. of TCC also received an honorable mention for its poster titled *Comparison of CDC Step 1 Field Trauma Triage Criteria and Patient Destination* recent National Association of State EMS Officials (NASEMSO) poster competition. To review the poster, please go to http://oemssupport.kayako.com/Knowledgebase/List/Index/48/data-in-use and open the PDF version.

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

"Don't Say You Didn't Know"

During the October 8th VAv3 Open Forum Div. of TCC staff unveiled the State's new electronic EMS medical record (EMR). The new EMR is designed to follow the phases of an EMS incident that have been discussed during the VAv3 forums and shown in last quarter's report. The phases being used are *Response, Patient Encounter, and Transport*. These phases (Figures 3,4, and 5) were developed to help segment the minimally required elements that must be reported based on each phase and help agencies transition from reporting on each response unit to reporting each EMS incident.

Figure 3 Response phase of the VA version 3 EMR

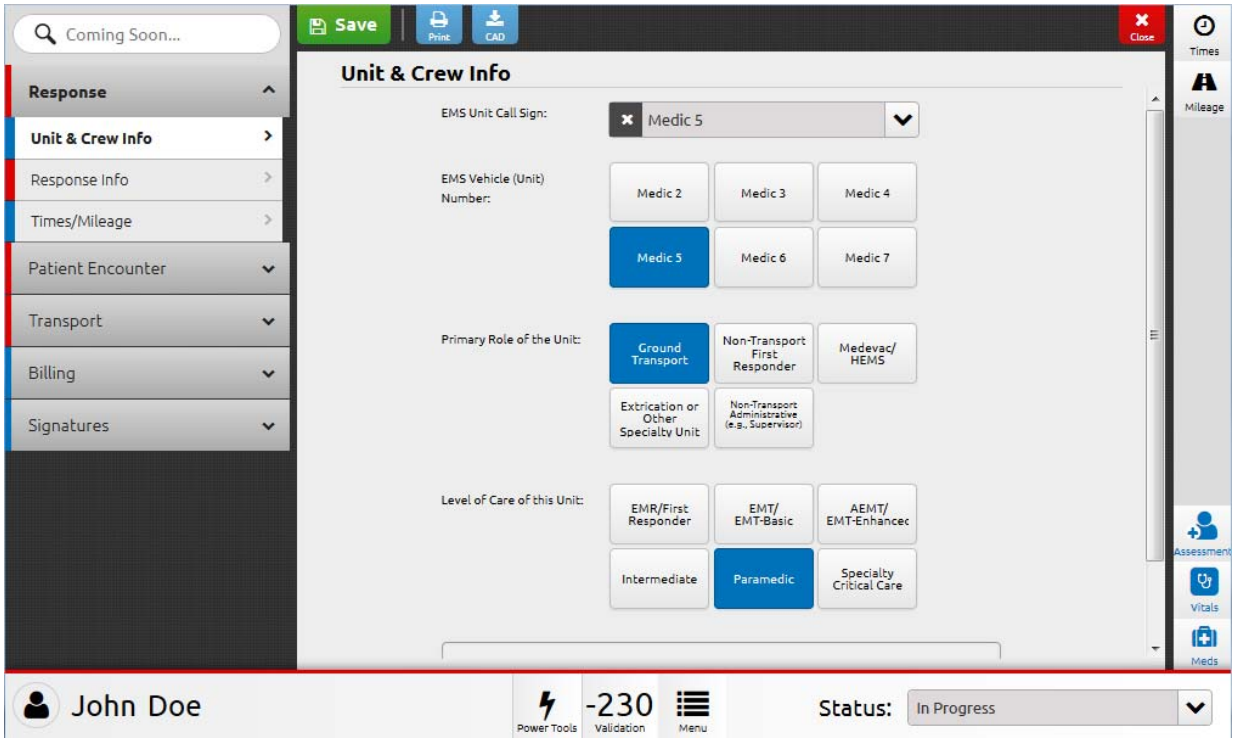


Figure 4 Patient Encounter phase of the VA version 3 EMR

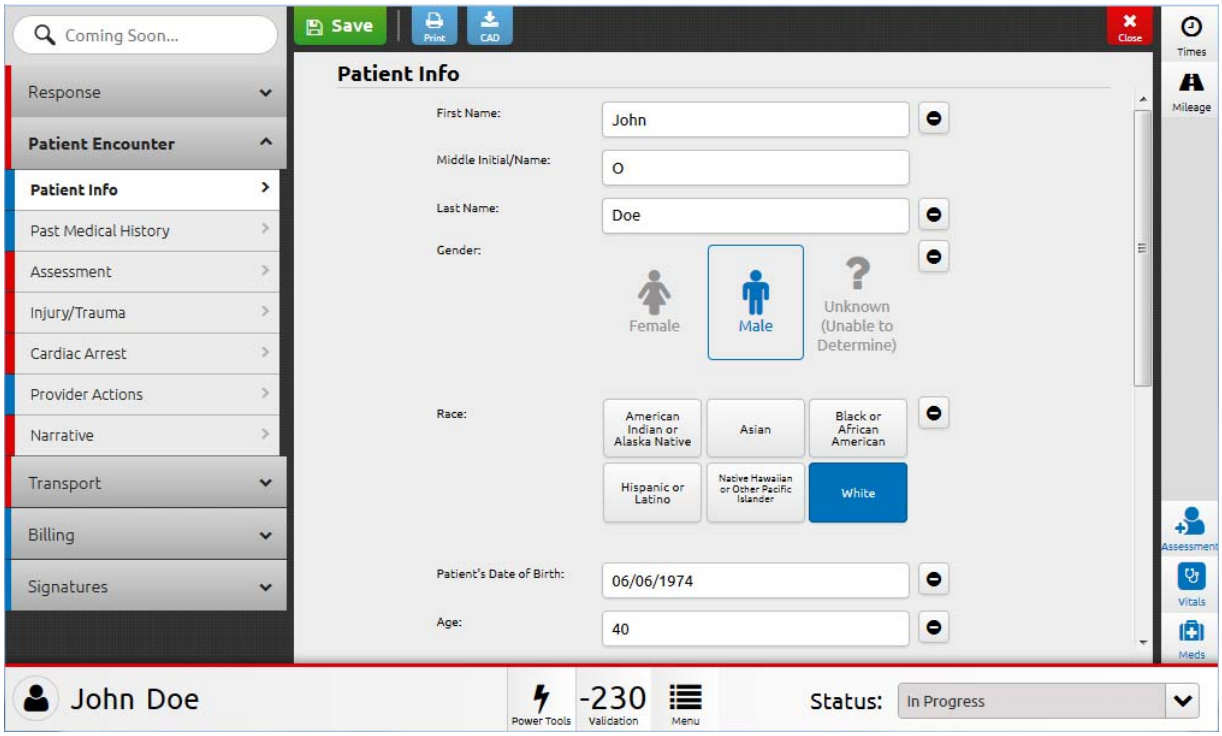
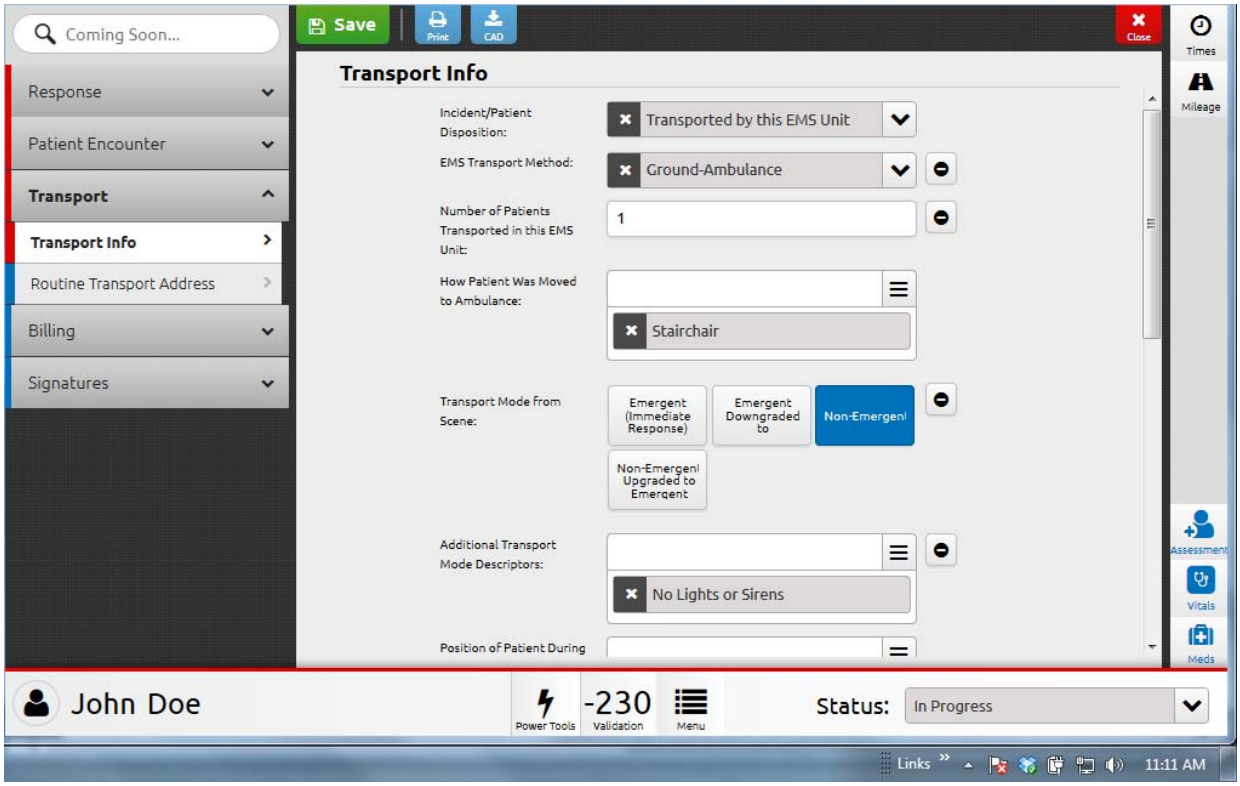


Figure 4 Patient Encounter phase of the VA version 3 EMR



Version 3 training has begun. EMS agencies that have opted to serve as "beta agencies" met at the OEMS on Monday, October 20th to receive training and orientation on using the new VPHIB system. These agencies will begin setting up their individual EMS agencies in the system and begin entering live patient information the week after symposium.

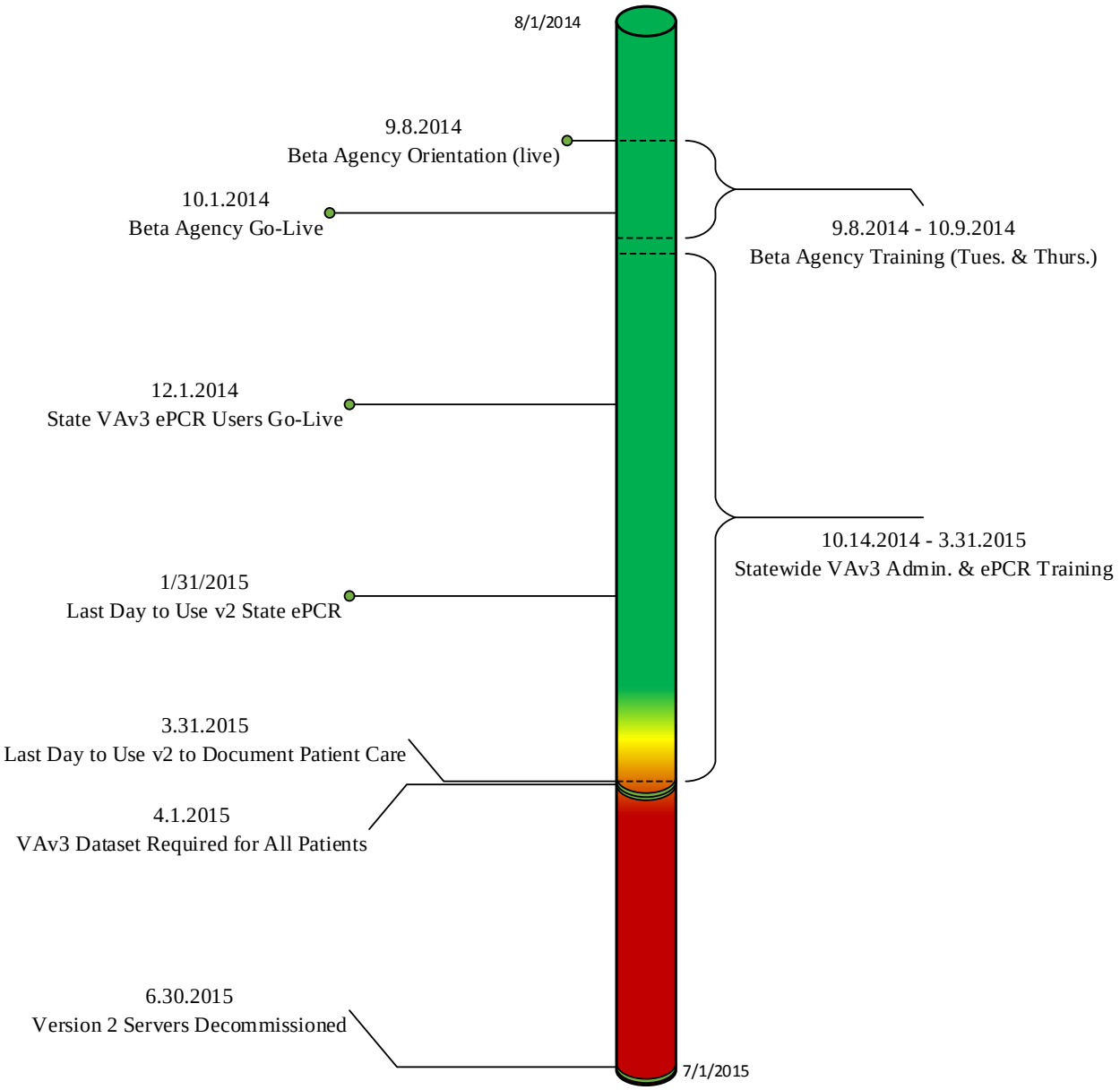
An OEMS/ImageTrend Summit will be held at the EMS Symposium site on the two days immediately before the symposium. This summit is by invitation only for agencies that own their own ImageTrend license. The purpose of holding a joint summit is to help assist agencies with setting up their new ImageTrend products in synergy with the state program in hopes to avoid technical and quality issues that can arise when state submission is a secondary phase of implementation.

OEMS has made similar offers to other vendors that serve Virginia. Zoll and Sansio have made it known that they plan to first implement their products in Virginia. We look forward to working with them as we all move to the new EMS data standard.

Div. of TCC staffs will also hold demonstration classes throughout the EMS symposium so attendees can "drop in" to these sessions as their schedules allow.

Ongoing training will be held via webinars and eventually training "videos" will also be available so agencies and providers can obtain training on a schedule that is most convenient for them.

Figure 5 Revised VAv3 Implementation Deadline



Schematron File Use in VAv3: Schematron is a rule-based validation language expressed in XML. NEMSIS introduced the use of Schematron for version 3 by requiring that each vendor being certified demonstrate their ability to utilize Schematron to perform validation checks prior to any electronic transfer of data i.e. from agency to state, agency to billing company, state to NEMSIS etc. Schematron has been a contentious issue on the national level during this quarter.

Validating EMS records using Schematron has some challenges. NEMSIS only requires that software vendors have the capability of "absorbing" a Schematron file and use of the national Schematron file. NEMSIS does not require that vendors generate a file. With NEMSIS stopping the standard at this point it leaves states and potentially EMS agencies with the responsibility to dedicate additional resources to develop and maintain Schematron files.

Additional challenges with Schematron are that this technology does not work at the provider level. Most software provides some level of instant feedback as a provider enter information into an EMR. Schematron can only be run once a record is saved and NEMSIS only requires its use when a record or file is electronically transmitted i.e. from agency to the state. It also has other limitations in its functionality that many, if not most states, know that it will only be able to provide 75% - 90% of validations needed.

The important point for Virginia agencies to understand is that the OEMS will not utilize Schematron as its validation tool. Virginia will provide a Schematron file with a goal timeline of 2/1/2015. Utilizing a "state Schematron file" is being done for the convenience of third party vendors and we will note in our list of validation rules which ones are included in our state Schematron file and which ones are not. Many of our quality rules (approximately 20%) will not be in our Schematron file and that does not make them optional. Agencies will need to work with their EMS software vendor or internally to mange how they will meet Virginia's quality rules that are not included in the state Schematron file. Agencies should be aware of claims the Schematron files will manage all of their data quality needs,

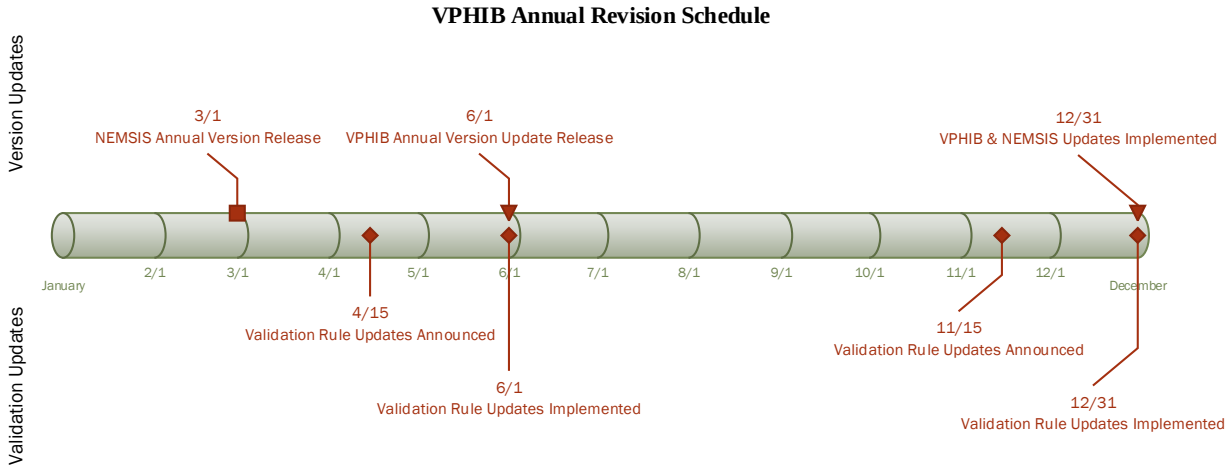
Likewise, Virginia EMS agencies are not required to utilize Schematron files if not desired, your software vendors do not use this technology, or opt not to use it.

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

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

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

Figure 6 VAv3 Revision Schedule



Virginia Statewide Trauma Registry (VSTR)

The new VSTR application went live at the New Year. All non-trauma designated hospitals have been submitting to the new trauma registry since January. Designated trauma centers, which all use third party trauma registry software to submit, were required to upload by July 1st. It appears most, if not all, trauma centers have uploaded.

Div. TCC staffs are behind in implementing a similar data quality program with the VSTR as it does with VPHIB. The delay is due to extending the implementation period at the request of hospitals that use third party software. This extension caused an overlap with the VAv3 implementation.

From the OEMS Informatics Coordinator

Virginia Statewide Trauma Registry (VSTR)

- Developed an "enhanced" dataset for the 2011-2013 data from VSTR v2. The data have been used for several projects, one of which is outlined below.
- Provided summary data for two trauma centers, as the legacy data for VSTR v2 was not yet available for use with the reporting tool in VSTR v3.

TSOM Performance Improvement (PI) Committee

- Conferred with TPIC Committee members by email and phone while working on the report described below.
- The PI Committee's quarterly meeting was held in September. A rough draft of the materials to be used in a report for the Commissioner were presented and discussed.

Virginia Pre Hospital Information Bridge (VPHIB)

- Developed an "enhanced" dataset for the 2013 data from VPHIB. The data have been used for several projects, one of which is described above.

EMS Councils Performance Improvement (PI)

- Continued to assist PI staff members with data analysis and reporting issues. Trained the new CSEMS PI staff person on how to use Report Writer 2.

VDH Data Warehouse (DW)

- This project involving the integration of the VPHIB data into the VDH DW appears to be on hiatus at the moment.

Data Requests

- Provided EMS agency location, staffing, and vehicle information for the VDH Office of Minority Health and Health Disparities to use in developing web based resources for rural health providers and stakeholders.
- Robert Davis from Virginia Beach EMS asked for average and 90th percentile EMS response time reported by South East Regional (Chesapeake, Norfolk, Portsmouth, Suffolk, Hampton, Newport News, and Virginia Beach) EMS providers during calendar years 2012 and 2013.
- Sherri Bee from Halifax Regional Hospital asked for information on the number of rescue squad transports to their ED from each rescue agency in their primary and secondary service area (Halifax County, Mecklenburg County, and Charlotte County) and the number of patients transported to other EDs. I provided counts of destinations and reasons for choosing the destination for January 2013 through June 2014. The names of other hospitals were blinded, as were the names of agencies transporting patients to facilities other than Halifax Regional Hospital.
- Worked with the Virginia Department of Criminal Justice Services as they prepared for the Attorney General's summit on heroin and prescription drug abuse. It turns out that our data could not provide what the organizers needed, but I was able to offer some advice on other sources of information.
- Provided monthly tallies for mileage and the number of calls for 3 specific units for Matt Tatum of Henry County Department of Public Safety for November 2010 through present day.

Other Activities

- Continued to assist with the training of our two new staff members – Karen Rice started on April 25th and Bryan Hodges started on May 27th.
- Wrote two abstracts and created the corresponding posters for the NASEMSO (National Association of State Emergency Management Services Officials) annual meeting in Cincinnati.
    - *Improving the Quality of Data Submitted by EMS Providers in Virginia* won third place
    - *Comparison of CDC Step 1 Field Trauma Triage Criteria and Patient Destination using EMS and Trauma Registry Data* was awarded an honorable mention

Virginia Stroke Systems Task Force

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

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

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

Division of Trauma/Critical Care on the National Scene

Pediatric Emergency Care Council (NASEMSO's PECC)

Please see the EMS for Children section of this report for detailed information about the PECC meeting at NASEMSO's Annual Meeting held recently. For this section we wish to acknowledge the contribution that David Edwards has made to the PECC. David has served as the Chair person for the PECC for the past two years and his term ended at the end of the Annual Meeting.

David was elected by his state peers to serve as Chair of the PECC because of his abilities and leadership. David will remain part of the PECC steering committee as the "immediate past chair." The extra work leading a national committee was greatly appreciated by his peers.

Data Managers Council (NASEMSO's DMC)

The Data Managers Council (DMC) had a face to face meeting at the NASEMSO Annual Meeting in Cleveland, Ohio. With 41 states in attendance a variety of hot topics primarily related to the national implementation of version 3 and educational presentation were covered. Items covered were the challenges being faced by states implementing version 3, updates from our federal partners such as NHTSA and NEMSIS, presentations of EMS performance measures, and work session with the NEMSIS technical assistance center (TAC).

The NEMSIS TAC also moved its annual meeting to the NASEMSO Annual Meeting in an effort to increase state participation. This year's NEMSIS meeting, Progression of the V3 Data Standard" was attended by 29 states compared to approximately six in the past. This meeting historically was the NEMSIS software developers meeting. The meeting was also well attended by EMS software vendors and most, but not all, of the vendors prevalent in Virginia were in attendance.

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

The DMC will also being forming a new workgroup focused on developing data output and data linkages. This group will explore developing standard reports and EMS performance measures to create resources for states to develop meaningful use of version 3 data.

The DMC membership as provide a liaison to national committees in areas such as helicopter EMS, community paramedicine, NEMSAC, and a data integration workgroup. DMC members

regularly attend NEMSIS lead meetings such as the EMS software developers' bi-weekly meeting, CAD integration workgroup, and medical device integration workgroup.

State Trauma Managers Council

Div. of TCC staff is also a member of NASEMSO's State Trauma Managers Council. Since the current FTE serves as both the Virginia data manager and the state trauma manager our participation with the trauma managers is currently less active that the DMC. Important topics were covered by the Trauma Managers Council including the roll-out of the new ACS trauma designation criteria, development of a crosswalk between the current/old criteria and the new, and efforts towards developing a joint statement on the development of trauma designation certificate of public needs processes for trauma.

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

NEMSIS Steering Committee

As Chair of the DMC, Div. TCC staff also holds one of eight positions on the NEMSIS Steering Committee. The NEMSIS steering committee has met once during this quarter to review proposed changes to the NEMSIS version 3 EMS data standard collected during public comment. Any of the proposed changes that are accepted by NEMSIS will be announced around March 1, 2015 and be required to be implemented by January 1, 2016.

Proposed changes to the national EMS data standard can be found on-line at http://www.nemsis.org/support/nemsisUserGroups.html

Other OEMS staffs are currently serving in key rolls or involved with projects at NASEMSO. For additional information see the Executive Management section of this report.

Emergency Medical Services for Children (EMSC)

EMS for Children Committee under New Leadership (Performance Measure [PM] 79)**:** The EMS for Children (EMSC) Committee met October 16 under the leadership of newly appointed Chair Dr. Samuel Bartle. The Committee took time to voice its appreciation for the past strong leadership of Dr. Robin Foster.

Dr. Bartle discussed his vision of the direction he wished for the Committee to take during his tenure, and challenged all participants to work collaboratively on behalf of children in Virginia. Current representation on the EMSC Committee is being evaluated and representatives will be re-confirmed if necessary or replaced going forward. The EMSC Committee, in addition to advising the EMS Advisory Board on pediatric matters provides advice to the Virginia EMS for Children program located within the Office of Emergency Medical Services.

A primary focus of the meeting was a thorough review of the nature of the Virginia EMSC program, including a review of goals and objectives stated within the current EMSC State Partnership Grant, and an evaluation of progress toward achieving the existing national EMSC Performance Measures. Based upon this review and discussion, members in attendance helped prioritize Virginia EMSC efforts moving forward through the rest of this grant period.

Members were encouraged to send their individual reports to the Committee membership in advance of scheduled meetings to allow for better discussion. Member reports for this meeting were discussed, assignments made, and the Committee confirmed that it next plans to meet on January 8, 2014 at 3:00 pm in the Office of EMS conference room at 1041 Technology Park Drive, Glen Allen, VA 23059.

Pediatric Track for 2014 EMS Symposium (PM 78)**:** The Virginia EMS for Children program is using federal EMSC grant resources received from the Health Services and Resources Administration (HRSA) to support pediatric training opportunities in Virginia. This EMSC is providing a *dedicated pediatric track* at the 2014 EMS Symposium. Please take the time to review the choices available for those working to improve their knowledge and skills related to the emergency care of children.

Child Immobilization Devices (PM 73)**:** The EMSC program is also utilizing HRSA funding to purchase a limited number of infant/pediatric immobilization devices for distribution to volunteer EMS agencies. Though procurement of these devices had been delayed, they will be purchased soon and will be distributed to the agencies that have already had contact with the EMSC program and agreed to accept them. Additional pediatric immobilization devices will be

purchased this fall, and a request for interested agencies will be circulated to develop a list for this purchase.

Volunteer EMS agency leaders who already know that they wish to have their agency be considered when the EMSC program procures more of these devices should contact David Edwards at the Office of EMS by email (david.edwards@vdh.virginia.gov) or phone (804-888-9144). If more requests are received than devices available, a drawing will determine which agencies will receive them.

On-Site Pediatric Training (PM 78,80)**:** EMS agencies interested in on-site pediatric training should contact David Edwards at 804-888-9144 (david.edwards@vdh.virginia.gov) or Dr. Robin Foster (rlfoster@hsc.vcu.edu). The Virginia EMSC program facilitates access to pediatric education and training, especially in the form of EPC (*Emergency Pediatric Care*), *Emergency Nursing Pediatric Course* (ENPC), and PEPP (Pediatric Education for Prehospital Professionals) courses around the Commonwealth, particularly in areas with historically difficult access to pediatric training.

New Generation Training Simulation System (PM 78)**:** The Virginia EMSC program plans to purchase an advanced training simulation system to enhance the ability of the Office of EMS (and other training partners) to conduct quality pediatric scenario training. The interactive system, made possible by federal EMSC funding through HRSA, will allow for scenario stations to be fully operational without the use of actual monitor/ defibrillators and their inherent safety issues, logistical and connectivity problems. Soon, additional pediatric training manikins will be procured to further support in this effort.

On-Site Emergency Department Pediatric Assessments (PM 74)**:** Requests are once again being accepted from Virginia hospital emergency departments to provide on-site collaborative assessments of pediatric needs and capabilities (at no cost to the hospital).

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

NASEMSO Pediatric Emergency Care Council (PECC) Bullets: The PEC Council is a standing council of the National Association of State EMS Officials (NASEMSO). A snapshot of current activities would include:

- Promoting the use of easily obtainable real pediatric patient videos as an educational tool for EMS providers.

- Delivery of "*Checklist Tool for Pediatric Disaster Preparedness* for State EMS Offices to HRSA for State EMS Offices for use in identifying preparedness gaps—this document was researched and prepared by the Virginia EMSC program for the PECC as part of a collaborative project agreement in place between HRSA and NASEMSO.

- Preparation of a successful resolution passed by NASEMSO (October 9th) which strongly supports the development of a scientific evidence base for ambulance and equipment crash testing (and related safe transport recommendations for children in ground ambulances). It urges HRSA, NHTSA, NIOSH, NIH, NEMSAC, FICEMS, and other federal agencies and national organization to reprioritize available grant funding that they have influence or authority over to help begin to establish a meaningful evidence base upon which to base standards for ambulances and their equipment, as well as the methods used by EMS providers to most safely handle and protect pediatric patients who are injured. Currently, many children transported by ambulance are not restrained or immobilized (two separate issues) appropriately—some are even transported in family members' laps, and the equipment and methods used to protect and transport injured children are not based upon appropriate standards or sufficient science.

- Working with the emergency preparedness community to include the needs of children in disaster planning and mitigation.

- Participating in the process of developing model evidence-based pediatric protocols.

- Promoting and facilitating the creation of pediatric facility recognition programs by the states and U.S. territories.

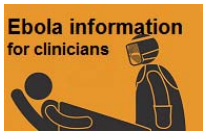
- Participating in implementation of the EMS Education Agenda for the Future.

- Working to develop specific pediatric quality improvement indicators.

- Providing a structured mentoring function for new State EMSC Managers.

- Promoting best practices among state EMSC programs to implement innovative effective education and training aids for pediatric

Note from HRSA to EMSC Program Grantees about Ebola: Health care providers across the Nation are concerned with Ebola. When you visit www.hrsa.gov, look for this graphic.



Click on it and go to the most current information from the CDC, created by CDC experts specifically for U.S. healthcare workers. This information from the CDC is available to you to

answer questions you may have. HRSA will continue to work with its colleagues at the CDC and elsewhere in the Department of Health and Human Services to link to the latest information available.

EMSC State Partnership Grant Notes: With the last two major EMSC assessments (hospital *and* EMS agency) complete, state EMS for Children grantees will soon be presented with a new set of Performance Measures that will guide all state EMSC programs going forward.

State EMSC Program Managers were recently required to attend a technical workshop presented by the National EMSC Data Analysis Resource Center (NEDARC) titled *"Communicating Your Performance Measures Results"* in preparation for receiving this newest generation of national Performance Measures.

Annual Progress Reports for state EMSC programs are due to HRSA by December 1, 2014, and are required before a new notice of grant award can be issued on or about March 1, 2015 that will authorized additional funding.

Suggestions/Questions

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

Durable Do Not Resuscitate (DDNR)

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

Respectfully Submitted

Office of EMS Staff

Appendix

A

STATE EMS ADVISORY BOARD

Proposed Slate of Nominations for 2014 through 2015

I. Chairman – Gary P. Critzer

II. Vice Chair – Genemarie McGee

a) Administrative Coordinator	David Hoback
• Rules and Regulations Committee	Jon Henschel
• Legislative & Planning Committee	Joan Foster
b) Infrastructure Coordinator	Matt Tatum
• Transportation Committee	Matt Tatum
• Communications Committee	Gary Critzer
• Emergency Management Committee	David Hoback
c) Patient Care Coordinator	Marilyn McLeod, M.D.
• Medical Direction Committee	Marilyn McLeod, M.D.
• Medevac Committee	Anita Perry
• Trauma System Oversight & Mgt. Committee	Michael B. Aboutanos, M.D.
• EMS for Children Committee	Samuel T. Bartle, M.D.
d) Professional Development Coordinator	Ron Passmore
• Training & Certification Committee	Ron Passmore
• Workforce Development Committee	Jose Salazar
• Provider Health & Safety Committee	Dan Wildman

<u>The Executive Committee</u>:

Chair – Gary Critzer
Vice Chair – Genemarie McGee
Four Coordinators:
Administrative Coordinator – David Hoback
Infrastructure Coordinator – Matt Tatum
Patient Care Coordinator – Marilyn McLeod, M.D.
Professional Development Coordinator – Ron Passmore

Appendix

B

SECOND QUARTER 2014

EMS Patient Safety Event Report

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

Welcome!

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

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

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

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

"…I reached around to prevent a fall. He swung his open hand striking the top of my head. I moved around to side to speak to him and again keep him from falling. As I did so he punched me in the face. …." – 2Q2014 EVENT Provider Violence Report #1

This is the aggregate Patient Safety E.V.E.N.T. summary report for second quarter 2014.

PROVIDED BY:

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

IN PARTNERSHIP WITH:

North Central EMS Institute

Paramedic Chiefs of Canada
Chefs Paramédics du Canada

NATIONAL EMS MANAGEMENT ASSOCIATION

NAEMT

NASEMSO

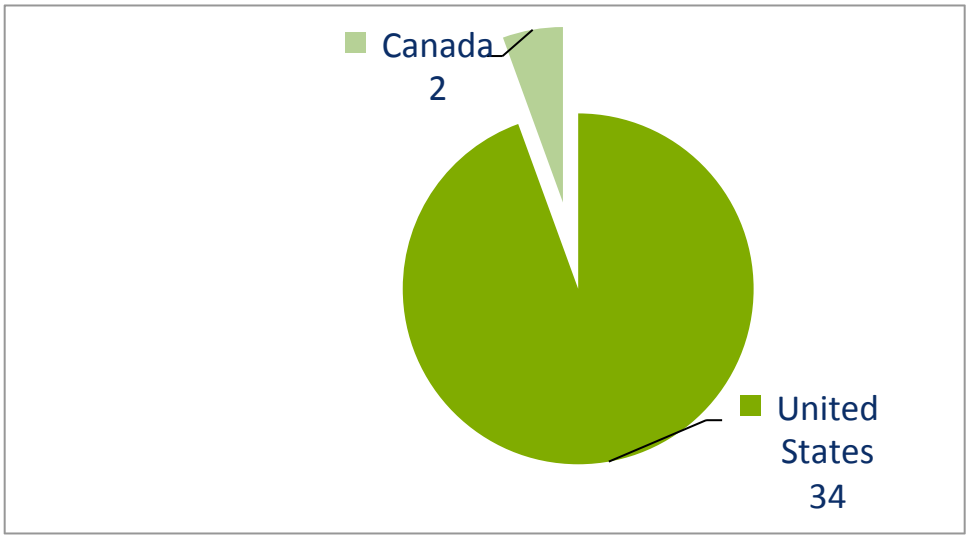
Patient Safety Event Reports Sorted Quarterly

	2012	2013	2014
Jan - Mar	6	31	30
Apr - Jun	9	39	29
Jul - Sep	13	35	
Oct - Dec	6	32	
Total	34	136	59

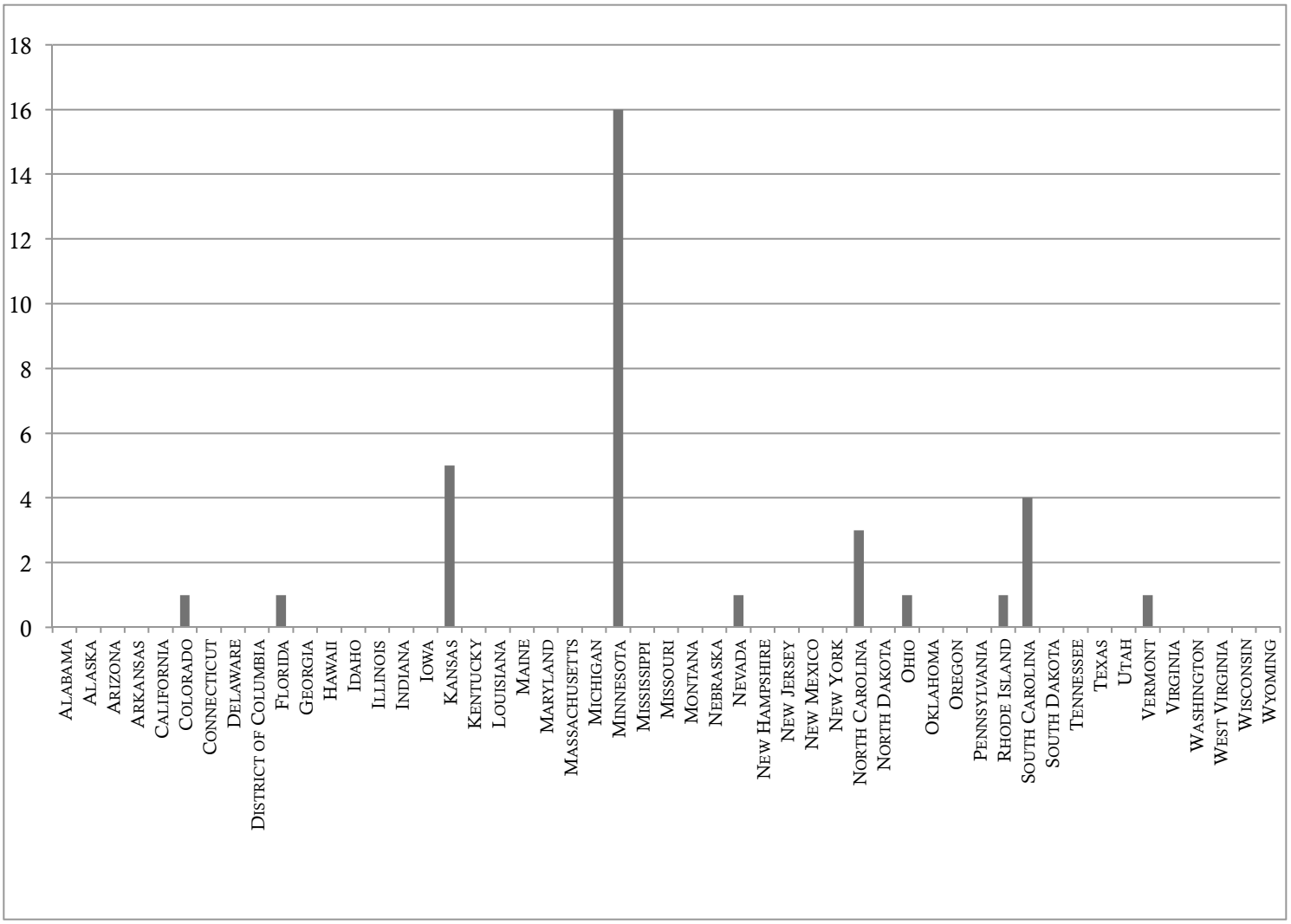
As you review the data contained in this report, please consider helping us advertise the availability of the report by pointing your colleagues to www.emseventreport.com.

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

Quarterly Patient Safety Events by Country



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



Many of our reports this quarter have been generated from Minnesota. Thanks to the Minnesota agencies and practitioners for supporting this body of knowledge! Kansas and South Carolina were also great contributors this quarter. If your EMS agency has an internal reporting system for patient safety events, we encourage you to have your staff member that receives those reports to also enter them into our anonymous system.


Alabama Emergency Medical Technicians Association


NAEMSP


CAAHEP


CECBEMS


CoAEMSP


HGH EMS
RESCUE


IEMSA
IOWA EMERGENCY MEDICAL SERVICES


NAED
National Academies of Emergency Dispatch


American College of Emergency Physicians
ADVANCING EMERGENCY CARE


NAEMT


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


NATIONAL
EMS
MANAGEMENT
ASSOCIATION


National
EMS
Memorial
Service


NOSORH
national organization of state offices of rural health


NASEMSO


NATIONAL VOLUNTEER FIRE COUNCIL
ORG. 1976
Supporting Those Who Serve


DEPARTMENT OF SAFETY
EMERGENCY MEDICAL SERVICES


VOLUNTEER AMBULANCE & RESCUE ASSOCIATION INC.
NEW YORK STATE


NORTH DAKOTA
EMS
EMS ASSOCIATION


North Central
EMS Institute


Oregon
EMS Association
www.oregonems.org


PENNSYLVANIA EMERGENCY
HEALTH SERVICES COUNCIL
Your Voice In EMS.


PAAW
PROFESSIONAL AMBULANCE
ASSOCIATION OF WISCONSIN


SOUTH CAROLINA
EMS ASSOCIATION

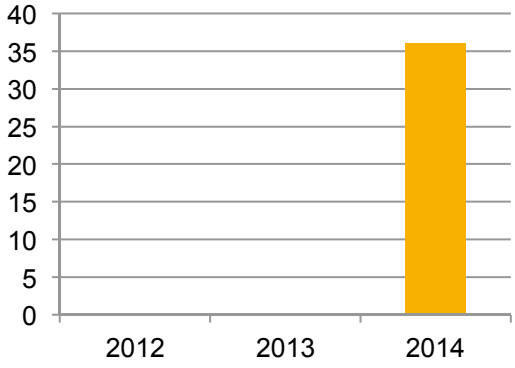

VFIS
A Division of Glatfelter Insurance Group


Virginia
OFFICE OF EMERGENCY MEDICAL SERVICES
Virginia Department of Health

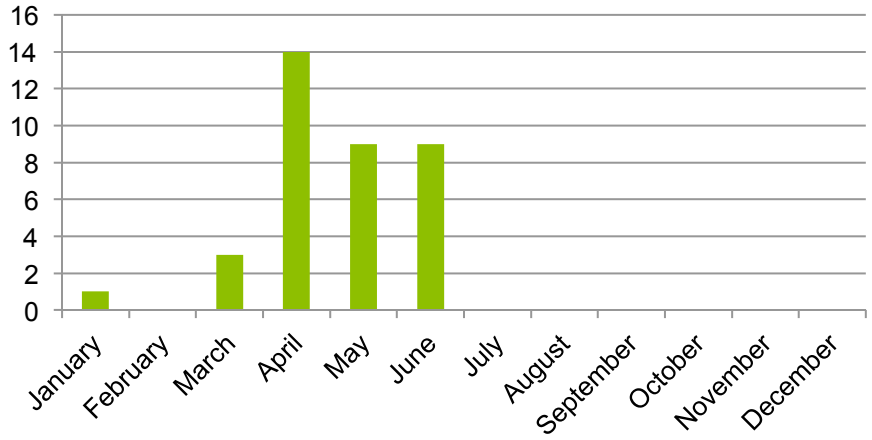

AAMS


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

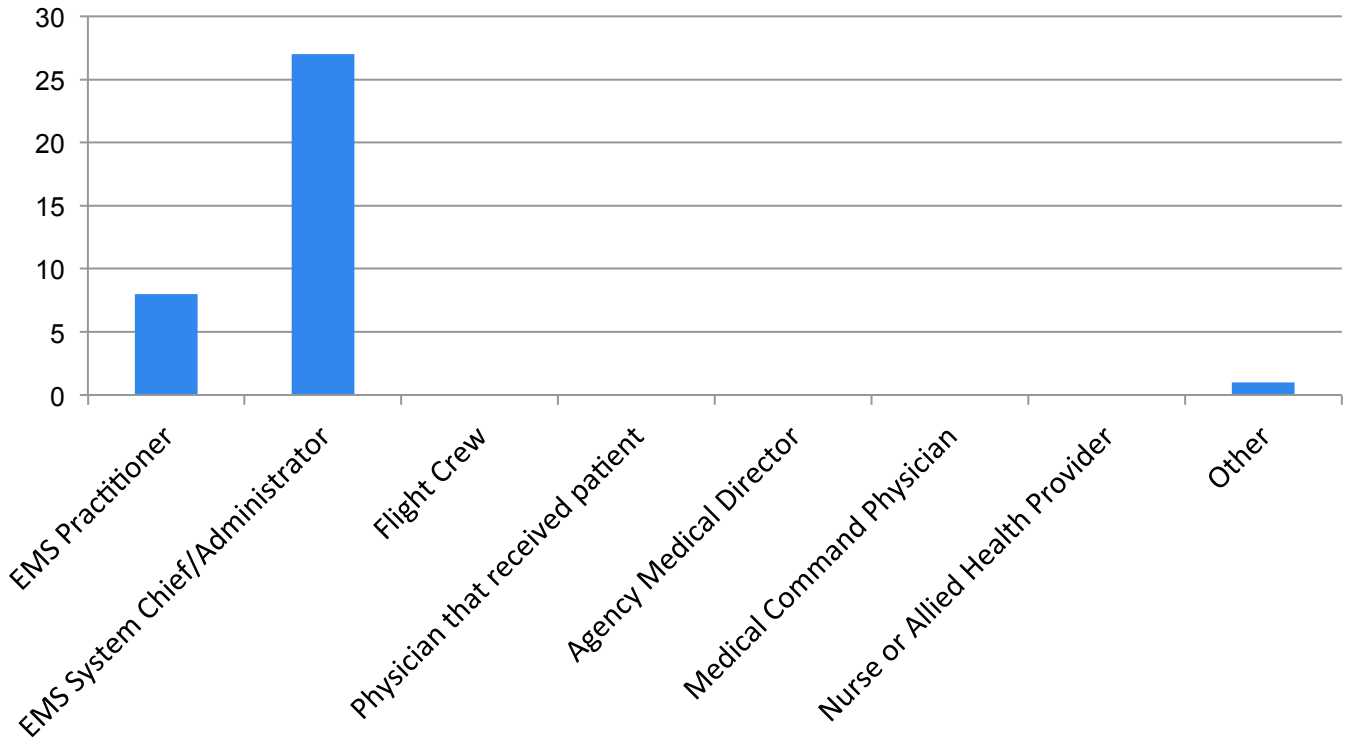
Year Reported Patient Safety Event Occurred



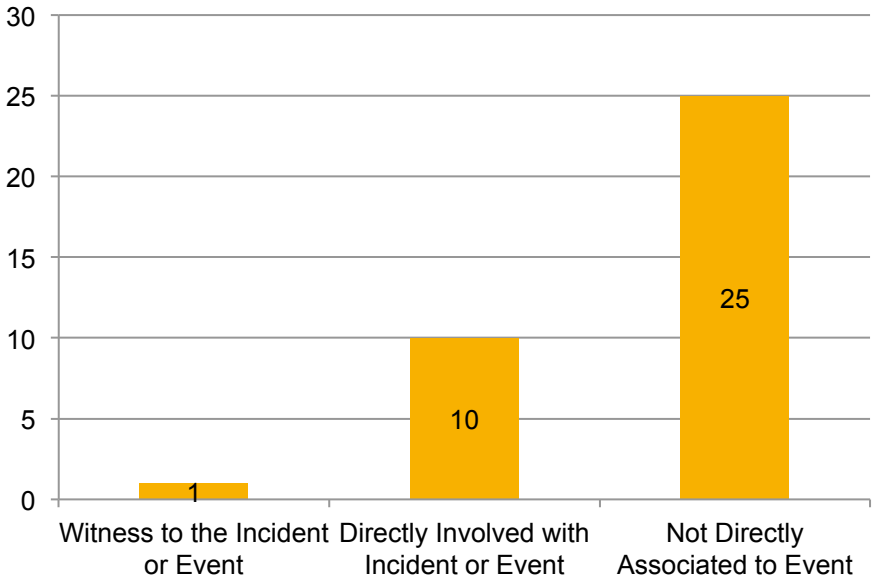
Month of Reported Patient Safety Event



Role of Person Reporting Incident

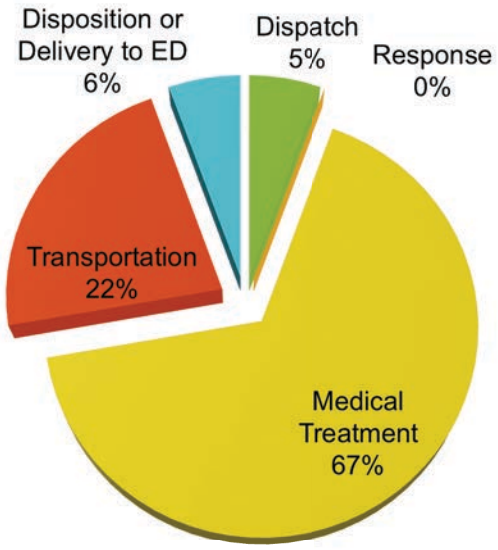


Involvement in Safety Event

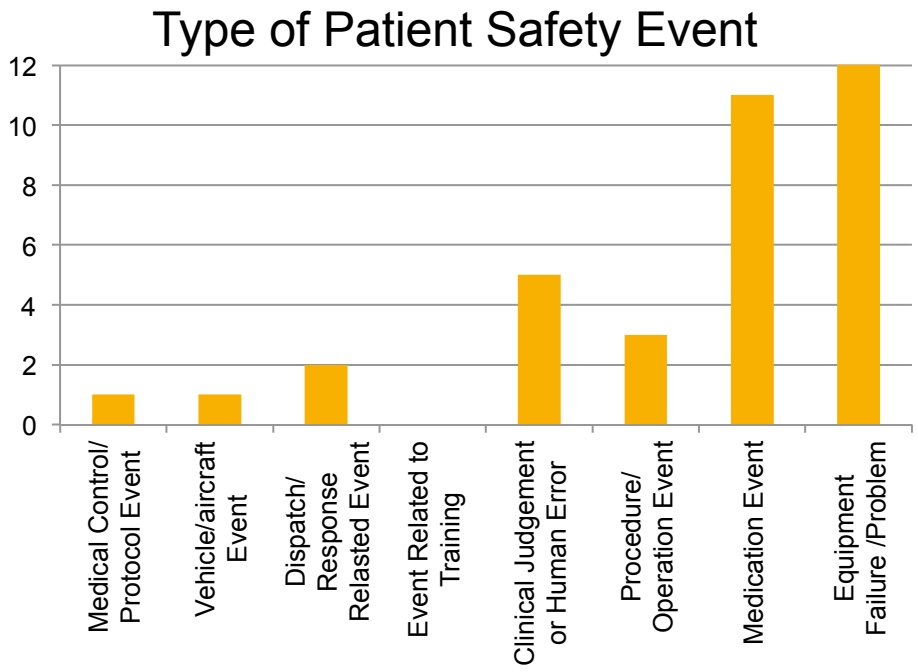


The reporters from this period are generally “not directly associated to the event”. The EMS system administrator dominates the “not directly associated” group.

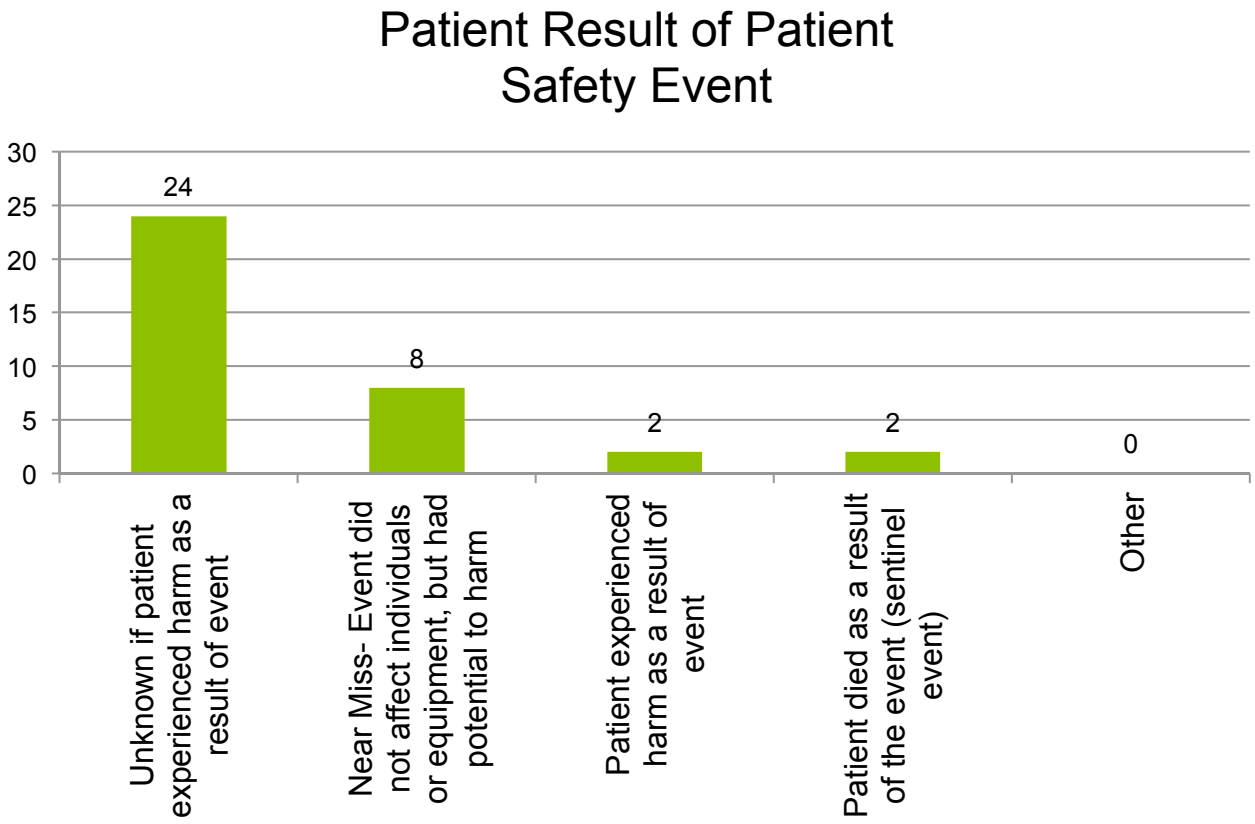
Category of Event



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



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



#	Summary of Safety Event Reported	Summary of EMS Provider Opinions on the Cause of the Safety Event and their suggestions for mitigation
1	Response to a trauma cardiac arrest. Experienced paramedic attempted to insert an intraosseous line in tibial plateau, with the driver of the device failing about 1/2 way through the insertion process. The drill "bogged down" and stopped. Device was well within limits for proper battery condition. No other unusual issues with insertion. Tissue less than half of the 25 mm IO needle.	Probable battery failure, or power loss to driver, intermittent in nature. Provide Routine testing pre-event and query company for best practices. Have a backup IO device ready.
2	On two sequential transports, have been unable to reach Emergency Department by radio to provide an encode. One of the patients was critical, and EMS practitioner had to use a cell phone to make contact with receiving facility. Had the practitioner not known the phone number to call, would have been unable to provide notification for an incoming critical patient.	Staff at receiving hospital do not know how to use the radio and do not understand importance of it. They have said they turn the volume off because "it makes annoying noise" and do not know how to key up and respond using radio. Staff requires training on usage and the importance of a radio with which they receive EMS communication.
3	An elderly patient in a crash who was easily removed from a vehicle with a flail segment. Excessive scene time of 50 minutes by the helicopter with a talking patient who received a facilitated intubation that took too long. Patient became hypothermic and the airway was pulled after all other indicators showed a confirmed tube. Due to the meds and her age a bradycardia occurred after the sequence meds. Hypothermia and poor perfusion led to a false oximetry reading triggering a poor clinical judgment to intubate verse rapid transport.	Inexperienced provider in aeromedical service. Loss of situational awareness. Misread monitoring equipment and failure to understand medication side effects Better recognition of shock and limitations of equipment. Altitude and age related issues with pulse oximetry. Situational awareness of scene time.
4	While transferring patient to another ambulance company, EMS providers failed to provide the other agency with proper documentation of the call.	Lack of training & drills. Use of an ePCR system. As well as proper training & drills to remind practitioners to provide proper documentation of the call to agencies patients are transferred to.
5	Patient was under-dosed with Diazepam.	Concentration dis similar to other similar medications such as Ativan or Morphine. Also my familiarity was with Ativan, so I was giving the dose for Ativan instead of the Diazepam I was giving. Make similar medications have same concentrations.
6	Inadvertently delivered 200% of intended drug.	Manufacturer's label was occluded due to in-house inventory control methods. Unfamiliar with new packaging/concentration of vial. Ensure that all labels are completely and totally free from any possible obstructions. Utilize double-check prior to administering all high-risk drugs. (MACC)
7	Fentanyl dose corrected using MACC	Uncertainty of appropriate dose Continue to use MACC as designed

#	Summary of Safety Event Reported	Summary of EMS Provider Opinions on the Cause of the Safety Event and their suggestions for mitigation
8	In multiple patient encounters, glucometer has provided results with do not correlate with patient presentation (reading 70-80mg/dl in unresponsive diabetic patients) and which were vastly different from readings at hospital. This has been repeated with multiple glucometers, on multiple days, with different lots of test strips. Multiple patients have failed to receive needed IV Dextrose due to falsely high readings on glucometer.	Defective or poor quality test strips and/or glucometer fail to provide accurate readings. Issue has been reported to manufacturer and units taken out of service. Perform verification testing of {device] against not only control solution, but against other glucometers known to be functioning well. Make practitioners aware of possible issue so they will treat the patient's clinical presentation and not just a meter reading.
9	[Ambulance] was transporting a cardiac patient to the hospital and [crew member 1] was pre-medicating the patient and drew up an entire vial of fentanyl for pain management. [Crew member 2] and [crew member 1] completed a MACC check prior to administering the Fentanyl and determined that 75mcg in 1.5ml of Fentanyl should be administered to the patient. After MACC check was completed [crew member 1] administered 50mcg in 1ml of Fentanyl to the patient. After returning to post and during the narcotic wasting process [crew member 3] and [crew member 1] discovered that the patient was under-dosed on the Fentanyl. Upon learning of the error [crew member 1] called the patient's nurse at the hospital and reported the incident. The patient was not harmed from the incident. The narcotic envelope and the patient care report were both edited to show that the incident had occurred.	Slip - error of action. [Crew member 1] and [crew member 2] were instructed to review the medication administration protocols and to specifically not draw up more than one dose at a time to accurately complete the MACC check. They both acknowledged understanding of proper procedures. [Crew member 1] was instructed to submit a QIR, contact the RN to advise the correct dose, and correct the PCR.
10	[Ambulance] was on call at [location] on 49 y/o male that was found unresponsive with depressed respirations. A MACC check was done for giving Narcan IM. The dose was 2mg IM for patient with no venous access found by [crew member 1]. [Crew member 2] confirmed this but advised that he believed to give in 0.5mg increments. Reviewing this in a darkened bedroom it appeared that it was correct with the incremental dosing showing IV/IN/IM at the heading. The Narcan was given by [crew member 1] and the patient level of consciousness improved. No further Narcan given. It was later found when reviewed and discussed that the incremental dosing was only for IV doses. [Crew member 1] and [crew member 2] was informed and report is written.	Uncertainty of appropriate dose, unable to determine dose due to environmental reasons, did not stop even though uncertain. The MACC is constructed such that if there is uncertainty, it must be rectified prior to administration. Uncertainty should be a red flag.
11	Fentanyl under-dose prevented.	Uncertainty of appropriate dose. Continue to use MACC as designed.
12	Prevented the administration of SoluMedrol and Mag Sulfate via the same line – incompatible.	Having a compatibility chart and using MACC

#	Summary of Safety Event Reported	Summary of EMS Provider Opinions on the Cause of the Safety Event and their suggestions for mitigation
13	While removing patient from ambulance at hospital, stretcher safety catch bar did not engage floor hook and dropped out landing upright in mid-height position. No apparent harm to patient or crew.	On inspection, the catch bar was bent in the middle and the fabric storage pouch attached to the bar had torn stitching and support components that may have impaired the functioning of the catch bar. Both the safety catch bar and the storage pouch have been replaced and the stretcher was returned to service. Limit the amount of weight and bulk of any equipment or supplies sitting on or placed inside the storage pouch.
14	Endotracheal tube cuff suspected of being damaged and deflated requiring re-intubation with new tube. Crew noted it was a difficult intubation & deflation of cuff discovered very early resulting in no harm to this arrested patient with ROSC later.	Damaged tube was not saved for inspection so cause of cuff failure could not be determined. It is possible that manipulation of the laryngoscope against the cuff could have caused the cuff to tear. Problem can also be the inflation valve or the tubing to the cuff. Exercising more caution during insertion of any endotracheal tube to prevent/avoid damage.
15	ECG failed to display during routine lead-2 cardiac monitoring. Nothing other than artifact appeared. No harm to patient being treated for a fall and not cardiac related. Run resulted in lift assist only & no patient transport.	Main ECG cable tested and failed. Likely a broken wire. Cable replaced & monitor returned to service. ECG cables supplied by manufacturer need to be more rugged to prevent failures in pre-hospital environment.
16	Pulse oximetry stopped providing reading about halfway through patient transport & error message indicated faulty cable. Initial readings were 85 - 100%on a patient with abdomen complaints and no resp. distress. Loss of SpO2 monitoring resulted in no harm to patient.	SpO2 cable tested faulty & was replaced. The cardiac monitor accessory for SpCO/SpO2 module has a cable that contains 12 very thin and easily damaged wires. We are experiencing many of our cables like this failing after 2 years of moderately frequent use. If the outer insulation is damaged, we see the cable fail within a short time. Cables with damaged insulation need to be replaced at a cost of around $650.
17	Ambulatory patient unexpectedly jumped out of side door of ambulance when being unloaded on arrival at hospital. Crew was standing at door ready to assist & coaching patient how to step down when suddenly & without warning jumped. Patient landed flatfooted & then fell back to her buttocks with no apparent injury. At scene, patient had walked out to meet ambulance & requested transport for a very minor complaint. Patient was placed into a wheelchair and examined and released from the hospital ED. Patient weight approximately 360 lbs. & known to crew from frequent transports.	Side door of ambulance typically has a step height of 15 to 20 inches. This can be intimidating to any impaired patients or non-patient passengers. Assistance is good prevention and a step stool employed at some hospitals is a great idea. Recommendation made that hospital might provide step device for unloading ambulatory patients from both ambulances or other private vehicles with high step distances. Within days, the hospital obtained a step stool with handrail that will be available as an option in the ED garage.

#	Summary of Safety Event Reported	Summary of EMS Provider Opinions on the Cause of the Safety Event and their suggestions for mitigation
18	During response to multi-patient/multi-fatality vehicle accident. Ambulance crew requested a driver from Fire Dept. personnel in order to have two attendants attend two patients classified as "critical" during transport. During extrication and treatment activities on 4-lane highway, ambulance had parked with egress route to northbound lane heading to hospital; however, as various law enforcement and fire resources arrived they staged vehicles in the left lane, leaving the far left lane open for opposing traffic flow. Law enforcement landed an EMS helicopter in the ambulance's path of egress of the northbound lanes. The FD driver, trying to avoid going off the right side of the roadway approached, opted to go under the stationary rotor blades. He approached slowly; as he did he stated he looked out of the window and saw that he had about "2-feet" of clearance between the roof of the ambulance and the rotor tips, so he opted to proceed. The diver did not account for three radio antennas mounted on top of the ambulance that range from 12-24 inches in height. The tallest of these antennas stuck one of the rotors approximately 6 to 8 inches from the tip. The ambulance continued to the hospital, about 10 minutes away, without further incident. The patients remaining on scene at that time were all unfortunately deceased (four total). The helicopter was grounded on scene for about an hour before a mechanic could come and determine that the aircraft was safe to fly back to the airport. The following day, the Director of Maintenance for the aircraft came and inspected the rotor, and after consultation with the manufacturer's technicians determined that the damage consisted of a "blemish" and aircraft was placed back in-service. There was no damage to the ambulance or antenna.	There were multiple contributing factors to this event: 1. Having a driver who is unfamiliar with the ambulance. Although authorized by state law to utilize a driver from another agency under the circumstance, and even though the FD person has been trained in emergency vehicle driving/operation, this was the first time he had driven one of our units. 2. Staging late arriving resources in the egress path of ambulances preparing to depart the scene. 3. Lack of a coordinated landing zone operation. Although law enforcement set up and secured the landing zone, once on the ground the integrity of the landing zone was compromised by multiple responders and vehicles. Current practices and policies are under review to address the contributing factors.
19	Patient fell, was walked, and when unable to do so, was put on a backboard and a collar affixed to his throat, whereupon he died. No questions were asked of him or of his wife.	EMT failure to assess patient status before moving him. Better training.
20	Over the past month, there have been two occurrences involving a wheel falling off a [manufacturer/model] stretcher undercarriage while transporting patients.	Inadequate thread counts in a critical screw point for the wheel assembly. An immediate internal recall of all [manufacturer/model]. Tight applied to the screw point and screw re-torqued by System Support Techs.

#	Summary of Safety Event Reported	Summary of EMS Provider Opinions on the Cause of the Safety Event and their suggestions for mitigation
21	EMS dispatched to an address for chest pain. Street address and nearest cross street was provided by dispatch. EMS approached the street at the approximate middle. No house/building numbers were visible from the intersection so the crew had to decide whether to turn left or right. The crew decided to turn left, which was later determined to be the wrong direction. After changing direction EMS passed the scene due to a lack of visible address markings and the error was quickly identified upon seeing other address markings on the street. The scene turned out to be a well-known, highly visible business and the only business on that street.	1) The patient reports that dispatchers were provided the name of the business along with the address when he called 911. Dispatchers admit that the name of business was available on their C.A.D. screen. This information was never provided to the responding EMS crew. 2) The business address was not clearly marked and/or visible from the street. When an emergency scene is a commercial site then the name of the business should be forwarded to responders. All addresses should be clearly marked and visible from the street.
22	EMS dispatched to an address for OB (labor). Street address and nearest cross street was provided by dispatch. No house/building numbers were visible from the street so passed the scene due to a lack of visible address markings. The error was quickly identified upon seeing other address markings on the street. The scene turned out to be a well-known, highly visible business and the only business on that street.	The caller reports that dispatchers were provided the name of the business along with the address when he called 911. Dispatchers admit that the name of business was available on their C.A.D. screen. This information was never provided to the responding EMS crew. The business address was not clearly marked and/or visible from the street. When an emergency scene is a commercial site then the name of the business should be forwarded to responders. All addresses should be clearly marked and visible from the street.
23	While removing patient from ambulance on stretcher, the safety catch bar did not engage floor hook & stretcher dropped to ground before wheel carriage could be lowered. Vehicle was parked outside on a slope with angle different from the plane the crew was standing on & the bar may have gone over the top of the floor hook. It was raining & crew admits they were rushing to get out of a storm. No injury to the patient or crew.	Crew did not notice that because of the sloped surfaces involved, the safety catch bar did not engage the floor hook. Manufacturer should re-engineer or redesign the catch bar safety mechanism due to frequent failures.
24	During unloading of patient on stretcher at hospital, the safety catch bar did not engage floor hook resulting in stretcher falling out and landing upright on garage floor. No injury to the patient or crew.	Crew believes that equipment stored on head-end fabric shelf interfered with movement of the safety catch bar mechanism & contributed to event. Testing of the stretcher later revealed that the safety catch bar would stick when equipment is placed on the fabric shelf. Redesign head-end storage pouch so that it does not attach to and interfere with safety catch bar.

#	Summary of Safety Event Reported	Summary of EMS Provider Opinions on the Cause of the Safety Event and their suggestions for mitigation
25	EtCO2 function on cardiac monitor failed to turn on or provide any values to verify and monitor an endotracheal tube insertion. The patient was in an asystolic cardiac arrest on an intercept with a BLS ground ambulance. Near the arrival time at the hospital, crew noted the ETT was accidently pulled partially out & then pushed back in resulting in a dislodgement not recognized until the airway reassessment at the hospital ED. Unknown if any direct harm to patient who met criteria for discontinuing resuscitation long before tube dislodgement occurred.	Failure of the EtCO2 contributed to the crew not recognizing dislodgement of the endotracheal tube (ETT) earlier. It was later determined to be a loose plug on the cable. Other contributors included the BLS level provider pulling back on the ETT when using the BVM and an ill-fitted cervical collar that made it difficult to secure the ETT. Crew could have used the available colormetric EtCO2 detector to verify placement and on-going patency of ETT.
26	A 9-month old seizure patient was administered liquid ibuprofen while unresponsive and still in GM seizure which could have compromised the airway. The same patient did not receive anti-seizure medication by the correct route or in a timely manner. Unknown if any patient harm resulted from medication administrations.	The paramedic attendant failed to perform a required medication safety check procedure with their crewmate and did not utilize available direct Medical Control. Improved teamwork and crew resource management related to decision process for patient treatments.
27	While loading a 190 lb. patient into ambulance, the stretcher fell back out during process of rising up the wheeled carriage. Stretcher was resting on loading wheels when it moved backwards & safety catch bar did not prevent it from dropping. Stretcher landed upright in lowest position on ground with no injury to patient. Foot-end operator sustained bruising to one knee.	Stretcher was found to be in good repair and no servicing needed. The crew likely did not properly follow procedure and engage the safety catch bar before raising the wheeled carriage. Manufacturer re-engineering or redesign of this safety mechanism is needed.
28	While moving a 291 lb. patient to the ambulance on the Large Body Surface (LBS) stretcher accessory, the wheels struck a crack between concrete and asphalt & caused the stretcher to tip. It was caught at 45-degree angle & prevented from hitting the ground by the crew who then lowered it completely to the ground on its side with patient still strapped in place. Lifting help was recruited from the clinic pick-up point & patient was moved to the ground before up righting the stretcher & continuing the transport. No injury to the patient who had a chronic leg lesion being treated at a clinic.	1. Crew was moving too fast over uneven and sloped surface. 2. Two extra helpers to move a patient on the LBS device were not being used as required by out protocol. The LBS add weight and makes the stretcher's center of gravity higher. When the LBS is attached to a stretcher, helpers on either side are needed in addition to the 2 operators to assure safety and prevent tip-overs.
29	A motorcycle MVC patient with head injury was administered two 10 mg doses of intranasal (IN) Versed to safely manage cares & control combativeness. The 2nd dose was incorrect per out protocol & should have been 5 mg or one-half the initial dose. No harm to patient who was actually administered more sedation during a successful RSI before air medical transport to trauma center.	Providers administering were not familiar with administration protocol and the 2nd dose was not printed on the medication dose chart packaged with the medication vial. Add the 2nd administration dosing information to the quick-reference card packaged with the medication vial.
30	During an arrest & endotracheal intubation, the EtCO2 function on the monitor failed. No waveform or numeric readings were displayed & crew unable to trouble-shoot device. All other indications and assessments were positive for correct tube placement with no patient harm. Resuscitation was discontinued at scene after 55+ minutes of resuscitation attempt.	EtCO2 cable was tested and found to be faulty. More frequent testing and preventative maintenance may have identified the faulty cable before failing during a patient use. However, the time and costs of daily testing EtCO2 equipment is not cost effective or any guarantee.

#	Summary of Safety Event Reported	Summary of EMS Provider Opinions on the Cause of the Safety Event and their suggestions for mitigation
31	Diltiazem (Cardizem) was administered to a stable patient in atrial flutter and bradycardia when not indicated for rate control. The dose was also incorrect for patient over 65 years. Paramedic administered the Diltiazem (Cardizem) at 20 mg on an ALS intercept while transporting in the BLS service vehicle. No apparent harm to chest pain patient when vitals signs remained stable and unchanged.	Human error due to the paramedic provider being unfamiliar with the correct indications and not doing verification with other providers. 1. Performing a medication safety check procedure with partner before administration. 2. Require utilization of other medication dosing resource before administration.
32	Crew unable to acquire a 12-lead ECG on a chest pain patient when monitor displayed an error message for a V-4 lead off. Limb lead ECG obtained did not suggest MI and very short transport to hospital resulted in no patient harm.	Testing of the main ECG cable revealed that it was faulty and likely there was a broken wire near the plug. Manufacturer should provide cables more durable for prehospital environmental rigors.
33	A. Fib patient, paramedic went directly to pharmacological treatment. Paramedic then administered a dose of Cardizem 5x the appropriate dose.	During investigation paramedic obviously did not understand proper dosing regardless of clarity of protocol and being a long-standing medic. Paramedic is undergoing extensive remediation. System wide additional education is being provided to make sure there is clarity as to dose, mixing, procedure and protocol. We are repacking Cardizem as a kit with a simple guide sheet, everything needed to administer, including a 20 cc syringe, which will limit dose.
34	Patient was a psych patient possibly suicidal. Patient AAOx4 ingested a pesticide x 2 in a possible attempt on patient's life. Paramedic attempted IV several times without success, never attempted EJ or IO. Patient had documented symptoms of Organophosphate Poisoning. No pharmacological treatment of issue. Only emergent transport.	Paramedic/EMT crew failed to connect the dots and render proper treatment. They did recognize the urgency. Possibly panic or negligence. Crew at a minimum will be remediated on poisoning, general and IV access protocols. More frequent in service training on less frequent types of calls. We as an industry tend to train more on what we do more often, and less on the infrequent and oddball incidents.
35	Aspirin was given to the patient for chest pains when it was counteracted (sic) due to bleeding. Family was surrounding us and talking non-stop, my partner was rushing because he knew the patient, children were running around yelling, and we forgot about he bleeding issue and gave aspirin to help with the chest pains.	It was given due to my error because I was distracted by everything going around the patient and myself. Have the family step into another room or have my partner obtain information from the family while I treated the patient or vise versa.
36	Paramedic to administer IV Gravol for nausea. While starting IV in back of ambulance patient vomited and rapidly moved arm. IV needle/cath came out of patient and punctured paramedic's hand. Needle has auto retract - but this occurred during insertion. Patient did not receive medication as a result and paramedic injured.	Patient Reaction to vomiting. IM Gravol had been considered, paramedic admin alone in back of ambulance, consider second paramedic to help secure arm when initiating IV if pt. is displaying increased movement or actions due to vomiting.

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

Appendix

C

SECOND QUARTER 2014

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

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

Welcome!

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

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

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

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

"…I reached around to prevent a fall. He swung his open hand striking the top of my head. I moved around to side to speak to him and again keep him from falling. As I did so he punched me in the face. …." – 2Q2014 EVENT Provider Violence Report #1

This is the aggregate Provider Violence E.V.E.N.T. summary report for Second Quarter 2014.

PROVIDED BY:

The Center for Leadership, Innovation and Research in Emergency Medical Services
CLIR

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

IN PARTNERSHIP WITH:

North Central EMS Institute

Paramedic Chiefs of Canada
Chefs Paramédics du Canada

National EMS Management Association

NAEMT

NASEMSO

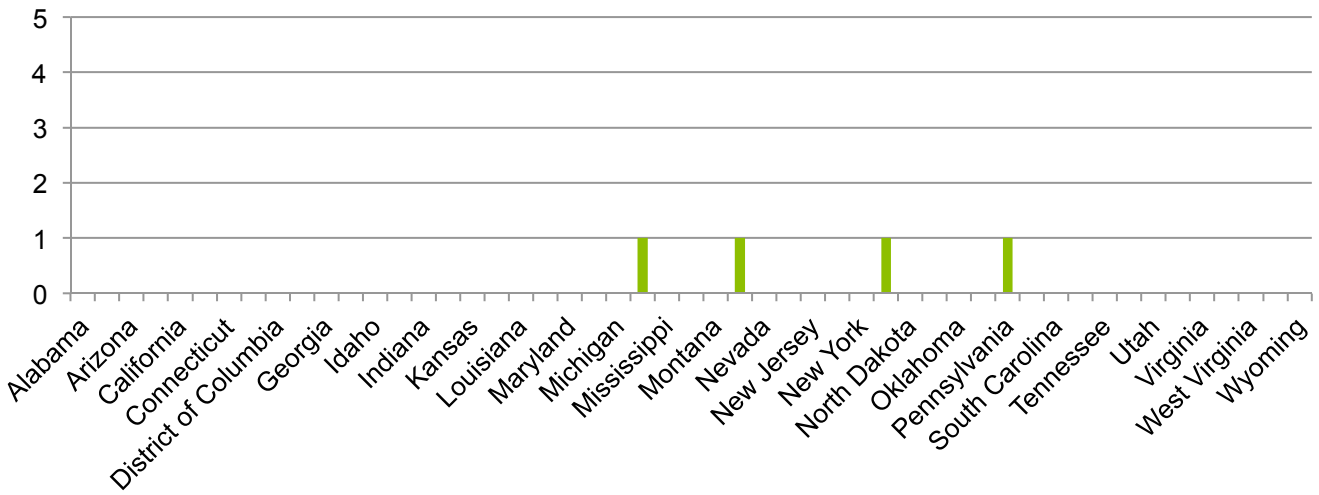
Table 1: Violence Events Quarterly

	2012	2013	2014
Jan - Mar	1	3	10
Apr - Jun		5	
Jul - Sep	9	18	
Oct - Dec	11	10	
Total	21	36	10

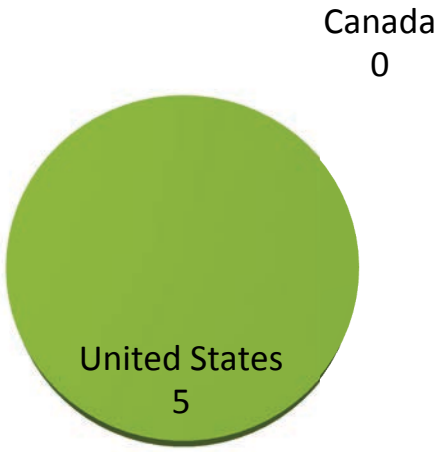
As you review the data contained in this report, please consider helping us advertise the availability of the report by pointing your colleagues to www.emseventreport.com.

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

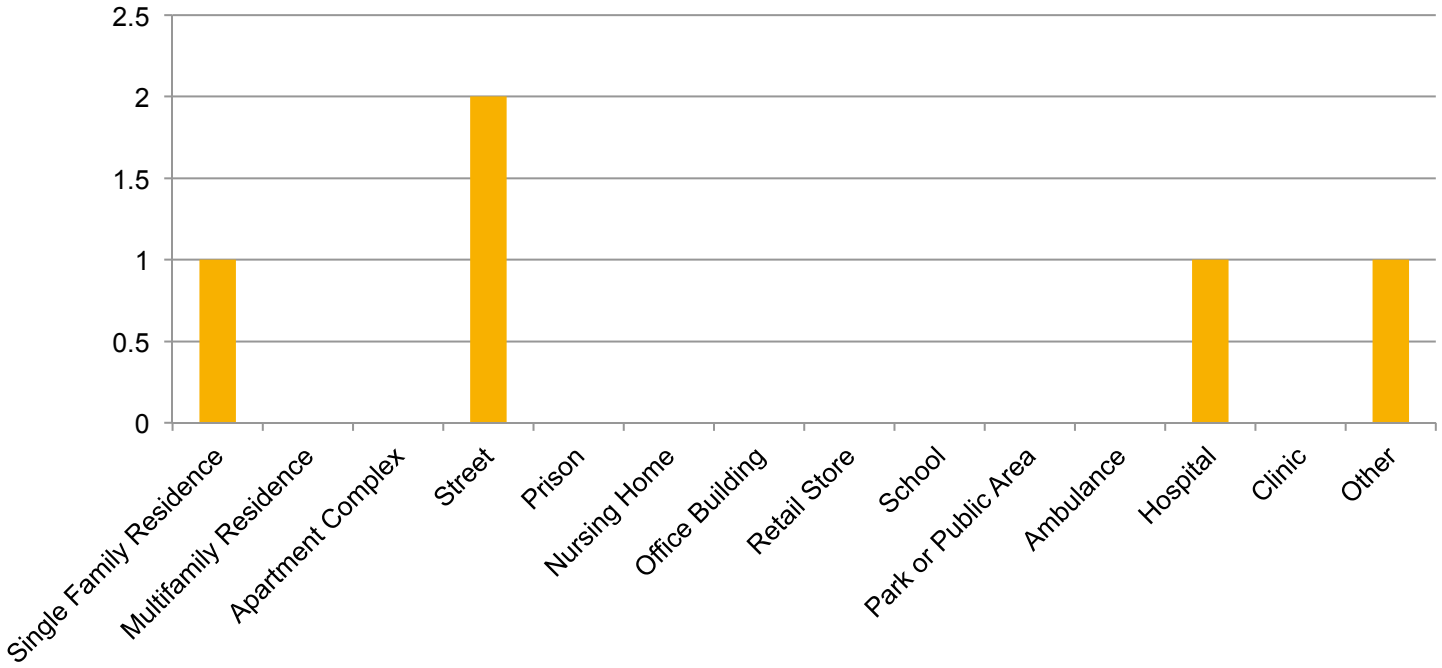
Violence Events by State



Quarterly Violence Events by Country



Place Violence Occurred




Alabama Emergency Medical Technicians Association


NAEMSP


CAA
HEP


CECBEMS


CoAEMSP


HGH EMS
RESCUE


IEMSA
IOWA EMERGENCY MEDICAL SERVICES


NAED
National Academies of Emergency Dispatch


American College of Emergency Physicians
ADVANCING EMERGENCY CARE


NAEMT


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


NATIONAL
EMS
MANAGEMENT
ASSOCIATION


National
EMS
Memorial
Service


NOSORH
national organization of state offices of rural health


NASEMSO


NATIONAL VOLUNTEER FIRE COUNCIL
ORG. 1976
Supporting Those Who Serve


DEPARTMENT OF SAFETY
EMERGENCY MEDICAL SERVICES


VOLUNTEER AMBULANCE & RESCUE ASSOCIATION INC.
NEW YORK STATE


NORTH DAKOTA
EMS
EMS ASSOCIATION


North Central
EMS Institute


Oregon
EMS Association
www.oregonems.org


PENNSYLVANIA EMERGENCY
HEALTH SERVICES COUNCIL
Your Voice In EMS.


PAAW
PROFESSIONAL AMBULANCE
ASSOCIATION OF WISCONSIN


SOUTH CAROLINA
EMS ASSOCIATION


VFIS
A Division of Glatfelter Insurance Group


Virginia
OFFICE OF EMERGENCY MEDICAL SERVICES
Virginia Department of Health


AAMS


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

Figure 4: Victim Age

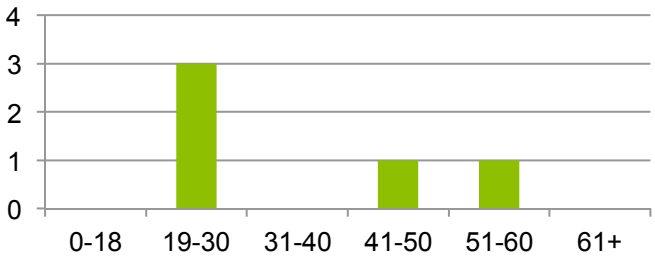
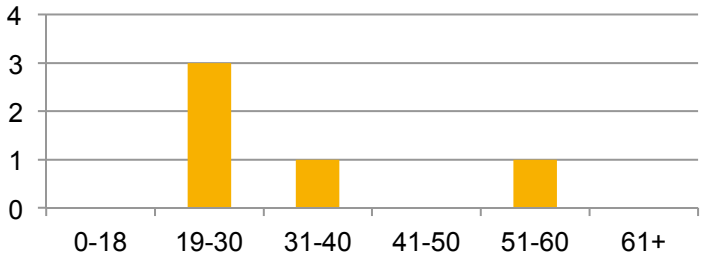
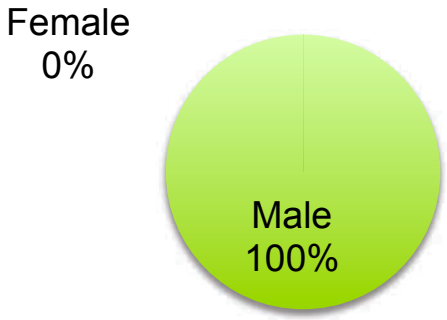


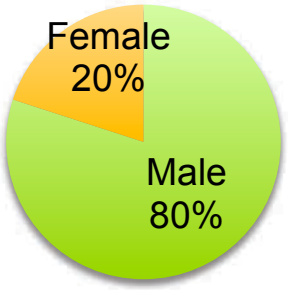
Figure 4A: Assailant Age



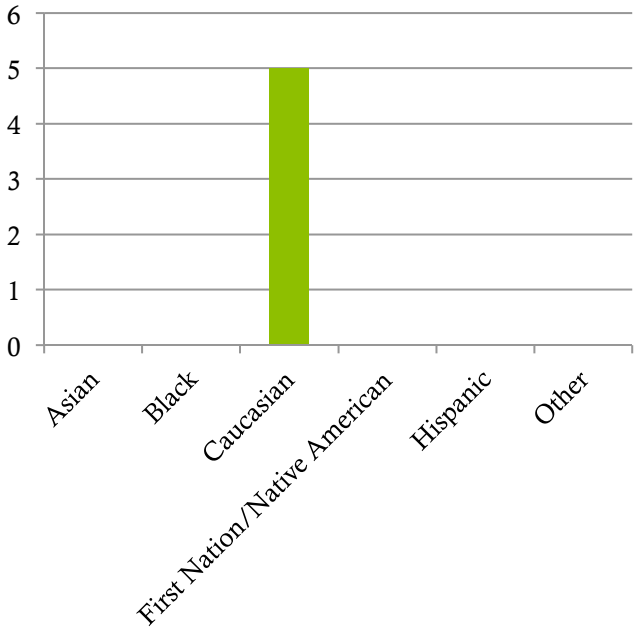
Victim Gender



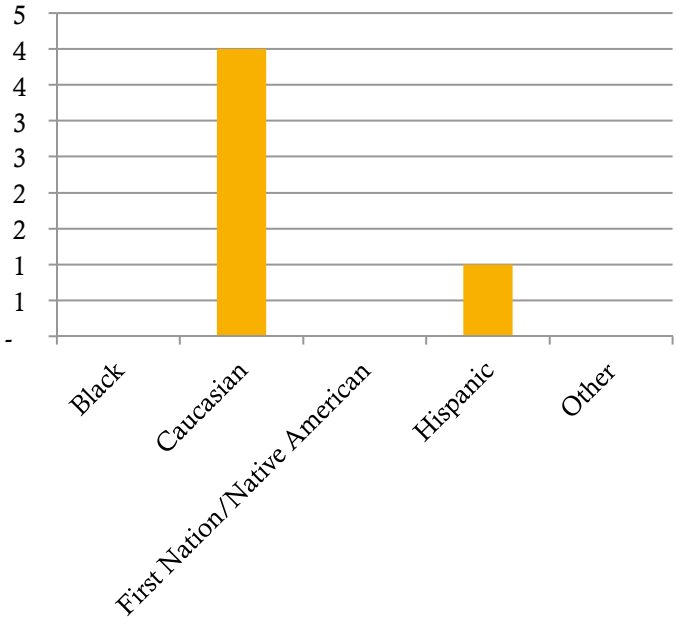
Assailant Gender



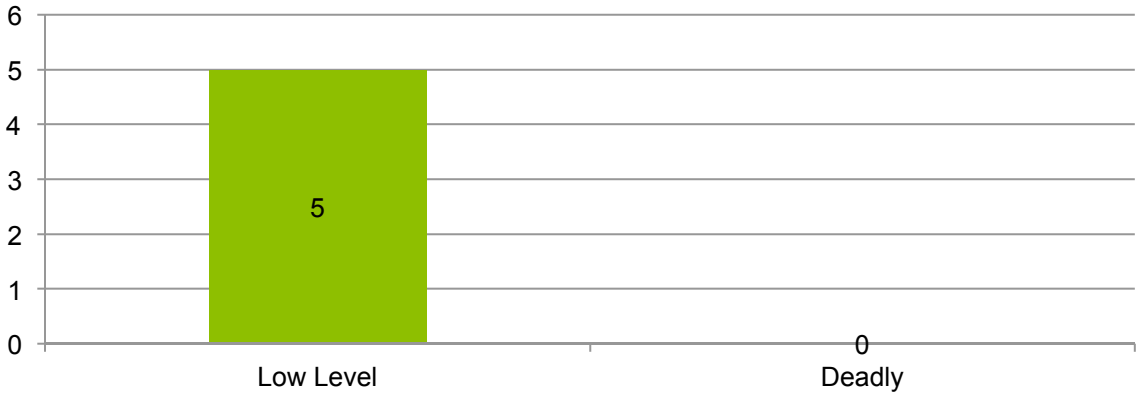
Victim Race



Asssailant Race



Paramedic's Perception of Harm



Type of Victim Injury

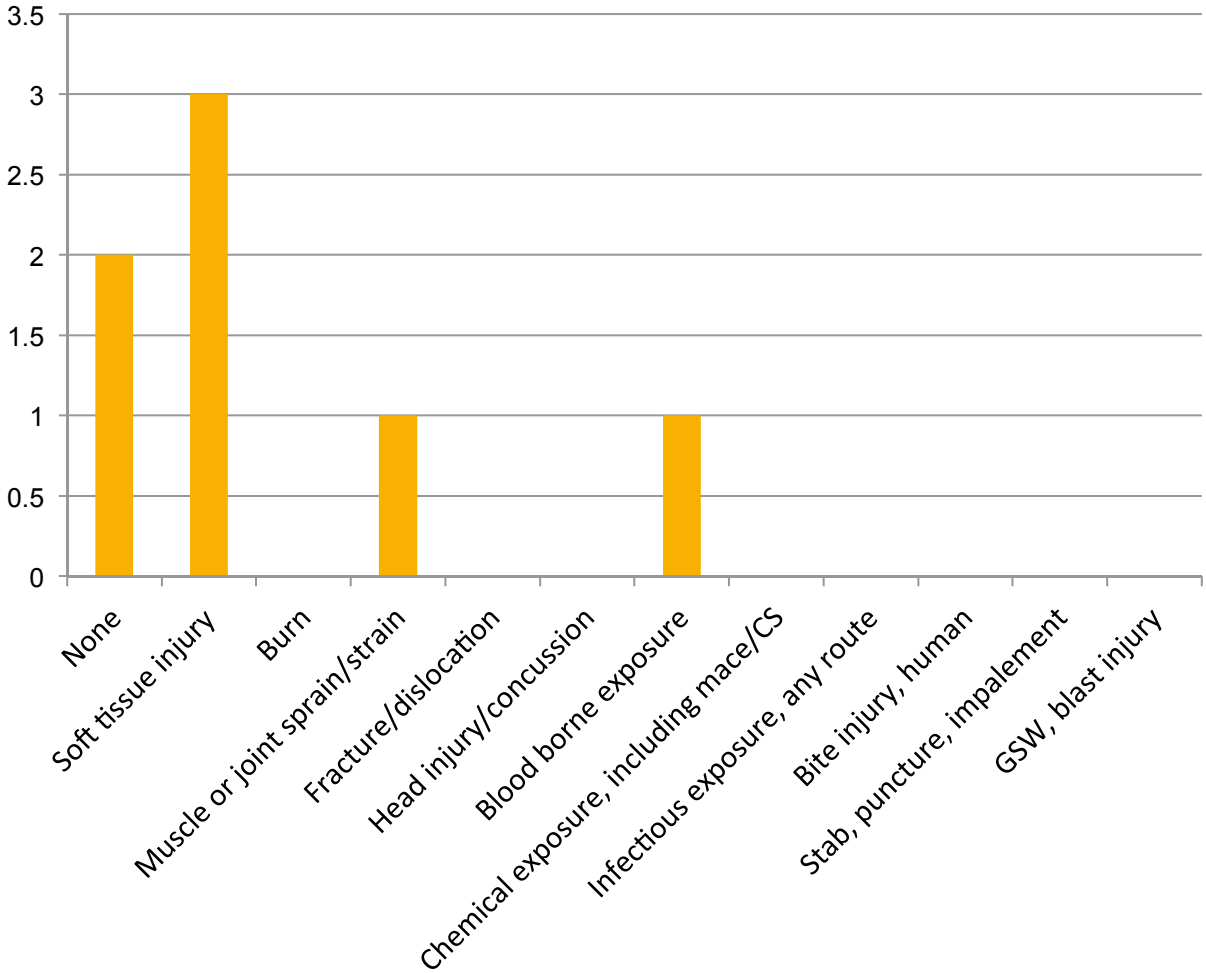


Figure 7: Type of Victim Treatment

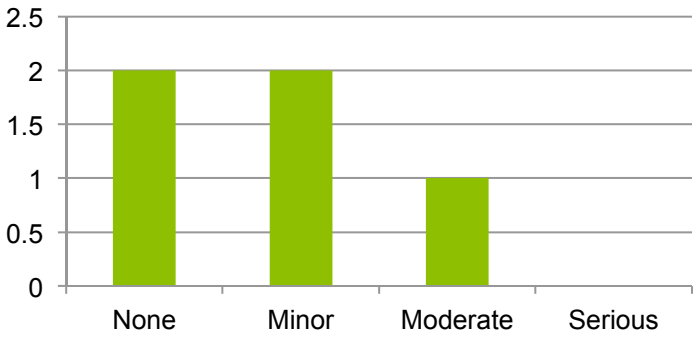


Figure 8: Method of Assault
Note: Multiple Options Reported

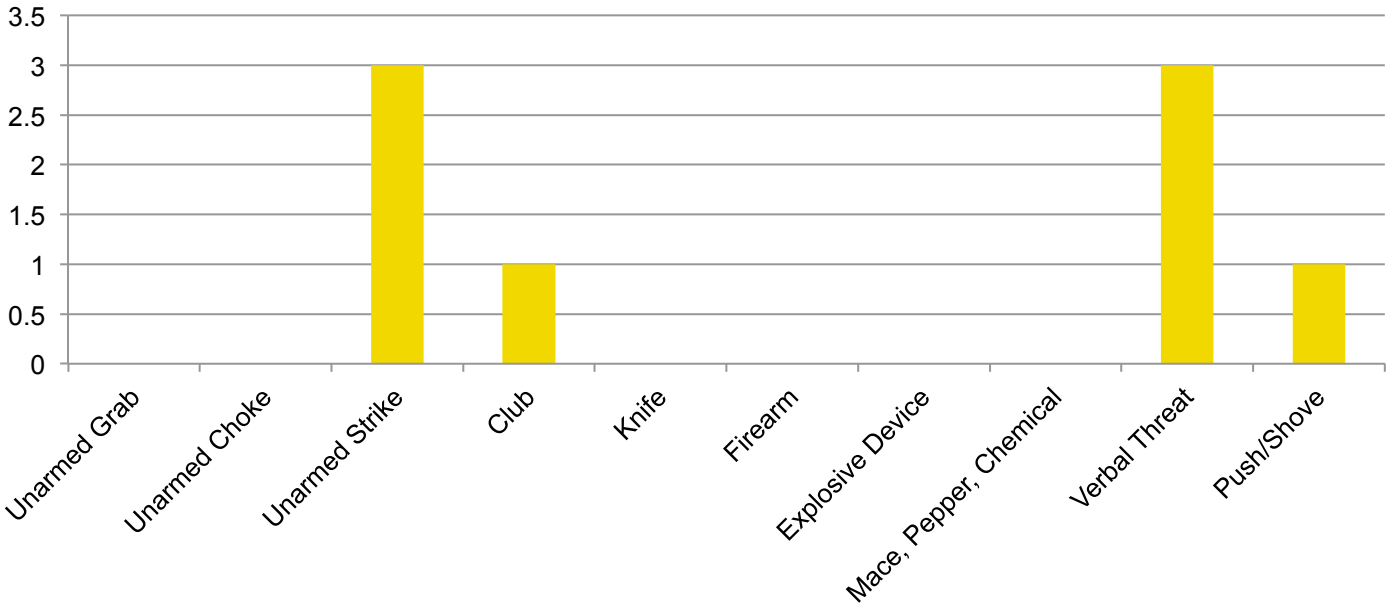


Figure 9: Internal Agency Report Filed

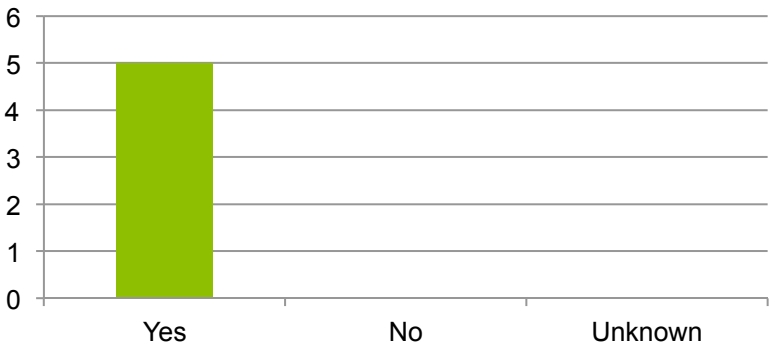


Figure 10: Law Enforcement Present or Notified

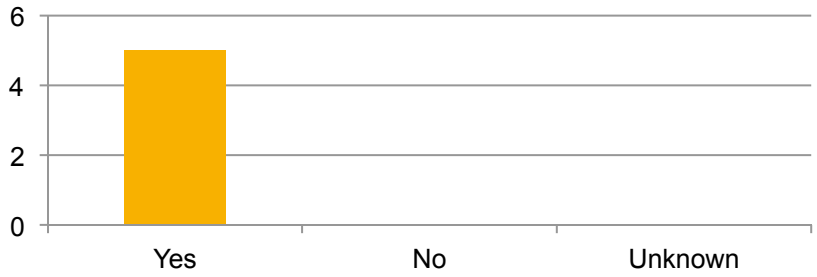
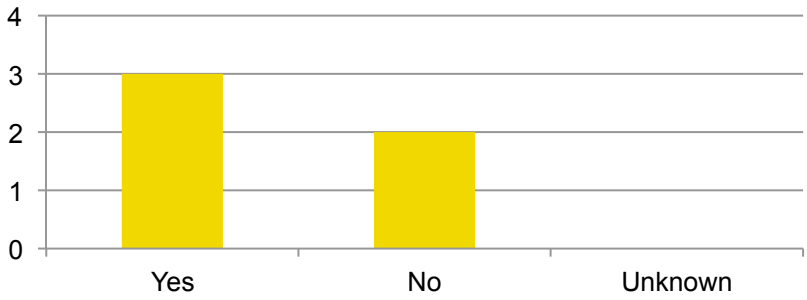


Figure 11: Assailant Arrest



#1	EMS responded to unconscious in taxi, patient roused with help of [law enforcement], patient uncooperative, patient refused medical attention and exited ambulance, on way out dropped personal belonging, when paramedic attempted to assist with gathering dropped belonging patient struck paramedic multiple times with cane. Patient subsequently arrested by [law enforcement], paramedic seen in emergency department for minor injuries and release to return to work in 3 days.
#2	Patient aroused at residence with ETOH on board. C/C chest pain. Refusing EMS but states he wanted to die. Threatened fire personnel on scene but calmed with law enforcement arrived then agreed to transport. Cardiac care carried out. At ED, patient became belligerent and telling EMS we did not provide any care. I was standing behind him and as he was moving around on stretcher, I reached around to prevent a fall. He swung his open hand striking the top of my head. I moved around to side to speak to him and again keep him from falling. As I did so he punched me in the face. My partner grabbed his other arm and before I could control his loose arm, I was struck again. Cut lip and nose bleed.
#3	Crewmember was in initial steps of obtaining BGL from slightly confused patient when patient unexpectedly punched provider in the face. Law enforcement officers witnessed & immediately subdued patient and placed into handcuff prior to ambulance transport. Patient had fallen down stairs in a residence and presented with some disorientation possibly related to either a seizure history or hypoglycemia. No harm to patient and provider sustained minor bruising to face. Patient appeared to be compliant with request to measure BGL & had extended his hand to provider before suddenly moved to punch with the same hand. Patient compliant for remainder of transport. Assault charges not pursued by provider or law enforcement.
#4	Medic unit dispatched to local police station for a 25 y/o male patient who requires admittance to local hospital for psych evaluation. Police on scene with patient at the police station and patient remaining calm. Patient was placed in the ambulance and once transport started patient became extremely violent with EMS making verbal threats of violence towards EMS. Patient also started to punch equipment in unit. Patient posed a extreme safety risk to EMS
#5	While on scene of an MVA with light entrapment of a child, the child's babysitter and driver was being assessed. She was sitting on the curb, thoroughly distraught, and smelling of alcohol. She became increasingly agitated when EMS was assessing her and asking medical questions, none of which were aimed towards the circumstances surrounding the accident, or potentially placing blame on the babysitter. Without warning, she swung her left arm towards the providers face while he was kneeling directly in from of her. Provider avoided begin hit, and promptly subdued the assailant. LEO observed the incident, and came running to assist. Assailant was placed under arrest for attempted felony assault of a healthcare worker.

Appendix

D

The Council of State Governments

RESOLUTION

RESOLUTION IN SUPPORT OF

THE RECOGNITION OF EMS PERSONNEL LICENSURE COMPACT (REPLICA)

WHEREAS, states have had the authority to license emergency medical service (EMS) personnel since the 1970s; and

WHEREAS, based on this authority, states have traditionally issued licenses according to their own individual regulations and assessments of an individual's fitness to practice; and

WHEREAS, these requirements vary considerably from state to state and no formal long-term inter-jurisdictional EMS licensing regime currently exists; and

WHEREAS, it is becoming increasingly common for EMS personnel to cross state borders to deliver emergency and life-saving services on a day-to-day basis; and

WHEREAS, this increased interstate movement places a new emphasis on how EMS personnel are licensed to ensure they are not practicing in a state in which they are not licensed to practice; and

WHEREAS, the growth of telehealth, a desire to increase access to health care professionals, the Affordable Care Act, and personal mobility are factors currently compelling several other medical professions to consider and adopt interstate licensing compacts; and

WHEREAS, the use of the interstate compact mechanism to address interstate emergencies and declared disasters is well established with interstate agreements such as the 50-state Emergency Management Assistance Compact and the regional Forest Fire Protection Compacts; and

WHEREAS, The Council of State Governments (CSG), through its National Center for Interstate Compacts, and in partnership with the National Associations of State EMS Officials (NASEMSO), with the support of the U.S. Department of Homeland Security has facilitated the development of the Recognition of EMS Personnel Licensure Compact (REPLICA) as a 50-state solution to this challenging policy issue; and

NOW, THEREFORE BE IT RESOLVED, that The Council of State Governments supports the establishment of the Recognition of EMS Personnel Licensure Compact (REPLICA) and encourages its member jurisdictions to consider the new interstate agreement as an innovative policy solution to the challenge of interstate EMS personnel emergency and life-saving operations.

Adopted this 13th Day of August, 2014 at the CSG National Conference in Anchorage, Alaska.

Appendix

E

RECOGNITION OF EMERGENCY MEDICAL SERVICES PERSONNEL LICENSURE

INTERSTATE COMPACT

("REPLICA")

September 2014

EMS PERSONNEL LICENSURE INTERSTATE COMPACT

SECTION 1. PURPOSE

In order to protect the public through verification of competency and ensure accountability for patient care related activities all states license emergency medical services (EMS) personnel, such as emergency medical technicians (EMTs), advanced EMTs and paramedics. This Compact is intended to facilitate the day to day movement of EMS personnel across state boundaries in the performance of their EMS duties as assigned by an appropriate authority and authorize state EMS offices to afford immediate legal recognition to EMS personnel licensed in a member state. This Compact recognizes that states have a vested interest in protecting the public's health and safety through their licensing and regulation of EMS personnel and that such state regulation shared among the member states will best protect public health and safety. This Compact is designed to achieve the following purposes and objectives:

1. Increase public access to EMS personnel;
2. Enhance the states' ability to protect the public's health and safety, especially patient safety;
3. Encourage the cooperation of member states in the areas of EMS personnel licensure and regulation;
4. Support licensing of military members who are separating from an active duty tour and their spouses;
5. Facilitate the exchange of information between member states regarding EMS personnel licensure, adverse action and significant investigatory information;
6. Promote compliance with the laws governing EMS personnel practice in each member state; and

7. Invest all member states with the authority to hold EMS personnel accountable through the mutual recognition of member state licenses.

SECTION 2. DEFINITIONS

In this compact:

A. **"**Advanced Emergency Medical Technician (AEMT)" means: an individual licensed with cognitive knowledge and a scope of practice that corresponds to that level in the National EMS Education Standards and National EMS Scope of Practice Model.

B. "Adverse Action" means: any administrative, civil, equitable or criminal action permitted by a state's laws which may be imposed against licensed EMS personnel by a state EMS authority or state court, including, but not limited to, actions against an individual's license such as revocation, suspension, probation, consent agreement, monitoring or other limitation or encumbrance on the individual's practice, letters of reprimand or admonition, fines, criminal convictions and state court judgments enforcing adverse actions by the state EMS authority.

C. "Alternative program" means: a voluntary, non-disciplinary substance abuse recovery program approved by a state EMS authority.

D. "Certification" means: the successful verification of entry-level cognitive and psychomotor competency using a reliable, validated, and legally defensible examination.

E. "Commission" means: the national administrative body of which all states that have enacted the compact are members.

F. "Emergency Medical Technician (EMT)" means: an individual licensed with cognitive knowledge and a scope of practice that corresponds to that level in the National EMS Education Standards and National EMS Scope of Practice Model.

G. “Home State” means: a member state where an individual is licensed to practice emergency medical services.

H. “License” means: the authorization by a state for an individual to practice as an EMT, AEMT, paramedic, or a level in between EMT and paramedic.

I. “Medical Director” means: a physician licensed in a member state who is accountable for the care delivered by EMS personnel.

J. “Member State” means: a state that has enacted this compact.

K. “Privilege to Practice” means: an individual’s authority to deliver emergency medical services in remote states as authorized under this compact.

L. “Paramedic” means: an individual licensed with cognitive knowledge and a scope of practice that corresponds to that level in the National EMS Education Standards and National EMS Scope of Practice Model.

M. “Remote State” means: a member state in which an individual is not licensed.

N. “Restricted” means: the outcome of an adverse action that limits a license or the privilege to practice.

O. “Rule” means: a written statement by the interstate Commission promulgated pursuant to Section 12 of this compact that is of general applicability; implements, interprets, or prescribes a policy or provision of the compact; or is an organizational, procedural, or practice requirement of the Commission and has the force and effect of statutory law in a member state and includes the amendment, repeal, or suspension of an existing rule.

P. “Scope of Practice” means: defined parameters of various duties or services that may be provided by an individual with specific credentials. Whether regulated by rule, statute, or court decision, it tends to represent the limits of services an individual may perform.

Q. “Significant Investigatory Information” means:

1. .investigative information that a state EMS authority, after a preliminary inquiry that includes notification and an opportunity to respond if required by state law, has reason to believe, if proved true, would result in the imposition of an adverse action on a license or privilege to practice; or

2. investigative information that indicates that the individual represents an immediate threat to public health and safety regardless of whether the individual has been notified and had an opportunity to respond.

R. “State” means: means any state, commonwealth, district, or territory of the United States.

S. “State EMS Authority” means: the board, office, or other agency with the legislative mandate to license EMS personnel.

SECTION 3. HOME STATE LICENSURE

A. Any member state in which an individual holds a current license shall be deemed a home state for purposes of this compact.

B. Any member state may require an individual to obtain and retain a license to be authorized to practice in the member state under circumstances not authorized by the privilege to practice under the terms of this compact.

C. A home state’s license authorizes an individual to practice in a remote state under the privilege to practice only if the home state:

1. Currently requires the use of the National Registry of Emergency Medical Technicians (NREMT) examination as a condition of issuing initial licenses at the EMT and paramedic levels;

2. Has a mechanism in place for receiving and investigating complaints about individuals;

3. Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding an individual;

4. No later than five years after activation of the Compact, requires a criminal background check of all applicants for initial licensure, including the use of the results of fingerprint or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation with the exception of federal employees who have suitability determination in accordance with US CFR §731.202 and submit documentation of such as promulgated in the rules of the Commission; and

5. Complies with the rules of the Commission.

SECTION 4. COMPACT PRIVILEGE TO PRACTICE

A. Member states shall recognize the privilege to practice of an individual licensed in another member state that is in conformance with Section 3.

B. To exercise the privilege to practice under the terms and provisions of this compact, an individual must:

1. Be at least 18 years of age;

2. Possess a current unrestricted license in a member state as an EMT, AEMT, paramedic, or state recognized and licensed level with a scope of practice and authority between EMT and paramedic; and

3. Practice under the supervision of a medical director.

C. An individual providing patient care in a remote state under the privilege to practice shall function within the scope of practice authorized by the home state unless and until modified by an appropriate authority in the remote state as may be defined in the rules of the commission.

D. Except as provided in Section 4 subsection C, an individual practicing in a remote state will be subject to the remote state's authority and laws. A remote state may, in accordance with due process and that state's laws, restrict, suspend, or revoke an individual's privilege to practice in the remote state and may take any other necessary actions to protect the health and safety of its citizens. If a remote state takes action it shall promptly notify the home state and the Commission.

E. If an individual's license in any home state is restricted or suspended, the individual shall not be eligible to practice in a remote state under the privilege to practice until the individual's home state license is restored.

F. If an individual's privilege to practice in any remote state is restricted, suspended, or revoked the individual shall not be eligible to practice in any remote state until the individual's privilege to practice is restored.

SECTION 5. CONDITIONS OF PRACTICE IN A REMOTE STATE

An individual may practice in a remote state under a privilege to practice only in the performance of the individual's EMS duties as assigned by an appropriate authority, as defined in the rules of the Commission, and under the following circumstances:

1. The individual originates a patient transport in a home state and transports the patient to a remote state;

2. The individual originates in the home state and enters a remote state to pick up a patient and provide care and transport of the patient to the home state;

3. The individual enters a remote state to provide patient care and/or transport within that remote state;

4. The individual enters a remote state to pick up a patient and provide care and transport to a third member state;

5. Other conditions as determined by rules promulgated by the commission.

SECTION 6. RELATIONSHIP TO EMERGENCY MANAGEMENT ASSISTANCE COMPACT

Upon a member state's governor's declaration of a state of emergency or disaster that activates the Emergency Management Assistance Compact (EMAC), all relevant terms and provisions of EMAC shall apply and to the extent any terms or provisions of this Compact conflicts with EMAC, the terms of EMAC shall prevail with respect to any individual practicing in the remote state in response to such declaration.

SECTION 7. VETERANS, SERVICE MEMBERS SEPARATING FROM ACTIVE DUTY MILITARY, AND THEIR SPOUSES

A. Member states shall consider a veteran, active military service member, and member of the National Guard and Reserves separating from an active duty tour, and a spouse thereof, who holds a current valid and unrestricted NREMT certification at or above the level of the state license being sought as satisfying the minimum training and examination requirements for such licensure.

B. Member states shall expedite the processing of licensure applications submitted by veterans, active military service members, and members of the National Guard and Reserves separating from an active duty tour, and their spouses.

C. All individuals functioning with a privilege to practice under this Section remain subject to the Adverse Actions provisions of Section VIII.

SECTION 8. ADVERSE ACTIONS

A. A home state shall have exclusive power to impose adverse action against an individual's license issued by the home state.

B. If an individual's license in any home state is restricted or suspended, the individual shall not be eligible to practice in a remote state under the privilege to practice until the individual's home state license is restored.

1. All home state adverse action orders shall include a statement that the individual's compact privileges are inactive. The order may allow the individual to practice in remote states with prior written authorization from both the home state and remote state's EMS authority.

2. An individual currently subject to adverse action in the home state shall not practice in any remote state without prior written authorization from both the home state and remote state's EMS authority.

C. A member state shall report adverse actions and any occurrences that the individual's compact privileges are restricted, suspended, or revoked to the Commission in accordance with the rules of the Commission.

D. A remote state may take adverse action on an individual's privilege to practice within that state.

E. Any member state may take adverse action against an individual's privilege to practice in that state based on the factual findings of another member state, so long as each state follows its own procedures for imposing such adverse action.

F. A home state's EMS authority shall investigate and take appropriate action with respect to reported conduct in a remote state as it would if such conduct had occurred within the home state. In such cases, the home state's law shall control in determining the appropriate adverse action.

G. Nothing in this Compact shall override a member state's decision that participation in an alternative program may be used in lieu of adverse action and that such participation shall remain non-public if required by the member state's laws. Member states must require individuals who enter any alternative programs to agree not to practice in any other member state during the term of the alternative program without prior authorization from such other member state.

SECTION 9. ADDITIONAL POWERS INVESTED IN A MEMBER STATE'S EMS AUTHORITY

A member state's EMS authority, in addition to any other powers granted under state law, is authorized under this compact to:

1. Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses and the production of evidence. Subpoenas issued by a member state's EMS authority for the attendance and testimony of witnesses, and/or the production of evidence from another member state, shall be enforced in the remote state by any court of competent jurisdiction, according to that court's practice and procedure in considering subpoenas issued in its own proceedings. The issuing state EMS authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service statutes of the state where the witnesses and/or evidence are located; and

2. Issue cease and desist orders to restrict, suspend, or revoke an individual's privilege to practice in the state.

SECTION 10. ESTABLISHMENT OF THE INTERSTATE COMMISSION FOR EMS PERSONNEL PRACTICE

A. The Compact states hereby create and establish a joint public agency known as the Interstate Commission for EMS Personnel Practice.

1. The Commission is a body politic and an instrumentality of the Compact states.

2. Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

3. Nothing in this Compact shall be construed to be a waiver of sovereign immunity.

B. Membership, Voting, and Meetings

1. Each member state shall have and be limited to one (1) delegate. The responsible official of the state EMS authority or his designee shall be the delegate to this Compact for each member state. Any delegate may be removed or suspended from office as provided by the law of the state from which the delegate is appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the member state in which the vacancy exists. In the event that more than one board, office, or other agency with the legislative mandate to license EMS personnel at and above the level of EMT exists, the Governor of the state will determine which entity will be responsible for assigning the delegate.

2. Each delegate shall be entitled to one (1) vote with regard to the promulgation of rules and creation of bylaws and shall otherwise have an opportunity to participate in the

business and affairs of the Commission. A delegate shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for delegates' participation in meetings by telephone or other means of communication.

3. The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws.

4. All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rulemaking provisions in Section XII.

5. The Commission may convene in a closed, non-public meeting if the Commission must discuss:

a. Non-compliance of a member state with its obligations under the Compact;

b. The employment, compensation, discipline or other personnel matters, practices or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;

c. Current, threatened, or reasonably anticipated litigation;

d. Negotiation of contracts for the purchase or sale of goods, services, or real estate;

e. Accusing any person of a crime or formally censuring any person;

f. Disclosure of trade secrets or commercial or financial information that is privileged or confidential;

g. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

h. Disclosure of investigatory records compiled for law enforcement purposes;

i. Disclosure of information related to any investigatory reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility of investigation or determination of compliance issues pursuant to the compact; or

j. Matters specifically exempted from disclosure by federal or member state statute.

6. If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The Commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release by a majority vote of the Commission or order of a court of competent jurisdiction.

C. The Commission shall, by a majority vote of the delegates, prescribe bylaws and/or rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of the compact, including but not limited to:

1. Establishing the fiscal year of the Commission;

2. Providing reasonable standards and procedures:

a. for the establishment and meetings of other committees; and

b. governing any general or specific delegation of any authority or function of the Commission;

3. Providing reasonable procedures for calling and conducting meetings of the Commission, ensuring reasonable advance notice of all meetings, and providing an opportunity

for attendance of such meetings by interested parties, with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and proprietary information, including trade secrets. The Commission may meet in closed session only after a majority of the membership votes to close a meeting in whole or in part. As soon as practicable, the Commission must make public a copy of the vote to close the meeting revealing the vote of each member with no proxy votes allowed;

4. Establishing the titles, duties and authority, and reasonable procedures for the election of the officers of the Commission;

5. Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar laws of any member state, the bylaws shall exclusively govern the personnel policies and programs of the Commission;

6. Promulgating a code of ethics to address permissible and prohibited activities of Commission members and employees;

7. Providing a mechanism for winding up the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment and/or reserving of all of its debts and obligations;

8. The Commission shall publish its bylaws and file a copy thereof, and a copy of any amendment thereto, with the appropriate agency or officer in each of the member states, if any.

9. The Commission shall maintain its financial records in accordance with the bylaws.

10. The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the bylaws.

D. The Commission shall have the following powers:

1. The authority to promulgate uniform rules to facilitate and coordinate implementation and administration of this Compact. The rules shall have the force and effect of law and shall be binding in all member states;

2. To bring and prosecute legal proceedings or actions in the name of the Commission, provided that the standing of any state EMS authority or other regulatory body responsible for EMS personnel licensure to sue or be sued under applicable law shall not be affected;

3. To purchase and maintain insurance and bonds;

4. To borrow, accept, or contract for services of personnel, including, but not limited to, employees of a member state;

5. To hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the compact, and to establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters;

6. To accept any and all appropriate donations and grants of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same; provided that at all times the Commission shall strive to avoid any appearance of impropriety and/or conflict of interest;

7. To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use, any property, real, personal or mixed; provided that at all times the Commission shall strive to avoid any appearance of impropriety;

8. To sell convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property real, personal, or mixed;

9. To establish a budget and make expenditures;

10. To borrow money;

11. To appoint committees, including advisory committees comprised of members, state regulators, state legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this compact and the bylaws;

12. To provide and receive information from, and to cooperate with, law enforcement agencies;

13. To adopt and use an official seal; and

14. To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of EMS personnel licensure and practice.

E. Financing of the Commission

1. The Commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities.

2. The Commission may accept any and all appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

3. The Commission may levy on and collect an annual assessment from each member state or impose fees on other parties to cover the cost of the operations and activities of

the Commission and its staff, which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the Commission, which shall promulgate a rule binding upon all member states.

4. The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall the Commission pledge the credit of any of the member states, except by and with the authority of the member state.

5. The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the Commission shall be audited yearly by a certified or licensed public accountant, and the report of the audit shall be included in and become part of the annual report of the Commission.

F. Qualified Immunity, Defense, and Indemnification

1. The members, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person.

2. The Commission shall defend any member, officer, executive director, employee or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

3. The Commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

SECTION 11. COORDINATED DATABASE

A. The Commission shall provide for the development and maintenance of a coordinated database and reporting system containing licensure, adverse action, and significant investigatory information on all licensed individuals in member states.

B. Notwithstanding any other provision of state law to the contrary, a member state shall submit a uniform data set to the coordinated database on all individuals to whom this compact is applicable as required by the rules of the Commission, including:

1. Identifying information;

2. Licensure data;

3. Significant investigatory information;

4. Adverse actions against an individual's license;

5. An indicator that an individual's privilege to practice is restricted, suspended or revoked;

6. Non-confidential information related to alternative program participation;

7. Any denial of application for licensure, and the reason(s) for such denial; and

8. Other information that may facilitate the administration of this Compact, as determined by the rules of the Commission.

C. The coordinated database administrator shall promptly notify all member states of any adverse action taken against, or significant investigative information on, any individual in a member state.

D. Member states contributing information to the coordinated database may designate information that may not be shared with the public without the express permission of the contributing state.

E. Any information submitted to the coordinated database that is subsequently required to be expunged by the laws of the member state contributing the information shall be removed from the coordinated database.

SECTION 12. RULEMAKING

A. The Commission shall exercise its rulemaking powers pursuant to the criteria set forth in this Section and the rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment.

B. If a majority of the legislatures of the member states rejects a rule, by enactment of a statute or resolution in the same manner used to adopt the Compact, then such rule shall have no further force and effect in any member state.

C. Rules or amendments to the rules shall be adopted at a regular or special meeting of the Commission.

D. Prior to promulgation and adoption of a final rule or rules by the Commission, and at least sixty (60) days in advance of the meeting at which the rule will be considered and voted upon, the Commission shall file a Notice of Proposed Rulemaking:

1. On the website of the Commission; and

2. On the website of each member state EMS authority or the publication in which each state would otherwise publish proposed rules.

E. The Notice of Proposed Rulemaking shall include:

1. The proposed time, date, and location of the meeting in which the rule will be considered and voted upon;

2. The text of the proposed rule or amendment and the reason for the proposed rule;

3. A request for comments on the proposed rule from any interested person; and

4. The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing and any written comments.

F. Prior to adoption of a proposed rule, the Commission shall allow persons to submit written data, facts, opinions, and arguments, which shall be made available to the public.

G. The Commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:

1. At least twenty-five (25) persons;

2. A governmental subdivision or agency; or

3. An association having at least twenty-five (25) members.

H. If a hearing is held on the proposed rule or amendment, the Commission shall publish the place, time, and date of the scheduled public hearing.

1. All persons wishing to be heard at the hearing shall notify the executive director of the Commission or other designated member in writing of their desire to appear and testify at the hearing not less than five (5) business days before the scheduled date of the hearing.

2. Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

3. No transcript of the hearing is required, unless a written request for a transcript is made, in which case the person requesting the transcript shall bear the cost of producing the transcript. A recording may be made in lieu of a transcript under the same terms and conditions as a transcript. This subsection shall not preclude the Commission from making a transcript or recording of the hearing if it so chooses.

4. Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

I. Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

J. The Commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

K. If no written notice of intent to attend the public hearing by interested parties is received, the Commission may proceed with promulgation of the proposed rule without a public hearing.

L. Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rulemaking procedures provided in the Compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than ninety (90) days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

1. Meet an imminent threat to public health, safety, or welfare;

2. Prevent a loss of Commission or member state funds;

3. Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule; or

4. Protect public health and safety.

M. The Commission or an authorized committee of the Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of thirty (30) days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing, and delivered to the chair of the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

SECTION 13. OVERSIGHT, DISPUTE RESOLUTION, AND ENFORCEMENT

A. Oversight

1. The executive, legislative, and judicial branches of state government in each member state shall enforce this compact and take all actions necessary and appropriate to effectuate the compact's purposes and intent. The provisions of this compact and the rules promulgated hereunder shall have standing as statutory law.

2. All courts shall take judicial notice of the compact and the rules in any judicial or administrative proceeding in a member state pertaining to the subject matter of this compact which may affect the powers, responsibilities or actions of the Commission.

3. The Commission shall be entitled to receive service of process in any such proceeding, and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the Commission shall render a judgment or order void as to the Commission, this Compact, or promulgated rules.

B. Default, Technical Assistance, and Termination

1. If the Commission determines that a member state has defaulted in the performance of its obligations or responsibilities under this compact or the promulgated rules, the Commission shall:

a. Provide written notice to the defaulting state and other member states of the nature of the default, the proposed means of curing the default and/or any other action to be taken by the Commission; and

b. Provide remedial training and specific technical assistance regarding the default.

2. If a state in default fails to cure the default, the defaulting state may be terminated from the Compact upon an affirmative vote of a majority of the member states, and all rights,

privileges and benefits conferred by this compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

3. Termination of membership in the compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by the Commission to the governor, the majority and minority leaders of the defaulting state's legislature, and each of the member states.

4. A state that has been terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.

5. The Commission shall not bear any costs related to a state that is found to be in default or that has been terminated from the compact, unless agreed upon in writing between the Commission and the defaulting state.

6. The defaulting state may appeal the action of the Commission by petitioning the U.S. District Court for the District of Columbia or the federal district where the Commission has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorney's fees.

C. Dispute Resolution

1. Upon request by a member state, the Commission shall attempt to resolve disputes related to the compact that arise among member states and between member and non-member states.

2. The Commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes as appropriate.

D. Enforcement

1. The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of this compact.

2. By majority vote, the Commission may initiate legal action in the United States District Court for the District of Columbia or the federal district where the Commission has its principal offices against a member state in default to enforce compliance with the provisions of the compact and its promulgated rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorney's fees.

3. The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or state law.

SECTION 14. DATE OF IMPLEMENTATION OF THE INTERSTATE COMMISSION FOR EMS PERSONNEL PRACTICE AND ASSOCIATED RULES, WITHDRAWAL, AND AMENDMENT

A. The compact shall come into effect on the date on which the compact statute is enacted into law in the tenth member state. The provisions, which become effective at that time, shall be limited to the powers granted to the Commission relating to assembly and the promulgation of rules. Thereafter, the Commission shall meet and exercise rulemaking powers necessary to the implementation and administration of the compact.

B. Any state that joins the compact subsequent to the Commission's initial adoption of the rules shall be subject to the rules as they exist on the date on which the compact becomes law in that state. Any rule that has been previously adopted by the Commission shall have the full force and effect of law on the day the compact becomes law in that state.

C. Any member state may withdraw from this compact by enacting a statute repealing the same.

1. A member state's withdrawal shall not take effect until six (6) months after enactment of the repealing statute.

2. Withdrawal shall not affect the continuing requirement of the withdrawing state's EMS authority to comply with the investigative and adverse action reporting requirements of this act prior to the effective date of withdrawal.

D. Nothing contained in this compact shall be construed to invalidate or prevent any EMS personnel licensure agreement or other cooperative arrangement between a member state and a non-member state that does not conflict with the provisions of this compact.

E. This Compact may be amended by the member states. No amendment to this Compact shall become effective and binding upon any member state until it is enacted into the laws of all member states.

SECTION 15. CONSTRUCTION AND SEVERABILITY

This Compact shall be liberally construed so as to effectuate the purposes thereof. If this compact shall be held contrary to the constitution of any state member thereto, the compact shall remain in full force and effect as to the remaining member states. Nothing in this compact supersedes state law or rules related to licensure of EMS agencies.

Appendix

F

State EMS Advisory Board
Motion Submission Form

Committee Motion: Name: _Trauma System Oversight & Management Committee

Individual Motion: Name: _____

Motion:

The TSO&MC moves that the EMS Advisory Board approve the 2015 Trauma Center Designation Manual.

It was determined at the June 2011 TSO&MC meeting to perform a full review and revision of the Trauma Center Designation Manual. Five subcommittees were established to review and make recommended changes to the Manual. The five areas of focus included operational, education/credentialing, performance improvement, special needs, and administrative.

The TSO&MC and the workgroups utilized the American College of Surgeons *Resources for the Optimal Care of the Injured Patient* as the national standard to base Virginia's trauma criteria on.

Upon completion of the work performed by the five workgroups; additional public meetings were held to provide pediatric stakeholders with additional opportunities to review and comment on these criteria.

EMS Plan Reference (include section number):
3.1.5 Maintain and Enhance Trauma Center Designation Process.

Committee Minority Opinion (as needed):
The committee member composition vote was Y: 8, N: 2, A: 0
One nay vote stated the agenda did not reflect discussing the action item, only voting on it.

For Board's secretary use only:
Motion Seconded By:
_____
Vote: _____ YEA _____ NAY _____ ABSTAIN

Board Minority Opinion:
_____
_____
_____

Meeting Date: _____

Appendix

G

2015

Virginia Department of Health's
Office of Emergency Medical Services

Paul Sharpe, Trauma/Critical Care
Coordinator

[VIRGINIA TRAUMA CENTER DESIGNATION MANUAL]

The purpose of the Virginia Trauma Designation Manual is to provide information and specific criteria on how trauma center designation is acquired and maintained.

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Manual Version History Log

Version Number	Release Date	Page(s) Affected	Description
V2015.1	2/16/2014	All	First release pre 3/5/2014 TSO&MC
V2015.1	9/4/2014		Approved by TSO&MC

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Table of Contents

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Preface

The purpose of the Virginia Trauma Center Designation Manual (Manual) is to provide information to hospitals, physicians, nurses, and administrators about trauma designation and verification in the Commonwealth of Virginia. This Manual contains the criteria and standards effective January 1, 2015 for the five designation levels of trauma designation recognized within the Commonwealth of Virginia.

Virginia trauma center standards are based upon national standards put forth by the American College of Surgeons (ACS) (ACS/COT, Resources for the Optimal Care of the Injured Patient, 2006) and the American College of Emergency Physicians (ACEP). Burn center criteria are based upon the American Burn Association's (ABA) standards (ACS/COT, Resources for Optimal Care of the Injured Patient 2006, Chapter 14, 2006). Neither set of standards is wholly adopted. Instead, stakeholder group input is utilized to adapt the standards to best fit the Virginia Trauma System. The State Board of Health (BOH) is the final approving body for these standards.

Development of the Manual begins with Virginia's statewide trauma committee, the Trauma System Oversight and Management Committee (TSO&MC). Once approved by the TSO&MC the Manual is presented to the Emergency Medical Services Advisory Board (EMS Advisory Board) for its approval. The EMS Advisory Board and the TSO&MC are advisory to the State Board of Health (BOH) and the Office of Emergency Medical Services (OEMS). Authority to approve the Manual rests solely with the BOH.

The purpose of the trauma designation process is to ensure a consistent minimum level performance of trauma centers in Virginia and to promote continued improvement and development of experienced centers thereby reducing morbidity and mortality of the traumatically and thermally injured patients of all ages.

Please direct questions or requests for further information or resources to the Virginia Department of Health's (VDH), Office of Emergency Medical Services (OEMS) Trauma/Critical Care Coordinator, 1041 Technology Park Drive, Glen Allen, Virginia 23059 or (804) 888-9100.

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Definitions

Adult Trauma Patient – A trauma patient 15 years of age or older.

Burn Center - A hospital that has been designated by the State Health Commissioner as a trauma/burn center after meeting the Level I trauma center and Level I burn center criteria contained within this document.

Burn Patient – A patient requiring treatment of burn-related injuries who should be referred to a designated trauma/burn center in the Commonwealth of Virginia for assessment and care.

Burn Service – An organized approach (within the designated trauma center) to the care of burn patients with a focus on performance improvement, education, and outreach. Burn Service administrative leadership addresses burn center standards under the direction of the Burn Medical Director.

Burn Service - The medical and surgical services that direct and coordinate the care of acute burn patients.

Burn Unit - The designated geographic area within a hospital that the majority of acute burn patients receive care.

Critical Deficiency – When a trauma or trauma/burn center demonstrates an absence or inadequate mechanism to address a specific critical criterion or criteria. Critical deficiencies shall be corrected as directed in this document to receive an unconditional designation.

Designated Trauma Center - The process by which the Virginia Department of Health (VDH) identifies hospitals that are prepared to consistently provide care to the traumatized patient.

Emergency Medical Services for Children (EMSC) – Is a state program supported by the Health Resources and Services Agency that supports state level programs focused on supporting the emergency medical needs of the pediatric population.

Experienced/Mature Trauma Center – A designated trauma or trauma/burn center that has completed at least one successful three-year verification cycle.

Immediately available - The physical presence of the health professional in a stated location able to provide care to the trauma patient.

Level I - Level I trauma centers have an organized trauma response and are required to provide definitive trauma care for every aspect of injury from prevention through rehabilitation. These facilities must have adequate depth of resources and personnel with the capability of providing leadership, education, research, and system planning.

Level IB – Meet all the requirements for Level I trauma center designation and the additional criteria specific to being designated as a trauma/burn center (denoted as Level IB or trauma/burn center). Designated trauma/burn centers must provide burn care across the age spectrum.

Pediatric Designation – Trauma centers designated as a pediatric trauma center will meet all the requirements of Level I trauma center designation, unless specified in the document, and additional pediatric criteria not required of other levels of designation. Hospitals that only manage pediatric patients will be required to meet Level I criteria for patient under 15 years of age.

Level II - Level II trauma centers have an organized trauma response and are also expected to provide initial definitive care, regardless of the severity of injury. Level II trauma centers must provide definitive trauma care for patients 15 years and older and provide prompt assessment, resuscitation, stabilization, emergency surgery, and arrange for the transfer of trauma patients under 15 years old. The specialty requirements may be fulfilled by on call staff members, which are promptly available to the patient. Due to some limited resources, Level II centers may have to transfer more complex injuries to a Level I center. Level II centers should also take on responsibility for education and system leadership within their region.

Level III - Level III centers, through an organized trauma response, can provide prompt assessment, resuscitation, stabilization, and emergency surgery for patients across the age spectrum. Level III centers may arrange for the transfer of trauma patients to a hospital that can provide definitive trauma care that cannot be managed by the resources dedicated to Level III designation. Level III centers should also take on responsibility for education and system leadership within their region.

Non-Critical Deficiency – The trauma or trauma/burn center demonstrates an absence or inadequate mechanism to address a specific non-critical criterion or criteria. While there is not an immediate negative impact on patient care, continuation of the present status will result in erosion of the program and development of a critical deficiency. Non-critical deficiencies seen during two consecutive site reviews shall be elevated to a critical deficiency.

Pediatric Trauma Patient – A trauma patient that is less than 15 years of age.

Tracer Methodology - The process involves interviewing the caregivers to evaluate the quality and safety of the patient care process. By evaluating the actual delivery of care services, less time is devoted to examining written policies and procedures.

Trauma Center – A hospital that has been designated by the Commissioner as a trauma center after demonstrating it meets the criteria throughout this document.

Team Leader – A surgeon that serves as the head of a trauma center site review team. This is typically a surgeon actively involved in an active trauma service.

Trauma Patient – The identification of patients that should be referred to a designated trauma center in the Commonwealth of Virginia for assessment and care. The Statewide Trauma Triage Plan (VDH/OEMS, 2011) sets the minimum standard for defining a trauma patient.

Trauma Registrar - The individual(s), responsible for entering, analyzing, and evaluating the data maintained in each trauma center's trauma registry.
Trauma Service - The medical and surgical services that direct and coordinate the care of acutely injured patients.

Trauma Team - A multidisciplinary healthcare team that is predetermined to provide an organized approach to providing trauma care.

TSO&MC - Trauma System Oversight and Management Committee is a subcommittee of the EMS Advisory Board and advises the OEMS and/or BOH. This is the Commonwealth's trauma stakeholder committee that works to develop, maintain, and improve Virginia's trauma system under the auspices of the BOH.

Virginia Statewide Trauma Registry (VSTR) - In Virginia, all hospitals that provide emergency services are required by the *Code of Virginia* §32.1-116.1 to report to the VSTR. The VSTR is used by Virginia's trauma system for performance improvement, research, injury prevention, resource utilization and the creation of state standards and benchmarks.

Abbreviations

ABLS – Advanced Burn Life Support sponsored by the American Trauma Society.
ACLS – Advanced Cardiac Life Support sponsored by the American Heart Association
ACS - American College of Surgeons.
ACS/COT - American College of Surgeons Committee on Trauma.
ATCN – Advanced Trauma Care for Nurses sponsored by the Society for Trauma Nurses.
ATLS – Advanced Trauma Life Support course sponsored by the ACS.
BOH – State Board of Health.
C – Critical criterion.
CEN – Certified Emergency Nurse.
CRNA – Certified Registered Nurse Anesthesiologist.
CEO – Chief Executive Officer.
CATN – Course in Advanced Trauma Nursing sponsored by the Emergency Nursing Association.
COT – Committee on Trauma.
CT – Computed Tomography Scanning.
CEU – Continuing Education Unit.
CME – Continuing Medical Education.
DOA – Dead on arrival.
ECG – Electrocardiogram
ED – Emergency Department.
EMS – Emergency Medical Services.
EMSC – Emergency Medical Service for Children.
ENA – Emergency Nurses Association.
ENPC – Emergency Nurses Pediatric Course sponsored by the ENA.
ENT – Ear, Nose, and Throat surgery service.
ETT – Endotracheal tube.
ISS – Injury severity score.
ICU – Intensive Care Unit.
ICD9 - Ninth edition of International Classification of Disease.
ICD10 - Tenth edition of International Classification of Disease.
ICP – Intracranial pressure.
IV – Intravenous.
LPN/LVN – Licensed professional nurse/licensed vocational nurse.
MRI – Magnetic resonance imaging.
MD – Medical doctor.
NC – Non-critical Criterion.
OEMS – The Virginia Office of Emergency Medical Services.
OR – Operating room.

PALS – Pediatric Advanced Life Support sponsored by the AHA.
PI – Performance improvement; used to describe quality assurance efforts (QA/QI/CQI).
PACU – Post Anesthesia Care Unit.
PGY4/PGY5 - postgraduate year; classification system for residents in postgraduate training. The number after PGY indicates the year of residency the physician is in since graduating from medical school.
PHTLS – Prehospital Trauma Life Support sponsored by the ACS/COT.
RN – Registered Nurse.
RTTDC – Rural Trauma Team Development Course sponsored by the ACS.
STN – Society of Trauma Nurses.
TEH - Trauma education hour(s) is the equivalent of 60 minutes of trauma education.
TMD – Trauma Medical Director.
TNCC – Trauma Nurse Core Curriculum sponsored by the ENA.
TPM – Traditionally called the trauma nurse coordinator (TNC); this position varies by center and is more frequently a trauma director or trauma program manager. This position will be referred to as the TPM throughout this document for reasons of editing only.
TSO&MC – The Trauma System Oversight and Management Committee; this is the Commonwealth's statewide trauma advisory committee.
VDH – Virginia Department of Health.
VDH/OEMS – Virginia Department of Health's Office of Emergency Medical Services.
VSTR – Virginia Statewide Trauma Registry.

Trauma Center Designation

This resource document, The Virginia Trauma Center Designation Manual, and other materials are available at www.vdh.virgina.gov/oems. Virginia trauma center criteria are based on the *Resources for Optimal Care of the Injured Patient: 2006* (ACS/COT, Resources for the Optimal Care of the Injured Patient, 2006).

The Trauma System Oversight and Management committee (TSO&MC), a subcommittee of the EMS Advisory Board (Advisory Board), is tasked with advising the State Board of Health (BOH) and the Office of Emergency Medical Services in matters related to the Virginia's trauma system, trauma center designation, and the Virginia Statewide Trauma Registry (VSTR).

Each subcommittee of the EMS Advisory Board maintains a vision, mission statement, and core objectives that are accepted by the full EMS Advisory Board. The TSO&MC's are as follows:

Vision – The TSO&MC will collaborate to support a statewide inclusive trauma system through evaluation, planning, and performance improvement.

Mission – To advise the BOH and the OEMS with maintaining an inclusive system that ensures when the severity and incidence of trauma cannot be prevented, that all injured persons within the Commonwealth have rapid access to optimal, equitable, and efficient specialized trauma care to prevent further disability or death utilizing a public health approach.

Core Objectives - Advise the OEMS on matters relating to:

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

(The vision, mission statement, and core objectives were created during the process to revise the August 13, 2010 EMS Advisory Board Bylaws)

The process of designation is voluntary on the part of the hospitals in the Commonwealth. It is meant to identify those hospitals that will make a commitment to provide a given level of care

for the seriously injured and/or burned patient and who welcome public acknowledgment of that capability. System knowledge of trauma and burn care capabilities, with improved prehospital categorization of trauma patients will help all those involved in the trauma and burn care delivery system make decisions that are in the best interest of the patient.

The designation process is as follows:

- Any hospital that desires consideration for designation will make a request to the Virginia Department of Health's (VDH) OEMS Trauma/Critical Care Coordinator. The request, with statement of community need or justification, and its impact on the regional trauma system will be included with the hospital's application for designation. The application can be obtained on-line at http://www.vdh.virginia.gov/OEMS/Trauma/TraumaSystem.htm or from the VDH/OEMS Trauma/Critical Care Coordinator.

- Items that comprise a complete trauma center designation application can be found in the application document titled Application Checklist Trauma Designation v2015.

- The application for designation should include the hospital name, parent company, chairperson of its board of directors, chief executive officer (CEO), nurse executive, administrator in charge of the trauma service, trauma medical director, trauma program manager, and the emergency department medical director.

- The Trauma/Critical Care Coordinator will review the application for the appearance of compliance with the required standards stated in this Manual. Additional clarifying documents or information may be required.

- A trauma center designation site review (site review) will only be scheduled after a hospital can demonstrate the appearance that it meets trauma center criteria, compliance with the VSTR data submission requirements (see criterion 10.2), and compliance with the Commonwealth's prehospital and interhospital trauma triage plan (VDH/OEMS, 2011).

- A site review will be scheduled within six months of receiving a completed application. The hospital will receive an agenda, list of documents required to be available, and personnel needed to be available at the time of the site review 30 days prior to the confirmed site review date.

- An initial site review will be scheduled for the purpose of awarding provisional status as a trauma center. Upon completion of one year as a provisional trauma center, the

hospital will be required to submit an interim report describing any changes since designation as a provisional center and undergo a modified site review.

- The modified site review will be conducted by a trauma center designation site review team (site review team) consisting of a surgeon team leader, a trauma/critical care RN, and the OEMS Trauma/Critical Care Coordinator. If there are no critical deficiencies identified during the modified site review, the site review team will recommend that the hospital be unconditionally designated as a trauma or trauma/burn center by the State Health Commissioner (Commissioner).

- Site review teams will be composed of the following roles:
    - For Level I and Level IB trauma center designation:
        - An out-of-state trauma surgeon (upon request of the applying hospital and /or review team).
        - An in-state trauma surgeon/team leader.
        - A trauma/critical care nurse.
        - An ED physician.
        - A hospital administrator.
        - OEMS Trauma/Critical Care Coordinator.

    - For Level II and Level III trauma center designations
        - An in-state trauma surgeon / team leader.
        - An ED physician.
        - A trauma / critical care nurse.
        - Hospital administrator.
        - OEMS Trauma/Critical Care Coordinator.

    - For pediatric trauma center designations
        - A pediatric trauma surgeon will be added to the above team.
        - A pediatric critical care RN will be added to the above team.

- At the conclusion of each site review, the site review team members will submit a summary of their findings and recommendations through a written team report to the Commissioner.

- This report may be developed on-site by the site review team or through individual reports submitted by the team members to the team leader, who in turns develops a summary report. If the team report is not completed on-site team members will have their summary to the team leader within 14 days. The team leader will have their report

and team members' reports to the OEMS Trauma/Critical Care Coordinator within 30 days of the site review date.

- The site review team may share the draft copy of the summary report to the candidate hospital at the conclusion of the review.

- OEMS staff may edit the draft team report for grammatical errors, spelling errors, and meet regulatory language without changing the intent of the site review team, prior to submission to the Commissioner.

- A trauma center designation verification site review will be required triennially. The triennial site review is based upon the date of full site review dates and not modified site review dates. Site review teams may recommend the verification cycle be of a lesser time period as deemed necessary.

- The finalized report will be submitted to the Commissioner for consideration to designate the hospital as a provisional trauma center for a one-year period or a designated trauma center for two-year period from the date of notification. Provisional trauma center designation is granted after an initial site review and full designation after the modified site review noted supra.

- Designation is at the discretion of the Commissioner and variations of designation cycles may be utilized, as well as special conditions.

- The hospital will receive a copy of the final version of the site review team's final report along with the Commissioner's determination to grant or deny trauma center designation.

- In the event that the hospital disagrees with the report, the hospital may choose to initiate an appeals process (see pediatric surgery section) as outlined later in this document.

Trauma Center Verification

Trauma center verification is the process used to confirm that existing designated trauma centers are maintaining the resources and ability to meet trauma center designation criteria. The process of trauma center verification is similar to initial trauma center designation as outline in the previous section and is as follows:

- A written renewal notice will be sent by the OEMS Trauma/Critical Care Coordinator to the hospital's Chief Executive Officer (CEO) with a courtesy copy to the trauma medical director and trauma program manager approximately six months prior to the expiration of the current designation.

- The hospital applying for trauma center verification shall submit proposed site review dates as prescribed by the OEMS within 30 days of receiving the renewal notice.

- The hospital will receive a confirmation date from OEMS within 30 days of the submitted proposed site review dates.

- The hospital shall submit a complete designation application no later than 60 days prior to the confirmed site review date. The completed application will include the following items:
    - Acknowledgement that the OEMS Trauma Designation File has been reviewed.
    - Submissions to the VSTR are up to date per the established submission schedule.
        - January 1st thru March 31st - due on May 31st
        - April 1st thru June 30th - due on August 31st
        - July 1st thru September 30th - due on November 30th
        - October 1st thru December 31st - due on February 28th/29th
    - A signed Trauma Center Code of Conduct (electronic form provided).
    - A completed Trauma Center Capabilities form (electronic form provided).
    - A current Organizational Chart describing the relationship of the trauma service within the hospital organizational structure.
    - An impact statement as stated later in the criteria.
    - Completion of the Trauma Center Criteria Checklist applicable to the Level of designation being applied for (electronic form provided).
    - Submission of a completed Trauma Center Questionnaire (electronic form provided).
    - A list of all emergency physicians employed in the ED during the verification cycle (includes locum tenens).
    - A list of all surgeons performing trauma call during the verification cycle (includes locum tenens).

- A copy of the trauma call schedule for the most recent three consecutive months.
- A copy of the trauma team activation / alert criteria for your hospital.
- A copy of your hospital's trauma team roles & responsibilities policy / procedure.
- A copy of all trauma activation / alert policies.
- An official copy of the Trauma Medical Director's (TMD) job description.
- Evidence of the TMD's board certification(s).
- Evidence of the TMD's current ATLS certification.
- Evidence of the TMD's compliance with continuing medical education (CME) requirements.
- Evidence of the TMD's attendance at a national conference (if applicable).
- Evidence of the Burn Medical Director's board certification (if applicable).
- Evidence of the Burn Medical Director's compliance with CME requirements (if applicable).
- A copy of the Trauma Program Manager's (TPM) job description (include Org. Chart).
- Evidence of the TPM's compliance with trauma educational hour (TEH) requirements.
- Evidence of the TPM's attendance at a national conference (if applicable).
- A copy of the burn Manager's job description (if applicable).
- Evidence of the Burn Manager's compliance with burn specific educational hour requirements (if applicable).
- A copy of each trauma registrars' (registrar) job description.
- Evidence of each registrar's compliance with continuing educational requirements.
- Provide a complete list of current nursing staffs that serve as the trauma team primary nurse in the trauma resuscitation room. Include whether the trauma team nurses possess active TNCC, ATCN, or CATN certifications.
- Evidence of the Emergency Medical Director's board certification.
- Evidence of the Emergency Medical Director's CME.
- Evidence of the Emergency Medical Director's current ATLS or the identified designee's current ATLS.
- Performance improvement (PI) process flow diagram.
- PI worksheet / tracking Sheet.
- PI plan / policy.
- Any other documents as requested.

➢ The site review team will be composed of a trauma surgeon / team leader, an emergency medicine representative, a trauma / critical care nurse, hospital administration representative, and the OEMS Trauma/Critical Care Coordinator. The OEMS

Trauma/Critical Care Coordinator can cover any vacant position except for the surgeon / team leader role if needed.

- The site review day will occur as follows:

  - There will be an opening conference with the key hospital staffs that routinely provide direct and ancillary services to trauma patients and the site review team. The key individuals include, but are not limited to: the TMD, TPM, Burn Medical Director, Emergency Medicine Medical Director, the hospital administrator that is the immediate supervisor for the trauma service, the liaisons from orthopedic surgery, anesthesiology, radiology, and neurosurgery and pediatric surgery if applicable, trauma nurse clinicians, nurse managers from the ED, operating room (OR), intensive care units (ICU), pediatric and trauma nursing floors, trauma registrar, PI coordinator, rehabilitation medicine, lab/blood blank representatives, local EMS Chiefs, and OMDs.

  - After the opening conference Trauma Service staffs will provide a presentation demonstrating their performance improvement process to the site review team. Including PI cases that have resulted in operational and clinical policy / protocol changes.

  - The site review team will tour the hospital with the hospital staff person that is in an equivalent role to the team member. Appointments for individual meetings between the site review administrative team member and the hospital's CEO, Chief Nursing Officer (CNO), and the administrator that is the immediate supervisor of the trauma service shall be arranged.

  - The site review team shall be provided with a work area to privately review hospital medical records. The team may also use a tracer methodology and review charts of active patients. Medical records are chosen in advance by the VDH/OEMS using the VSTR, EMS registry, other validated sources, and from any public concerns submitted to the OEMS. Additional medical records may be requested during the review.

  - There shall be a review of PI documentation.

  - There will be an exit conference with the TMD, TPM, and the hospital administrator with direct responsibility for the trauma service, and the CEO and CNO if desired will be held.

- At the conclusion of each site review, the site review team will document their findings in the form of team report that includes the strengths, opportunities for improvement, non-critical deficiencies, and critical deficiencies observed during the site review.

- The site review team members will include in the team report a recommendation to the Commissioner of whether the hospital should be verified as a designated trauma center within the team report.

- The team report may be developed on-site by the site review team or through individual reports submitted by the team members to the team leader, who in turns develops a summary report. If the team report is not completed on-site team members will have their summary to the team leader within 14 days. The team leader will have their report and team members' reports to the OEMS Trauma/Critical Care Coordinator within 30 days of the site review date.

- The site review team may share the draft copy of the summary report with the trauma center at the conclusion of the site review.

- OEMS staff may edit the draft team report for grammatical errors, spelling errors, and meet regulatory language without changing the intent of the site review team, prior to submission to the Commissioner.

- The finalized team report will be submitted to the Commissioner for consideration to verify the hospital as a designated trauma center.

- Acting upon the recommendation of the site review team, the Commissioner may verify the designation of the trauma and / or trauma/burn center for a three-year period from the date of the full site review.

- Designation is at the discretion of the Commissioner and variations of designation cycles may be utilized, as well as special conditions.

- A trauma center designation verification site review will be required triennially. The triennial site review is based upon the date of the initial full site review and not modified site review date(s). Site review teams may recommend the verification cycle be of a lesser time period as deemed necessary.
- If a trauma or trauma/burn center fails to meet critical criteria / receives a critical deficiency during a site review or by other evidence, the hospital will receive written notification by the OEMS Trauma/Critical Care Coordinator.

- The trauma center will submit a written plan of correction for each critical deficiency within 30 days after formal written notification. The trauma center will have six months, from the date of notification to correct all deficiencies and undergo a modified site review performed by the team leader, OEMS staff, and other team members as needed from the initial review. The team leader may be replaced for extenuating circumstances. The team leader may also deem a repeat review unnecessary with the submission of appropriate documentation that demonstrates the deficiency has been corrected.

- If the deficiencies are not corrected within the six-month period trauma center designation will be withdrawn by the Commissioner. If the hospital desires designation as a trauma center, it must wait a minimum of six months and reapply.

Burn Center Designation

The purpose of the burn center designation process is to ensure consistent performance of trauma / burn centers in Virginia and to promote continued improvement and development of experienced burn centers and thereby reducing morbidity and mortality of the thermally injured patient.

The intent of this document is to outline the criteria for the designation and verification of trauma / burn centers in Virginia. This document defines the essential components of burn centers in Virginia and outlines administrative guidelines describing the procedures and steps required for the process and interpretive guidelines describing how burn center criteria should be evaluated during a site review.

The objective is to provide a consistent, objective, and meaningful approach to the designation and verification process. Hospitals seeking burn center designation must be physically co-located with a Level I trauma center.

Pediatric Trauma Center Designation

All designated trauma centers are required to provide emergent stabilization and life or limb saving emergency surgery for trauma patients of all ages. All trauma centers are required to provide definitive trauma care for trauma patients 15 years of age and older based on their level of designation.

As of this version of the Commonwealth's Trauma Center Designation Manual, any hospital that solely treats a pediatric population (for the purposes of the Virginia Trauma System pediatric is defined as less than 15 years of age) may be granted trauma center designation.

If a "pediatric hospital" wishes to seek and maintain trauma center designation, it shall meet all criteria for Level I trauma center designation adjusted as age appropriate for trauma patients less than 15 years of age. The pediatric hospital that is designated as a trauma center shall not treat trauma patients 15 years of age or older. In such a case that a pediatric hospital exists as a trauma center, the State or regional trauma triage plan for its catchment area will clearly define the appropriate point-of-entry plan for utilization of this resource.

Trauma Center Criteria

The criteria are listed below as either "C," which are critical criteria or "NC" which are non-critical criteria. Failure to meet any single critical criterion constitutes a failure to pass designation or verification. Receiving the same non-critical criteria during two consecutive designation or verification site reviews constitutes a failure to pass designation or verification.

Level:	I	IB	Peds	II	III
1. Organization Requirements					
1.1. The Trauma Service shall be a recognizable service line within the hospital.	C	C	C	C	C
1.2. There shall be evidence of the hospital's Board of Directors supporting the Trauma Service's care for all levels of designation sought.	C	C	C	-	-
1.3. There shall be evidence of the hospital's Board of Directors support for the Trauma Service.	-	-	C	C	C
Measure: current resolution that is reaffirmed triennially from the Board of Directors or equivalent body.					
1.4. Support of the hospital's Board of Directors. (The Board of Directors shall be notified of applications for all levels of trauma designation, verification, and approval by the State Health Commissioner after a site review).	C	C	C	C	C
1.5. The hospital shall provide sufficient infrastructure and support to the trauma service to ensure the adequate provision of trauma care.	C	C	C	C	C
1.6. There shall be evidence of support for trauma center designation by the hospital's medical staff executive committee.	C	C	C	C	C-
Measure: current resolution that is reaffirmed triennially from the medical staff executive committee or equivalent body.					
1.7. Hospital administration shall be supportive of the trauma service.	C	C	C	C	C
1.8. Upper level administrative personnel shall demonstrate knowledge, familiarity, and commitment to maintaining trauma center at all levels of designation.	C	C	C	C	C
1.9. Upper level administration participation shall be available to support the trauma service as needed for issues that require a higher level of authority to accomplish resolution of issues.	C	C	C	C	C
1.10. There shall be evidence of an annual trauma service specific budget that includes utilization of funding received from the Trauma Center Fund.	C	C	C	C	C
1.11. The hospital shall provide adequate human and physical	NC	NC	NC	NC	NC

Level:	I	IB	Peds	II	III
resources to provide acute trauma care consistent with its level of trauma center designation.					
Interpretive Guidance: Institutions should have an allocated budget for the trauma or burn program(s), however; the institution can demonstrate compliance with the criteria by documenting that the expenses and revenues associated with the program are routinely evaluated. Development and maintenance of any level of trauma center requires non-clinical time, space, equipment and supplies. Allowances for these should be included in the budget. As the number of patients admitted to the service increases, it is reasonable to expect increasing demands in terms of non-clinical time and support. For example, according to ACS recommendations, a full time registrar is expected to manage information entry and retrieval on 750 patients or less. The site review team should identify sufficient resources to support non-clinical activities. They will be aware of the fact that multiple management responsibilities may prevent functioning at full time status. There should also be demonstrated effort to identify costs related to the trauma service. It is important for the hospital leadership to be aware of this in order to avoid sudden discoveries of expenses and equally sudden withdrawals. Additionally, it is difficult to determine if resources are adequate if program expenses are unknown. In recent years, trauma centers have also been asked to provide information on the cost of trauma care in order to assess the overall impact of this on Virginia healthcare; in this setting provision of general information on expenses and reimbursement is a means of participation in the trauma system. There is currently no standard reporting format for expenses, reimbursement, and budgetary allocations. Financial information on the trauma or burn program should be collected and reported to the administration, TMD, and TPM in a manner which is meaningful and useful for planning.					
2. Trauma Service Infrastructure					
2.1. The Trauma Service shall be an identifiable service within the hospital.	C	C	C	C	C
2.2. The Trauma Service shall have a surgeon as its director / physician-in-charge (referred to throughout this Manual as the TMD.)	C	C	C	C	C
The institution may choose to add an emergency physician co-director to the program. The presence of a co-director does not change requirements for experience, education, and participation of the surgeon in the program. Advantages of a co-director include assistance in performing administration, coordination, education, and evaluation of care normally assigned to the surgeon director. Additionally, the emergency physician will provide a different emphasis on the management of trauma with a greater focus on acute resuscitation. No requirements are provided for the position of trauma co-director. However; if the institution chooses to include this position, it must provide a job description and qualifications.					
2.3. The Trauma Service shall have a trauma director / trauma program manager / trauma nurse coordinator (referred to throughout this document as the TPM.)	C	C	C	C	C
2.4. The Trauma Service shall have a trauma registrar(s).	C	C	C	C	C

Level:	I	IB	Peds	II	III
2.5. There shall be a trauma service manual that reflects the actual procedures and protocols being practiced on the service.	C	C	C	C	C
2.6. There shall be an identifiable trauma response for the resuscitation of seriously or potentially seriously injured patients.	C	C	C	C	C
2.7. There shall be a consistent implementation of the trauma response as described in the trauma service manual.	C	C	C	C	C
2.8. The Trauma Service shall have a written mission statement describing the provision of comprehensive trauma care within a trauma system.	C	C	C	C	C
2.9. The Trauma Service shall have an impact statement describing the role of the trauma center in the regional trauma system.	NC	NC	NC	NC	NC
2.10. The Trauma Service shall develop and maintain a long-term strategic plan.	NC	NC	NC	NC	NC
Interpretive Guidance: This version of the designation criteria continues to emphasize continuous development and improvement. Presence of a planning process for the program(s) (which may include a business or strategic plan) allows for anticipated response to changes in the trauma care environment as well as possible improvements in delivery of care. Programs are expected to show progress and capacity for change in response to environmental stresses. During the site review opening conference the director will be asked to list strengths and weaknesses of the program.					
2.11. The TMD shall participate in trauma call.	C	C	C	C	C
2.12. The TMD shall be active in delivering clinical care to trauma patients.	C	C	C	C	C
2.13. The TMD shall have the responsibility and authority to determine each general surgeon's ability to perform trauma call.	NC	NC	NC	NC	NC
2.14. The TMD shall oversee all aspects of multidisciplinary trauma care from the time of injury to discharge.	C	C	NC	C	C
2.15. The TMD shall have the responsibility and authority to ensure compliance with trauma center designation and verification criteria.	NC	NC	NC	NC	NC
2.16. The TMD shall be involved in the development of the hospital's bypass/diversion protocol development.	NC	NC	NC	NC	NC
2.17. The TMD shall be involved in the decisions regarding bypass.	NC	NC	NC	NC	NC
2.18. The TMD shall participate in regional and national trauma organizations.	NC	NC	NC	NC	NC

Level:	I	IB	Peds	II	III
Interpretive Guidance: It is essential that the TMD remain active in development and management of the trauma system on the state and regional level. This will be demonstrated by evidence of attendance and participation in regional, state, or national level trauma system and trauma performance groups.					
2.19. The TMD shall be actively involved in prehospital personnel training, the PIPS process, and development of trauma components of EMS.	NC	NC	NC	NC	NC
2.20. The TMD shall be involved in trauma research which includes the need to create a publication of results and presentations.	C	C	-	-	-
2.21. The Trauma Service shall have a dedicated full time equivalent (FTE) for a TPM.	C	C	C	C	C
Interpretive Guidance: The TPM is essential to the integration and smooth functioning of the trauma service. This individual acts as the liaison between the trauma service and the hospital services necessary to provide care for the multiply injured patient. The TPM also is the primary contact and resource for the nursing services required for trauma care from the time of admission to rehabilitation and follow up care. On most services the TPM also provides the logistical support for implementing the performance improvement program.					
2.22. The TPM shall have overall management responsibilities for the trauma service.	C	C	C	C	C
2.23. There shall be a defined job description delineating the TPM role and responsibilities.	C	C	C	C	C
Interpretive Guidance: While specific job descriptions vary based on trauma service organization and support, it is essential that a job description be present and accurately reflective of what is expected. An organizational tree should indicate reporting relationships. These two documents should outline sufficient levels of authority to perform PI, interact with nursing and ancillary services and to perform any other tasks outlined in the job description.					
2.24. The TPM shall be reflected in the hospital's organizational chart.	C	C	C	C	C
2.25. The Trauma Service shall have an additional FTE dedicated to the Trauma Service. This additional FTE may be utilized for outreach, PI, education, or other essential trauma related needs that best supports the growth and sustainment of the individual trauma service and determined by the TPM.	C	C	C	C	NC
Interpretive Guidance: Some programs include more than one nursing position. The titles for these positions may vary for example: trauma case manager, trauma nurse coordinator (in a program where there is a Trauma Program Manager) etc. The requirements above apply only to the individual identified as primarily responsible for the trauma service. However, if a nursing or other position is assigned to the trauma service, there must be a job description for the position, inclusion in the program organizational chart and plan for education commensurate with the position described.					

Level:	I	IB	Peds	II	III
2.26. The Trauma Registrar shall be a minimum of one full FTE dedicated to the trauma registry.	C	C	C	C	
2.27. The Trauma Registrar shall be a minimum of one-half FTE dedicated to the trauma registry.	-	-	-	-	C
Interpretive Guidance: The trauma registrar is responsible for extracting information from charts, maintaining the trauma registry and developing and delivering reports from the registry. This role is vital in the maintenance of a robust PI program and in delivery of required trauma registry data to the state. The minimum requirement for Level I and II centers is a full time registrar; however, with larger services more registrars or assistants are necessary. In order to extract information from patient charts, the registrar must be familiar with how the trauma service works, as well as, terminology, coding and the use of various scoring systems used to describe the severity of trauma. The educational program for a full time trauma registrar consists of 24 hours in three-years on trauma, critical care, registry, or data collection. While 24 hours is optimal for a part time registrar, there must be an educational experience at least proportional to the portion of time spent in that position.					
2.28. The maximum number of patients / records managed by any single trauma registrar shall not exceed 750 per FTE based upon the most current National Trauma Data Bank (ACS/COT, National Trauma Dataset, 2014) recommendation for patient inclusion into a hospital trauma registry. FTE requirements should be prorated based on this number.	C	C	C	C	C
2.29. The Trauma Registrar(s) shall have adequate time allotted for the level of tasks expected.	NC	NC	NC	NC	NC
2.30. There shall be a defined job description delineating the Trauma Registrar's roles and responsibilities.	C	C	C	C	C
Interpretive Guidance: The job description for the trauma registrar should clearly define the need to access patient records and to extract data. Key elements of the position include data extraction from charts, registry maintenance and report delivery.					
2.31. The Trauma Registrar shall be identified on the hospital's organizational chart.	C	C	C	C	C
3. Burn Service Infrastructure					
3.1. The Burn Service shall be integrated into the Trauma Service at a state designated/verified Level I trauma center.	-	C	-	-	-
3.2. The Burn Service shall formally establish and maintain an organized Burn Service that is responsible for coordinating the care of burn patients.	-	C	-	-	-
3.3. The Burn Service shall have demonstrable medical and administrative commitment to the care of patients with burns. This is demonstrated by administrative leadership and financial support for personnel to	-	C	-	-	-

	Level:	I	IB	Peds	II	III
	maintain the elements as outlined throughout this Manual.					
3.4.	The Burn Service shall maintain an organizational chart that identifies key Burn Service staffs within the Burn Service and hospital.	-	C	-	-	-
3.5.	The Burn Service shall maintain a policy and procedural manual that is reviewed annually by the Burn Medical Director and Burn Program Manager. Policies and procedures shall include the following components: • The administration of the Burn Service. • Staffing on the burn unit. • Criteria for admission to the burn unit by the Burn Service. • Use of burn unit beds by other medical and surgical services. • Use of "tanking" and dressing facilities by non-burn program physicians. • Pediatric and adult conscious sedation procedures. • Criteria for admission, discharge, and follow-up care. • The availability of beds and transfer of burn patients to other medical surgical units within the hospital. • How burn care will be managed in areas of the hospital other than the burn unit.	-	C	-	-	-
3.6.	The Burn Service shall have hospital policies and procedures for the use of allograft tissues and they shall be in compliance with all federal, state, and Joint Commission requirements and when feasible and appropriate, with standards of the American Association of Tissue Banks (AATB, 2012).	-	C	-	-	-
3.7.	The Burn Service shall admit an average of 50 or more burn patients annually with acute burn injuries averaged over three-years.	-	C	-	-	-
3.8.	There shall be at least one FTE attending burn surgeon staff involved in the management of burn patients for each 200 acute inpatients admitted annually.	-	C	-	-	-
3.9.	The Burn Medical Director shall be granted the necessary authority to direct and coordinate all care for patients admitted to the Burn Service.	-	C	-	-	-
3.10.	The Burn Medical Director may appoint a qualified attending burn surgeon to participate in the care of the	-	C	-	-	-

Level:	I	IB	Peds	II	III
patients on the Burn Service.					
3.11. The Burn Medical Director shall be the physician of record or overseeing the outcomes of all surgeons within the program for 50 or more burn patients annually or one third of the burn patients admitted annually, averaged over a three-year period.	-	C	-	-	-
3.12. The Burn Service shall maintain an on-call schedule for residents and attending staff burn surgeons available to the Burn Service. Residents and staff surgeons shall be primarily available on a 24-hour per day basis.	-	C	-	-	-
3.13. If residents rotate on the Burn Service, the Burn Medical Director, or his or her designee, shall be responsible for an orientation program for new residents.	-	C	-		
3.14. Each burn unit shall have a method to determine acuity levels of the patients in determining staffing needs. The system shall be used to determine daily staffing needs.	-	C	-		
3.15. The Burn Service shall have an educational program for medical staff members, including emergency medicine attending physicians and residents.	-	C	-		
4. **Pediatric Trauma Service Infrastructure**					
4.1. Hospitals that pursue designation as pediatric trauma centers shall meet the Level I requirements in this document except adult only criteria.	-	-	C	-	-
4.2. Annually admits 200 or more injured children younger than 15 years of age.	-	-	C	-	-
4.3. An organized pediatric trauma service led by a pediatric trauma medical director must be present.	-	-	C	-	-
4.4. The Pediatric Trauma Service shall have a Pediatric Trauma Program Manager.	-	-	C	-	-
4.5. The Pediatric Trauma Program Manager shall be a 1.0 FTE.	-	-	NC	-	-
4.6. Pediatric trauma centers shall have a pediatric trauma registrar.	-	-	C	-	-
5. Trauma Team Response					
5.1. There shall be a clearly delineated trauma team response to the arrival of the patient with suspected or known major trauma in the ED 24 hours per day.	C	C	C	C	C
Interpretive Guidance: The hallmark of a trauma service is the trauma team response. This must be described in the trauma service manual and demonstrated on chart review for any site review type other than provisional. The goal to the trauma team response is to expedite the diagnosis					

	Level:	I	IB	Peds	II	III
and management of injuries for the trauma patient.						
5.2.	A minimum of two attending level physicians shall respond to all highest tiered responses, each of whom is an anesthesiologist, ED physician, or general surgeon. A qualified general surgeon is expected to participate in major therapeutic decisions and be present in the ED for major resuscitations and at operative procedures on all seriously injured patients.	C	C	C	C	C
5.3.	All physicians on the pediatric trauma team shall have pediatric board certification in their respective specialties. When the numbers of pediatric surgeons on staff are too few to sustain the pediatric trauma call, general surgeons who are board certified or board eligible by the American Board of Surgery, according to current requirements, may perform pediatric trauma call. In this circumstance, they shall be credentialed by the hospital to provide pediatric trauma care, be members of the adult trauma call schedule, and be approved by the Pediatric Trauma Director.	-	-	C	-	-
5.4.	The hospital shall establish a policy detailing the expected time for the trauma surgeon to arrive at the bedside in the ED for patients meeting the highest level of alert. The goal shall be to have the trauma surgeon meet the patient in the ED upon the patient's arrival and that policy shall state that the trauma surgeon's response does not exceed 15 minutes from the arrival of the patient in the ED. A PGY4 or PGY5 general surgery resident capable of assessing emergent situations, providing control, and leadership of the care of the trauma patient may meet this requirement. In the event that this requirement is provided by a resident, the trauma surgeon shall be available in a timely manner.	C	C	C	C	-
Interpretive Guidance: Every center must have a procedure for a full team response. This means that all team members (including the surgeon) are included and every effort is made to assure that the team is available ***at the bedside*** at the time of patient arrival. In addition, an operating suite must be available at short notice and arrangements include the rapid access to red blood cells for transfusion. The assumption is that the critically injured patient may require very rapid intervention for stabilization and surgical intervention for definitive care of injuries.						
5.5.	The hospital shall establish a policy detailing the expected amount of time for the trauma surgeon to arrive at the bedside in the ED for patients meeting the highest level of alert. The goal shall be to have the trauma surgeon meet the patient in the ED upon the	-	-	-	-	C

	Level:	I	IB	Peds	II	III
	patient's arrival and that policy shall state that the trauma surgeon's response does not exceed 30 minutes from arrival of the patient in the ED. A PGY4 or PGY5 general surgery resident capable of assessing emergent situations, providing control, and leadership of the care of the trauma patient may meet this requirement. In the event that this requirement is provided by a resident, the trauma surgeon shall be available in a timely manner.					
5.6.	Trauma / general surgeons participating in the Trauma Service and taking active call shall be dedicated to the hospital while on trauma call.	C	C	C	C	C
5.7.	The emergency physician shall be a designated member of the trauma team and may direct resuscitation and care of the patient until the arrival of the trauma team leader. A PGY3 level emergency medicine resident may fulfill this function provided there is an attending emergency medicine physician present in the ED. When a pediatric ED is required by criterion 13.22 or 13.24 a Pediatric Emergency Medicine (PEM) fellow may fulfill this function within the pediatric ED only provided there is an attending emergency medicine physician present in the ED.	C	C	C	C	C
5.8.	There shall be RN's, PA's, NP's, LPN/LVN's and nursing assistants / technicians in adequate numbers in the initial resuscitation area based on acuity and trauma team composition as outlined in the Trauma Service's Trauma Service Manual, policies, or processes.	C	C	C	C	C
5.9.	There shall be a written protocol for the expectations and responsibilities of the trauma nurse and other team members during trauma resuscitations.	C	C	C	C	C
Interpretive Guidance: The site review team will review the trauma service manual, patient records, and the quality improvement program to determine the following: • Alerts occur as described in the trauma service manual. • Criteria are appropriate. • Criteria address the needs of severely injured patients. • That the full team response is timely. • Tiered response is used as indicated in the trauma service manual.						
5.10.	Nursing documentation for trauma activation patients shall be on a trauma flow sheet or electronic medical record equivalent.	C	C	C	C	C

Level:	I	IB	Peds	II	III
Interpretive Guidance: Electronic medical records vary from hospital to hospital. Ideally there should be staff available for assistance to navigate the record to adequately review for arrival times, timely documentation, vital signs, and to assist the site review team in reviewing documentation.					
6. Medical / Surgical Services Availability					
6.1. The trauma center shall be capable of performing emergent trauma care to patients of all ages.	C	C	C	C	C
6.2. The trauma center shall be capable of providing all the services prescribed by the criteria in this manual for trauma patients 15 years of age or older.	C	C	-	C	C
6.3. Designated trauma centers cannot exceed a maximum diversion time of five percent.	NC	NC	NC	NC	NC
6.4. The trauma center shall avoid diverting burn patients except for rare instances such as loss of power, etc. This includes patients arriving by EMS and from referral hospitals within the region.	-	C	-	-	-
6.5. The decision to transfer an injured patient during the acute care phase is based solely on the needs of the patient.	NC	NC	NC	NC	NC
6.6. There shall be a mechanism in place to allow for direct physician-to-physician contact for arranging patient transfers.	NC	NC	NC	NC	-
6.7. Definitive surgical care shall be instituted by the trauma surgeon in a timely fashion.	-	-		C	C
There shall be in-house 24 hours per day capabilities in general surgery with two separate posted call schedules (one for trauma and one for general surgery). In those instances where a physician may simultaneously be listed on both schedules, there shall be a defined back-up surgeon listed on the schedule to allow the trauma surgeon to provide care for the trauma patient. A PGY4 or PGY5 capable of assessing emergent situations in their respective specialties may fulfill this requirement. The PGY4 or PGY5 shall be capable of providing surgical treatment immediately and provide control and leadership for the care of the trauma patient.	C	C	C	-	-
Interpretive Guidance: There must be a mechanism in place for acquiring additional surgeons if the first call surgeon is in the operating room with a patient or there are multiple simultaneous trauma patients requiring major resuscitation and / or surgery.					
The hospital shall have clinical capabilities in general surgery available 24 hours per day with two separate posted call schedules (one for trauma and one for general surgery). In those instances	-	-	-	C	C

Level:	I	IB	Peds	II	III
where a physician may simultaneously be listed on both schedules, there shall be a defined back-up surgeon listed on the schedule to allow the trauma surgeon to provide care for the trauma patient. A PGY4/ PGY5 capable of assessing emergent situations in their respective specialties may fulfill this requirement. The PGY4 or PGY5 shall be capable of providing surgical treatment immediately and provide control and leadership for the care of the trauma patient.					
6.8. Any adult trauma center that annually admits 100 or more injured children younger than 15 years of age shall have its entire trauma / general surgeon staff which perform trauma call credentialed for pediatric trauma care by the hospital's credentialing body.	NC	NC	-	NC	NC
6.9. Pediatric trauma centers shall have at least two surgeons, board-certified or eligible for certification by the American Board of Surgery according to current requirements in pediatric surgery.	-	-	NC	-	-
6.10. The trauma surgeon shall remain active in the clinical management of the trauma patient during the acute phase of care. The trauma surgeon may collaborate with other specialties to enhance the quality of care rendered in the ICU or PICU as applicable.	C	C	C	C	C
6.11. The trauma service shall work collaboratively with the pediatric critical care providers and the service shall be aware of all significant clinical changes.	NC	NC	NC	-	-
6.12. There shall be a mechanism for documenting the trauma surgeon's presence for all trauma operative procedures.	NC	NC	NC	NC	NC
6.13. The ED shall have a designated medical director.	C	C	C	C	C
6.14. The ED has an appropriate number of physicians to ensure immediate care for injured patients.	C	C	C	C	C
6.15. There shall be at least two ED physicians who are board-certified or board eligible in pediatric emergency medicine.	-	-	C	-	-
6.16. There shall be 24 hour per day staffing by physicians physically present in the ED. This shall include an attending emergency physician.	C	C	C	C	C
6.17. The pediatric section of the ED shall be staffed by individuals credentialed by the hospital to provide pediatric trauma care in the respective areas.	-	-	C	-	-
Interpretive Guidance: The intent of this criterion is to assure that there is always qualified medical staff to care for pediatric trauma patients.					

Level:	I	IB	Peds	II	III
6.18. Orthopedic surgery service shall be on-call and promptly available.	C	C	C	C	C
Measure: Call schedules shall be available to site review teams.					
6.19. Orthopedic team members shall have a dedicated trauma call schedule with a second backup available.	NC	NC	NC	NC	NC
6.20. On, staff, there shall be at least one board-certified surgeon or one surgeon eligible for certification by an appropriate board according to the current requirements of that board that also has had pediatric fellowship training.	-	-	C	-	-
6.21. There shall be at least one additional board-certified orthopedic or surgeon eligible for certification by an appropriate board according to the requirements of that board, who is identified with demonstrated skills and interest in pediatric trauma care.	-	-	NC	-	-
6.22. There shall be an orthopedic liaison designated to the trauma service.	NC	NC	NC	NC	NC
6.23. There shall be an anesthesiologist in-hospital 24 hours a day and able to immediately respond to assist with managing difficult airways.	C	C	C	-	-
6.24. There shall be an anesthesiologist on call and promptly available to assist with managing difficult airways 24 hours per day.	-	-	-	C	C
6.25. An anesthesiologist shall be present for all emergent operative procedures on major trauma patients.	C	C	C	C	C
6.26. There shall be an anesthesiologist in- house 24 hours a day. (Requirements may be met by anesthesia residents; CRNAs capable of assessing emergent situations in trauma patients and providing any indicated treatment. Anesthesia personnel shall be capable of providing anesthesia service for surgical trauma cases including major vascular, neurosurgical, pediatric, orthopedic, thoracic, ENT, and other required surgical cases. If residents or CRNAs are used, a staff anesthesiologist shall be present in the OR suite during surgery. Training and experience in both invasive and non-invasive monitoring is essential.	C	C	C	-	-
6.27. There shall be an anesthesiologist available 24 hours a day. Anesthesia personnel shall be capable of providing anesthesia service for surgical trauma cases including major vascular, neurosurgical, pediatric, orthopedic, thoracic, ear, nose and throat (ENT), and other required surgical sub-specialties involved in trauma cases. If	-	-	-	C	-

	Level:	I	IB	Peds	II	III
	residents or certified registered nurse anesthetists are used, a staff anesthesiologist shall be present in the OR suite during surgery. Training and experience in both invasive and non-invasive monitoring are essential.					
6.28.	Anesthesiologist shall be on-call and promptly available for trauma patients. Requirements shall be filled by anesthesia personnel capable of assessing emergent situations in trauma patients and providing any indicated treatment. Anesthesia personnel shall be capable of providing anesthesia service for surgical trauma cases including: major vascular, neurosurgical, pediatric, orthopedic, thoracic, ENT, and other required surgical sub-specialties involved in trauma cases. If residents or CRNAs are used, a staff anesthesiologist shall be present in the OR suite during surgery. Training and experience in both invasive and non-invasive monitoring is essential.	-	-	-	-	C
Measure: Response times shall not exceed 30 minutes.						
6.29.	There shall be an anesthesiology liaison designated to the trauma service.	NC	NC	NC	NC	NC
6.30.	An attending neurosurgeon shall be promptly available. The in-house requirement may be fulfilled by an in-house neurosurgery resident, surgeon, nurse practitioner, or physician assistant designee who has special competence, as judged by the Chief of Neurosurgery, in the care of patients with neural trauma and who is capable of initiating diagnostic procedures.	C	C	C	-	-
6.31.	An attending neurosurgeon shall be promptly available. This requirement may be fulfilled by a resident, surgeon, nurse practitioner, or physician assistant designee who has special competence, as judged by the Chief of Neurosurgery, in the care of patients with neural trauma and who is capable of initiating diagnostic procedures. This may be on-call from outside of the hospital.	-	-	-	C	-
6.32.	If a neurosurgeon is responsible for more than one hospital at the same time, there shall be a second backup schedule.	C	C	C	-	-
6.33.	If an attending neurosurgeon is not dedicated to the Level II trauma center, the center shall have a backup call list OR the center shall demonstrate no more than 24 emergency neurosurgical procedures per year AND the center shall provide a neuro-trauma diversion plan.	-	-	-	C	-

Level:	I	IB	Peds	II	III
6.34. There shall be at least one surgeon board certified or board eligible for certification by the American Board of Neurological Surgery according to the current requirements of that board who also has had pediatric fellowship training.	-	-	C	-	-
6.35. There shall be at least one additional board-certified neurosurgeon or surgeon eligible for certification by the American Board of Neurological Surgery according to the requirements of that board, who is identified with demonstrated skills and interest in pediatric trauma care.	-	-	NC	-	-
6.36. There shall be a neurosurgical liaison designated to the trauma service.	NC	NC	NC	NC	-
6.37. There shall be the following age appropriate surgical sub-specialty services physically present within 30 minutes of request for a threat to life or limb and the need to go to the OR and promptly available as otherwise needed.					
6.37.1. Thoracic surgery	C	C	C	C	-
6.37.2. Maxillofacial, E.N.T., and plastic surgery	C	C	C	C	-
6.37.3. Gynecological surgery/obstetrical surgery	C	C	C	C	-
6.37.4. Urological surgery	C	C	C	C	-
6.37.5. Ophthalmic surgery	C	C	C	NC	-
6.37.6. Cardiac surgery	C	C	C	-	-
6.37.7. Pediatric surgery	C	C	C	-	-
6.37.8. Hand surgery.	C	C	C	-	-
6.37.9. Microvascular/replant surgery	C	C	C	-	-
6.37.10. Oral surgery (may be part of 6.37.2)	C	C	C	-	-
6.38. There shall be the following age appropriate non-surgical sub-specialties and shall be promptly available as needed.					
6.38.1. Internal medicine	C	C	-	C	C
6.38.2. Pathology	C	C	C	C	C
6.38.3. Radiology	C	C	C	C	C
6.38.4. Cardiology	C	C	C	C	-
6.38.5. Interventional radiology	C	C	C	C	-
6.38.6. Neurology	C	C	C	C	-
6.38.7. Pulmonology	C	C	C	-	-
6.38.8. Gastroenterology	C	C	C	-	-

Level:	I	IB	Peds	II	III
6.38.9. Hematology	C	C	C	-	-
6.38.10. Infectious disease	C	C	C	-	-
6.38.11. Nephrology	C	C	C	-	-
6.38.12. Pediatrics	C	C	C	-	-
6.38.13. Psychiatry	C	C	C	-	-
Interpretive Guidance: The purpose of the sections on clinical capabilities is to ensure that the trauma center is capable of providing the services required for its level of designation, as denoted by being marked as essential and being able to manage corresponding injury types on a full time basis. The hospital must offer each of the relevant services, although dedicated call to the trauma center is not necessary and the specialist need not be immediately available. A 24-hour call schedule for the program is NOT necessary. The hospital has the flexibility of organizing a plan to manage corresponding injuries on site in a manner best suited to staff and resources. For example, in the absence of a 24 hour call schedule for ENT the center may have a plan for immediate coverage of maxillofacial trauma patients with a rotating call schedule. PI processes should be in place to oversee the plan and to identify any potential problems. The plan may NOT involve transfer of patients with the injury type of concern.					
6.39. There shall be a designated surgical director or co-director for the ICU.	C	C	C	C	-
6.40. There shall be at least two physicians who are board certified or eligible for certification by the American Board of Pediatrics according to current requirements in pediatric critical care medicine or in pediatric surgery and surgical critical care by the American Board of Surgery.	-	-	C	-	-
6.41. There shall be in-house physician coverage immediately available for the ICU 24 hours per day. This physician cannot be the sole physician for the ED.	C	C	C	C	-
6.42. There shall be pediatric critical care physician coverage immediately available in the PICU 24 hours per day.	-	C	C	-	-
6.43. The PICU shall be staffed by individuals credentialed by the hospital to provide pediatric trauma care in their respective areas.	-	-	C	-	-
6.44. The surgical director of the PICU shall actively participate in the administration of the PICU, as evidenced by the development of pathways and protocols for care pediatric surgical patients in the PICU and in unit-based performance improvement.	-	-	C	-	-
6.45. Pediatric surgeons or trauma surgeons with pediatric privileges shall be included in all aspects of care of	-	-	NC	-	-

Level:	I	IB	Peds	II	III
injured children admitted to an ICU.					
6.46. There shall be an OR(s) immediately available 24 hours per day.	C	C	C	C	C
6.47. For burn cases there shall be an OR(s) immediately available 24 hours per day with the Burn Service having timely access for urgent/emergent cases. This is defined as "within six hours of posting".	-	C	-	-	-
6.48. There shall be OR personnel in-house and immediately available 24 hours per day.	C	C	C	C	-
6.49. The OR staffs shall be fully dedicated to the duties in the OR and not have functions requiring their presence outside of the OR.	C	C	C	C	C
6.50. There shall be OR personnel immediately available 24 hours per day. This requirement may be fulfilled using in-house or on-call staff.	-	-	-	-	C
6.51. There shall be a second OR team on-call and promptly available when the in-house team is participating in an operative case.	C	C	C	C	-
6.52. There shall be PACU nursing staff immediately available 24 hours per day. This requirement may be fulfilled using in-house or on-call staff.	C	C	C	C	C
7. Trauma Nursing					
7.1. The TPM shall be a RN.	C	C	C	C	C
7.2. The TPM shall possess experience in emergency / critical care nursing.	C	C	C	C	-
7.3. The TPM shall obtain 30 TEH per three-year verification cycle of which 50 percent shall be via an extramural source. This may be prorated by the OEMS Trauma/Critical Care Coordinator for new hires or shorter periods of time due to extenuating circumstances.	C	C	C	C	C
7.4. The TPM shall attend one national or international meeting within the three-year verification or designation period.	C	C	C	C	C
7.5. The Burn Program Manager shall be a RN with a baccalaureate or higher degree that has two more years of experience in acute burn care and serves the function of the Burn Program Manager. This manager shall work closely with the Burn Medical Director to develop policies and procedures and the burn PI program. The Burn Program Manager may have other administrative duties within the medical center, but shall commit at	-	C	-	-	-

	Level:	I	IB	Peds	II	III
	least 25 percent of their FTE for every 150-inpatient admissions to the Burn Service.					
7.6.	The Burn Program Manager shall participate in eight or more hours of burn related education annually or 24 hours averaged over a three-year period.	-	C	-	-	-
7.7.	The trauma registrar(s) shall obtain 24 TEH per three-year verification cycle of which 50 percent shall be from an extramural source.	NC	NC	NC	NC	NC
7.8.	If assistants are used to supplement the registrar position sufficient training shall be provided.	NC	NC	NC	NC	NC
7.9.	All nursing staff members participating in the trauma team response shall have documented trauma specific orientation.	C	C	C	C	C
7.10.	All nursing staff members who participate in the acute care of trauma patients, including those working on nursing units that regularly provide care to trauma patients such as general surgery, orthopedics, neuroscience, progressive care, ICU, PICU, post-anesthesia care unit (PACU), OR, ED, and pediatrics shall have a minimum of four hours of trauma specific education hours (TEH) annually.	C	C	C	C	C

Interpretive Guidance - Nursing TEH may encompass care of the trauma patient in any aspect of the continuum; from point of injury, to rehabilitation, and injury prevention. Acceptable means of education may include but are not limited to use of equipment, processes, and protocols, PI, conferences, workshops, symposiums, scientific assemblies, in services, refresher courses, participation in a simulation lab, online education, classes, skills labs, case studies, journal article reviews, and providing course instruction and lectures.

- Course instruction - hours will be awarded only for the trauma specific content presented and may be used toward credit only once in a 12 month period.
- Registrars – in addition to the education options listed above, approved areas include: developing spreadsheets and other custom reports, injury identification, scoring and any database functions primarily associated with trauma; statistics and data analysis.

External Source –national and international conferences, online or self-study courses or professional journal articles with appropriate documentation, seminars and webinars, mission, goodwill or training activities/events/ excursions with appropriate documentation

The appropriateness of course content must be approved by the TPM. This does not apply to fully recognized national certification courses. Documentation of content such as a course outline, bibliography, competency validation checklist, or manual may be considered in evaluating a trauma specific focus.

Level:	I	IB	Peds	II	III
Recognized national certification courses include: • ENPC – Emergency Nurses Pediatric Course • TNCC – Trauma Nurse Core Curriculum (ENA) • ATCN – Advanced Trauma Care for Nurses (STN) • PHTLS – Prehospital Trauma Life Support • RTTDC – Rural Trauma Team Development Course • ABLS – Advanced Burn Life Support • National Disaster Management Courses • CATN – Course in Advanced Trauma Nursing (ENA) Excluded national certification courses: • ACLS – Advanced Cardiac Life Support • PALS – Pediatric Advanced Life Support • NALS – Neonatal Advanced Life Support • Or any education or training with a non-trauma specific content.					
7.11. There shall be a Burn Service orientation program that documents nursing competencies specific to the care and treatment burn patients including critical care, wound care, and rehabilitation that is age appropriate.	-	C	-	-	-
7.12. Burn center nursing staff members who participate in the resuscitation of the burn patient shall be provided with a minimum of an additional two burn specific nursing education hours. These hours may be either intramural or extramural.	-	C	-	-	-
7.13. There shall be documentation of trauma and burn specific orientation and continuing education for pediatric and burn care if these patients are regularly admitted to the trauma center.	C	C	C	-	-
7.14. For trauma centers with a pediatric ICU (PICU) there shall be a nursing staff that specializes in pediatric critical care.	C	-	C	-	-
7.15. ICU Nursing staff members shall be educated in trauma care.	C	C	C	C	C
7.16. The patient to nurse ratio shall not exceed 2:1 for critically ill patients in the ICU.	C	C	C	C	C
7.17. There shall be a written provision/plan for the acquisition of additional staffing on a 24 per hour basis to support all patient care areas units with increased patient acuity and/or volume, multiple emergency procedures, and admissions shall exist.	C	C	C	C	C
7.18. Each nursing unit shall have a copy of their staffing plan available for review during the site review.	C	C	C	C	C

Level:	I	IB	Peds	II	III
8. Ancillary Services					
8.1. Radiological Services shall be available 24 hours per day.	C	C	C	C	C
8.2. Radiological procedures for pediatric patients shall follow ALARA standards (NRC, 2013).	C	C	C	C	C
8.3. Radiological interpretations by a radiologist shall be available.	C	C	C	C	C
8.4. Critical radiological information shall be verbally communicated to the trauma team in a timely manner and final reports accurately reflect communications, including changes between preliminary and final interpretations.	NC	NC	NC	NC	NC
8.5. Computed Tomography (CT) Scanning shall be available.	C	C	C	C	C
8.6. Angiography / interventional radiology shall be available.	C	C	C	C	-
8.7. Magnetic Resonance Imaging (MRI) shall be available.	C	C	C	C	-
8.8. Sonography shall be available.	C	C	C	C	-
8.9. There shall be a radiology technician in-house.	C	C	C	C	C
8.10. There shall be a CT technologist in-house.	C	C	C	C	C
8.11. There shall be cardiac emergency carts with standard resuscitative equipment, medications, airway management, and IV therapy available in radiology suites used for trauma patients.	C	C	C	C	C
8.12. There shall be at least one radiologist appointed as liaison to the Trauma Services.	NC	NC	NC	NC	NC
8.13. Clinical Laboratory Services shall be available 24 hours per day.	C	C	C	C	C
8.14. Standard analysis of blood, urine, other body fluids, and a comprehensive blood bank shall be available.	C	C	C	C	C
8.15. Blood typing and cross matching shall be available.	C	C	C	C	C
8.16. The blood bank shall have an adequate supply of red blood cells, fresh frozen plasma, platelets, cryoprecipitate, and appropriate coagulation factors to meet the needs of injured patients.	C	C	C	C	-
8.17. The blood bank shall have and adequate supply of red blood cells, fresh frozen plasma, and appropriate coagulation factors to meet the needs of injured patients.	-	-	-	-	C
8.18. There shall be a massive transfusion protocol in place.	C	C	C	C	-

Level:	I	IB	Peds	II	III
8.19. A respiratory therapist shall be available to care for trauma patients 24 hours per day.	C	C	C	C	C
8.20. There shall be renal dialysis services available 24 hours per day or a transfer agreement in place.	C	C	C	NC	-
8.21. There shall be physical therapists available.	C	C	C	C	C
8.22. There shall be occupational therapists available.	NC	NC	C	NC	-
8.23. Rehabilitative services, physical and occupational therapy specialists shall be available during the acute phase of trauma care.	NC	NC	NC	NC	-
8.24. There shall be access to rehabilitation services capable of managing burn patients.	-	C	-	-	-
8.25. Rehabilitative services shall be available within its physical facilities or to a freestanding rehabilitation hospital.	NC	NC	NC	NC	-
8.26. The hospital shall provide speech therapy services.	NC	NC	NC	NC	-
8.27. A Department of Social Services consultation / case management shall be available to the injured patient.	NC	NC	NC	NC	-
Interpretive Guidance: Early discharge planning is essential for patients with multiple injuries. Trauma centers may avail themselves of a variety of consulting services to facilitate appropriate discharge plans such as social workers, case managers, patient representatives, and home health services.					
8.28. There shall be pediatric social services available.	-	-	C	-	-
8.29. Pediatric trauma patients with prolonged hospitalizations shall have their academic needs assessed and met as clinically indicated.		NC	NC	-	-
8.30. There shall be child life and support programs available.		NC	NC	-	-
8.31. The trauma center shall have an established relationship with a recognized organ procurement agency.	C	C	C	C	C
8.32. There shall be a recognizable mandated reporter process and appropriate resources in place to identify when to initiate and engage Child Protective Services (CPS) and/or Adult Protective Services (APS).	C	C	C	C	C
8.33. Pediatric trauma centers must have a mechanism in place to assess children for maltreatment.	-	-	C	-	-
8.34. There shall be a written policy for triggering notification of the organ procurement agency.	C	C	C	C	C
8.35. There shall be written protocols for the declaration of brain death.	C	C	C	C	C
9. Medical Staff Education and Credentials					
9.1. Supporting documentation shall be available for	C	C	C	C	C

	Level:	I	IB	Peds	II	III
	medical staff education and credentials for designation / verification site reviews. Attestations and tracking sheets are not acceptable as evidence for education.					
9.2.	The TMD shall be a board certified/eligible general surgeon.	C	C	-	C	C
9.3.	The TMD shall have a minimum of three years experience with a trauma service or be trauma fellowship trained.	C	C	C	-	-
9.4.	The TMD shall have 30 hours of Category I trauma/critical care CME every three-years and attend one national meeting whose focus is trauma or critical care.	C	C	C	C	C
9.5.	The TMD shall maintain current ATLS provider or instructor certification.	C	C	C	C	C
9.6.	All general / trauma surgeons shall be board certified / eligible in general surgery.	C	C	C	C	C
9.7.	Pediatric general / trauma surgeons shall be board certified/eligible in pediatric surgery.	C	C	C	-	-
9.8.	Each surgeon, emergency physician, nurse practitioner, or physician's assistant participating / taking call in the program or could possibly be caring for trauma alert patients in the ED shall complete 30 Category I CME in trauma / critical care across the three-year verification period. Updating ATLS may be included in these CME.	C	C	C	C	C
9.9.	In pediatric trauma centers 12 hours of the 30 hours CME in criterion 9.7 shall be pediatric trauma specific.	-	-	C	-	-
9.10.	In pediatric trauma centers, other specialists (in anesthesiology, neurosurgery, orthopedic surgery, emergency medicine, radiology, and rehabilitation) providing care to injured children who are not pediatric-trained providers should also have sufficient training and experience in pediatric trauma care and be knowledgeable about current management of pediatric trauma in their specialty. The service must make specialty-pediatric education available for these specialists.	-	-	C	-	-
9.11.	All general / trauma surgeons shall have successfully completed an ATLS course at least once.	C	C	C	C	C
9.12.	The Burn Medical Director shall be a licensed physician with board certification(s) by the American Board of Surgery or the American Board of Plastic Surgery.	-	C	-	-	-

Level:	I	IB	Peds	II	III
9.13. The Burn Medical Director shall have completed a one-year fellowship in burn treatment or shall have experience in the care of patients with acute burn injuries for two or more years during the previous five years at a VDH or ACS verified / designated Level I trauma center.	-	C	-	-	-
9.14. The Burn Medical Director shall participate in CME of burn related education at a minimum of 30 hours averaged over a three-year period and attend one national / regional meeting.	-	C	-	-	-
9.15. Privileges for physicians participating in the Burn Service shall be determined by the medical staff credentialing process and approved by the Burn Medical Director.	-	C	-	-	-
9.16. The Burn Medical Director shall be the physician of record or overseeing the outcomes of all surgeons within the program for 50 or more burn patients annually or one third of the burn patients admitted annually, averaged over a three-year period.	-	C	-	-	-
9.17. Attending staff burn surgeons shall be board certified or eligible in general or plastic surgery.	-	C	-	-	-
9.18. Attending staff burn surgeons shall have completed a one-year fellowship in burn treatment or shall have experience in the care patients with acute burn injuries for two or more years during a previous five years at a designated Level I trauma center.	-	C	-	-	-
9.19. Attending staff burn surgeons shall participate in CME of burn related education at a minimum of 30 hours or more averaged over a three-year period.	-	C	-	-	-
9.20. The Pediatric Trauma Medical Director must be certified or eligible for certification by the American Board of Surgery according to the requirements for pediatric surgery or alternatively, a pediatric surgeon who is a fellow of the American College of Surgeons with a special interest in pediatric trauma care, and must participate in trauma call.	-	-	C	-	-
9.21. The Pediatric Trauma Medical Director shall have 30 hours category I trauma/critical care CME every three years. Of these hours 12 shall be clinical pediatric trauma related.	-	-	C	-	-
9.22. The Emergency Medicine Medical Director shall have 30 hours of Category I CME every three years and attend one national meeting with some content in	C	C	C	C	C

Level:	I	IB	Peds	II	III
trauma or critical care.					
9.23. The Emergency Medicine Medical Director or designee shall maintain a current ATLS instructor or participant certification.	C	C	C	C	C
9.24. ED physicians shall be board certified / eligible in emergency medicine or pediatric emergency medicine by the American Board of Medical Specialties, the Bureau of Osteopathic Specialist or the Royal College of Physicians and Surgeons of Canada. Emergency department physicians not board as noted above shall hold another board certification and meet the following criteria 9.8 and 9.27.	C	C	C	C	C
9.25. ED physicians shall meet the educational requirements in criterion 9.8.	C	C	C	C	C
9.26. ED physicians that meet criterion 9.8 shall possess a current ATLS or have successfully completed the ATLS course at least once.	C	C	C	C	C
9.27. ED physicians to do not meet criterion 9.8 shall maintain current ATLS instructor or provider certification.	C	C	C	C	C
9.28. There shall be documentation available for ATLS and continuing education as outlined throughout this document. Attestations and tracking sheets are not acceptable as evidence for education.	C	C	C	C	C
9.29. Orthopedic surgeons performing trauma call shall be board certified within five years of successfully completing residency.	C	C	C	C	C
9.30. Neurosurgeons performing trauma call shall be board certified within five years of successfully completing residency.	C	C	C	C	-
9.31. The surgical director of the ICU shall have added certification in surgical critical care from the American Board of Surgery.	C	C	-	C	-
9.32. The primary burn therapist shall have eight hours of burn related education annually, or 24 hours averaged over a three-year period.	-	C	-	-	-
10. Performance Improvement					
10.1. The Trauma Service shall have an organized PI program to examine the care of the injured patient within the hospital that looks towards improving outcomes by decreasing complications and improving.	C	C	C	C	C

Level:	I	IB	Peds	II	III
Interpretive Guidance: The presence of a PI program is critical to the existence of the trauma or trauma/burn center. While every hospital participates in PI, not every PI program addresses the needs of a trauma or burn program. Site review teams will be looking for a program specifically oriented to trauma and burn patients; one that covers multidisciplinary issues as well as all phases of trauma and burn care from pre-hospital care to rehabilitation. The TMD, Burn Medical Director, TPM, and/or Burn Manager shall have oversight for the program.					
10.2. Participation in the VSTR as mandated by the *Code of Virginia § 32.1-116.1*. Data shall be submitted on the schedule noted in (b) below and include all patients: • With an ICD10-CM code(s) of S00-S99, T07, T14, T20-T28 with 7th digit character modifier of A, B, or C. (D through S are excluded), and • Were admitted to the hospital, or • Were admitted for observation (not ED observation unless held in the ED due to no inpatient bed availability), or • Were transferred from one hospital to another for treatment of acute trauma, or • The patient dies within the hospital due to injury (includes, the ED and DOA's). **Note:** VSTR requirements relate to all patients meeting these criteria hospital-wide and shall not be interpreted as limited to Trauma Service patients or limited to patients within the trauma center's in-house trauma registry.	C	C	C	C	C
10.3. Compliance with criterion 10.2 above shall per the schedule published by the VDH/OEMS. The current schedule is on a quarterly basis at a minimum. The submission schedule is based on the patient's discharge date from the hospital and shall be the following schedule: • January 1st thru March 31st – due on May 31st • April 1st thru June 30th – due on August 31st • July 1st. thru September 30th – due on November 30th • October 1st thru December 31st – due on February 28/29th **Note:** Should the submission date fall on a weekend or state holiday, the due date shall be the next regular state business day.	C	C	C	C	C
10.4. There shall be a procedure in place to monitor the validity of data being entered into the hospital's trauma	NC	NC	NC	NC	NC

Level:	I	IB	Peds	II	III
registry and State's trauma registry.					
10.5. The trauma center shall be able to identify the trauma population within their hospital.	NC	NC	NC	NC	NC
Measure: The center shall have a means of identifying injured patients within its facility such as a standard query / report that can be pulled from the hospital's admission records and not solely depend upon Trauma Service tracking methods.					
Interpretive Guidance: Need to identifying patients that did not receive a trauma team response but met criteria or may have benefitted from trauma consultation.					
10.6. Mature trauma centers PI programs shall utilize VSTR or NTDB data for institutional, regional, or state research or for benchmarking for PI or injury prevention programs.	NC	NC	NC	NC	NC
10.7. Pediatric trauma centers shall submit data to the NTDB.	-	-	NC	-	-
10.8. The Trauma Service shall have the authority to address PI issues that involve multiple disciplines.	NC	NC	NC	NC	NC
10.9. The Trauma Service shall have adequate support from administration and defined lines of authority to ensure comprehensive evaluation of all aspects of trauma care.	C	C	C	C	C
10.10. There shall be a written trauma specific PI plan (including burn as applicable).	C	C	C	C	C
10.11. There shall be a written pediatric trauma specific PI plan.	-		C	-	-
10.12. Any adult trauma center that annually admits 100 or more injured children younger than 15 years of age shall have a pediatric-specific trauma PIPS program.	NC	NC	-	NC	NC
Interpretive Guidance: Written PI plan(s) should be provided and should describe the following: • Selection of audit filters • Management of unique events or reports • Review of information and reports received • Routing of pre-hospital care, nursing, and medical staff issues • Means of implementing change • Documentation with regard to implementing change • Maintenance and review of PI plan • Describe who has the authority and responsibility to implement the plan.					
10.13. Each trauma center shall maintain a document that reflects the functional process for providing case specific complimentary and/or constructive feedback to the top three referring/receiving facilities for extraordinary situations.	C	C	C	C	C

Level:	I	IB	Peds	II	III
10.14. Each trauma center shall have in place a method for showing their involvement with the EMS agencies and /or personnel within its region. The trauma center shall be involved in EMS education, PI and a method of providing complimentary and / or constructive feedback in general or case specific as needed.	C	C	C	C	C
10.15. The Burn Service shall offer education on current burn concepts of emergency and inpatient care treatment to pre-hospital and hospital care providers within its service area.	-	C	-	-	-
10.16. There shall be a multi-disciplinary forum that includes the TMD, ED Director, TPM, liaisons from orthopedic surgery, anesthesiology, neurosurgery, and radiology as specific issues present for multidisciplinary review of care of the injured patient including policies, procedures, system issues, and outcomes. The forum may include pre-hospital, nursing, ancillary personnel, a hospital administrator, and other physicians involved in trauma care. (The forum in (10.17), below, may be combined with this meeting.)	C	C	C	C	C
10.17. The hospital shall have a structured trauma peer review committee which shall have a method of evaluating trauma care. This committee shall meet at least quarterly and include physicians representing pertinent specialties that includes at a minimum, trauma surgery, pediatric surgery (if applicable), emergency medicine, orthopedics, anesthesiology, neurosurgery, and may include hospital management and other subspecialties as required. The TPM or their designee(s) may be a member. Outcomes of peer review shall be incorporated into the educational and policy program of the Trauma Service. (The forum in (10.16) may be combined with this meeting.)	C	C	-	C	C
10.18. The burn PI program multidisciplinary committee, which oversees the PI program, shall meet at least quarterly. Sufficient documentation shall be maintained to verify problems, identify opportunities for improvement, and take corrective actions and resolved issues.	-	C	-	-	-
10.19. Burn morbidity and mortality conferences shall be held every other month and include physicians other than the immediate burn care team to ensure objective review of the presentations. Attendees at this conference shall	-	C	-	-	-

Level:	I	IB	Peds	II	III
include specialists and other committee members that do not practice in the trauma/burn center.					
10.20. There shall be a burn patient care conference held at least weekly to review and evaluate the status of each burn patient admitted to the burn unit. The conference shall include, but not be limited to, a burn physician, critical care intensivist, burn nurse, respiratory therapist, social work, burn occupational therapy or physical therapy, dietitian, and clinical psychologist.	-	C	-	-	-
10.21. There must be a trauma peer review committee chaired by the Pediatric Medical Director with participation from the core pediatric / general surgeons and liaisons from pediatric / general surgery, orthopedic surgery, neurosurgery, emergency medicine, pediatric critical care medicine, radiology, and anesthesiology to improve trauma care be reviewing selected deaths, complications, and sentinel events with the objectives of identification of issues and appropriate responses.	-	-	C	-	-
10.22. All pediatric and general surgeons performing trauma call shall attend at least 50 percent of the pediatric trauma peer review meetings and their attendance must be documented.	-	-	NC	-	-
10.23. There shall be 50 percent attendance by committee members (or designee) at multi-disciplinary and peer review meetings.	C	C	C	C	C
10.24. The TMD shall ensure that the information and findings of peer review are documented and disseminated to non-core surgeons performing trauma call.	C	C	C	C	C
10.25. Burn patient care conferences shall be documented in the progress notes of each patient and in the minutes of the patient care conference kept separately.	-	C	-	-	-
10.26. The PI program shall follow these state audit filters at a minimum. • Morbidity, mortality, and complication reviews classified as anticipated, or not anticipated with or without opportunity for improvement. • Appropriateness of trauma alert activations. • Surgeon response time to highest tier activations. • Anesthesia response time. • OR team response. • Surgeon arrival in OR time. • Changes in radiology results between initial reading and final report.	C	C	C	C	C

Level:	I	IB	Peds	II	III
• Organ donation rate. • Transfers					
10.27. The PI program shall follow these additional state audit filters: • Missed intubations • Unplanned extubations • Extubation within 24 hours of rapid sequence intubation (excluding operative procedures) • Hypocapnia or Hypocapnia • Resuscitation volumes • Vascular access problems • Unplanned operation following non-operative management • Unplanned hypothermia • Nosocomial pneumonia • Missed injury • Transfers	C	C	C	-	-
10.28. The PI program shall participate in the creation of institutional and regional based audit filters as identified by the institution or regional PI committees.	NC	NC	NC	NC	-

Interpretive Guidance: Every center must audit its trauma (including burn) deaths. In addition, the center should include audit filters based on its previous experience, those filters recommended by the State and filters designed to identify potential problems. Because each center is different, a list of audit filters will not only include the State audit filters, but institutionally needed filter.

Process filters which evaluate whether or not a process is observed are valuable when developing a new trauma service or setting up a procedure for a currently existing program.

Outcome filters describe the results of trauma and burn care. While death is certainly the ultimate outcome filter, a PI plan should address other outcomes such as disability at discharge or time to definitive procedures. Experienced trauma and trauma/burn centers are expected to place increasing emphasis on outcome oriented audit filters; their PI plan and program and are judged accordingly.

While deviation from the description of the alert system in the trauma service, manual may occur from time to time, the site team will be evaluating the program for patterns of deviation especially in instances where the pattern is not identified by the institution's PI plan and addressed through the plan. Examples of such patterns include, but are not restricted to:

- Delay in calling a full team response until after the patient is evaluated.
- Severely injured patients or patients requiring emergent surgery not receiving full team response.

Level:	I	IB	Peds	II	III
• Frequent need for upgrades in tiered response. • Delay in arrival of team members for full team response. • Mortality or morbidity attributable due to delays in team arrival. • PI plan does not identify and address issues in team response.					
10.29. If greater than 10 percent of injured patients are admitted to non-surgical services, there shall be a PI process to demonstrate the appropriateness of this practice.	NC	NC	NC	NC	NC
10.30. The PI program shall define when the attending surgeon's immediate hospital presence is required.	C	C	C	C	C
10.31. The Burn Service shall provide ongoing review and analysis of nosocomial infection data and risk factors that relate to infection prevention and control for burn patients. These data shall be available to the burn team to assess infection risk factors that relate to infection prevention and control for burn patients.	-	C	-	-	-
10.32. Each trauma center shall annually collaborate with the top three referring / receiving facilities to assess, plan, implement, and evaluate the physician and nursing trauma educational needs of those facilities transferring severely injured patients.	C	C	C	C	C
10.33. Each trauma center shall collaborate with the top three regional transferring / receiving facilities to design and provide an annual hospital specific registry report by using the hospitals PI infrastructure for transmission.	C	C	C	C	C
10.34. The PI program shall demonstrate the application of outcome and benchmarking based activity.	NC	NC	NC	NC	NC
10.35. There shall be a demonstrable relationship between PI outcomes and new or revised clinical protocols.	C	C	C	C	-
10.36. The Burn Service shall conduct audits released annually that include, but are not limited to, the severity of burn mortality, incidence of complications and length of hospitalization.	-	C	-	-	-
10.37. The PI program shall include regional trauma systems.	NC	NC	NC	NC	NC
10.38. There shall be a trauma research program designed to produce new knowledge applicable to the care of injured patients to include an identifiable institutional review board process.	C	C	-	-	-
10.39. The trauma research program shall be designed to produce new knowledge applicable to the care of injured patients to include; three adult peer reviewed publications and one pediatric peer reviewed	C	C	-	-	-

Level:	I	IB	Peds	II	III
publication over a three-year period that could originate in any aspect of the trauma service.					
10.40. There shall be nursing specific trauma research program designed to produce new knowledge applicable to the care of the injured patients. There shall be a minimum of one publication per three-year verification cycle.	NC	NC		-	-
11. Disaster Planning and Management					
11.1. There shall be demonstration that the trauma center participates in disaster preparation and management. • Shall meet the disaster-related requirements for the Joint Commission for Accreditation of Healthcare Organizations or other CMS approved accreditation organization. • A surgeon from the trauma panel shall participate on the hospital's disaster committee. • Hospital drills that test the individual hospital's disaster plan shall be conducted every six months. • Trauma Centers shall have a hospital disaster plan described in the hospital's policy and procedure manual or equivalent.	C	C	C	C	C
12. Community Outreach / Injury Prevention					
12.1. Each trauma center shall have in place a method for showing their involvement with the community in their region. The trauma center shall be involved in community awareness of trauma and the trauma system.	C	C	C	C	C
12.2. The Burn Service shall document burn specific participation in public awareness programs.	-	C	-	-	-
12.3. There shall be documentation that injury prevention activities are based upon regional needs.	C	C	C	C	C
13. Facilities and Equipment					
The ED shall have the following equipment for all ages:					
13.1. There shall be resource information on pediatric medication dosing and equipment sizes i.e. a Broselow Tape.	C	C	C	C	C
13.2. There shall be airway control and ventilation equipment (laryngoscopes with a variety of straight and curves blades, endotracheal tubes (ETT) of all sizes, bag valve mask, and methods to continually provide supplemental oxygen.)	C	C	C	C	C
13.3. There shall be equipment to manage a difficult airway.	C	C	C	C	C

Level:	I	IB	Peds	II	III
13.4. There shall be suction devices in adequate numbers to be able to care for the multi system trauma patient.	C	C	C	C	C
13.5. There shall be CO_2 detection device(s) to confirm placement of ETT	C	C	C	C	C
13.6. There shall be a cardiac monitor immediately available with capabilities to include ECG, pacing, and external and internal defibrillation	C	C	C	C	C
13.7. There shall be large caliber venous access and intraosseous devices available.	C	C	C	C	C
13.8. There shall be thermal control equipment for blood and IV fluids.	C	C	C	C	C
13.9. There shall be an IV fluid and blood rapid infuser for administration and warming of IV fluid and blood products located in the ED.	C	C	C	C	C
13.10. There shall be sterile surgical sets / trays to include airway control, cricothyrotomy, thoracotomy, vascular access, chest tube insertion, peritoneal lavage, and central line access.	C	C	C	C	C
13.11. There shall be thermal control equipment for cooling and warming patients.	C	C	C	C	C
13.12. There shall be availability of sonography to perform FAST exams.	C	C	C	C	C
13.13. There shall be pediatric equipment available that meets the most current recommended list by the American College of Pediatrics "Guidelines for Care of Children in the Emergency Department" (AAP/ACEP, 2009)	C	C	C	C	C
13.14. The Burn Unit shall maintain an identified nursing unit where staffs specialize in burn care.	-	C	-	-	-
13.15. There shall be an identified Burn Unit that is a fixed physical and geographic location within the hospital for the treatment and coordination of burn care.	-	C	-	-	-
13.16. The burn unit shall have effective means of isolation that is consistent with the principles of universal precautions and barrier technique to decrease the risk of cross infection and cross-contamination.	-	C	-	-	-
13.17. There shall be a specific area as designated by the Burn Medical Director for wound care assessment and treatment which would include the capability for minor wound debridement, escharotomy, wound cleansing, procedural techniques such as line placement, and overall assessment.	-	C	-	-	-
The Burn Unit shall have the following equipment for burn					

Level:	I	IB	Peds	II	III
patients of all ages:					
13.18. There shall be weight-measuring devices.	-	C	-	-	-
13.19. There shall be thermal control equipment for cooling and warming patients.	-	C	-	-	-
13.20. There shall be bedside and central ECG, pulse oximetry, and pressure monitoring devices.	-	C	-	-	-
13.21. There shall be electrocautery available in the Burn Unit.	-	C	-	-	-
13.22. Any adult trauma center that annually admits 100 or more injured children younger than 15 years of age shall have a pediatric emergency department.	NC	NC	-	NC	NC
13.23. Any adult trauma center that annually admits 100 or more injured children younger than 15 years of age shall have a PICU.	NC	NC	-	NC	NC
13.24. There shall be a pediatric ED area.	-	-	C	-	-
13.25. There shall be a pediatric ICU.	-	-	C	-	-
Operating Room					
13.26. There shall be the capability for resuscitation, stabilization, continuous monitoring of temperature, hemodynamics, and gas exchange.	C	C	C	C	C
13.27. There shall be a rapid infuser for the administration and warming of IV fluids and blood products in the OR.	C	C	C	C	C
13.28. There shall be thermal control equipment for cooling and warming patients in the OR.	C	C	C	C	C
13.29. There shall be 24 hour per day x-ray capability, including C-Arm image intensifier.	C	C	C	C	C
13.30. There shall be endoscopes and bronchoscopes in the OR.	C	C	C	C	C
13.31. There shall be adequate equipment available in the OR to perform craniotomies.	C	C	C	C	C
13.32. There shall be the capability of fixation of long bones.	C	C	C	C	C
13.33. There shall be adequate equipment to assure the capability of surgical treatment of pelvic fractures including, but not limited to, open pelvic fractures and acetabular fractures requiring complex surgical interventions.	C	C	C	-	-
13.34. In the event that patients are boarded in the PACU as ICU overflow patients, then the equipment listed in criteria 13.4013.37 - 13.48.	C	C	C	C	C

Level:	I	IB	Peds	II	III
13.35. There shall be a fixed physical and geographic location within the hospital identified as the pediatric intensive care unit (PICU).	-	C	C	-	-
13.36. There shall be a fixed physical and geographic location within the hospital identified as the ICU.	C	C	C	C	C
There shall be the following equipment appropriate for the age of patients managed in the ICU:					
13.37. There shall be a fixed physical and geographic location within the hospital identified as the intensive care unit (ICU).	C	C	C	C	C
13.38. There shall be resource information on pediatric medication dosing and equipment i.e. a Broselow Tape.	C	C	C	C	C
13.39. There shall be adequate airway control and ventilation equipment (laryngoscopes with a variety of straight and curved blades, ETT of all sizes, bag valve masks, suction devices in adequate numbers, and methods to continually provide supplemental oxygen.)	C	C	C	C	C
13.40. There shall be equipment to manage a difficult airway.	C	C	C	C	C
13.41. There shall be a temporary transvenous pacer.	C	C	C	C	C
13.42. There shall be the availability of portable cardiac monitor immediately available with capabilities to include ECG, pacing, and external and internal defibrillation.	C	C	C	C	C
13.43. There shall be mechanical ventilators available ICU.	C	C	C	C	C
13.44. There shall be patient weighing devices in the ICU	C	C	C	C	C
13.45. There shall be temperature control devices for patients.	C	C	C	C	C
13.46. There shall be thermal control equipment for blood and IV fluids.	C	C	C	C	C
13.47. There shall be a rapid infuser device for the administration and warming of IV fluids and blood products.	C	C	C	C	C
13.48. There shall be an intracranial pressure-monitoring device.	C	C	C	C	C

ADMINISTRATIVE GUIDELINES

Purpose:

The purpose of the administrative and interpretive guidelines is to provide information pertaining to the process of designation and verification of trauma and trauma/burn centers in Virginia. It is divided into two sections: 1) administrative guidelines describing the procedures and steps required for the process, and 2) interpretive guidelines describing how trauma and burn center criteria should be evaluated during a site review. The document is designed to be used with Virginia trauma and trauma/burn center Criteria.

The objective is to provide a consistent, objective, and meaningful approach to the designation process.

Background:

In Virginia, the lead EMS agency is VDH/OEMS. VDH/OEMS coordinates the development and administration of trauma center designation throughout the state. The earliest Level I trauma centers were designated in 1983 and 1984. Burn specific designation was introduced to the designation manual in 2012. Pediatric trauma designation was added in 2015.

The trauma system in Virginia is inclusive. All hospitals with 24-hour emergency departments provide some degree of trauma and burn care. The decision to become a designated trauma center is voluntary. Designation carries a cost related to the fact that the trauma programs shall be continuously available for patients who may or may not require their services. Triage guidelines act to direct severely injured patients to the nearest appropriate trauma center.

Designation occurs at five levels, Level I, IB, IP, II, and III. Level I, IB, IP, and II trauma centers should be capable of managing severely injured patients. Level I, IB, and IP centers shall demonstrate a higher level of commitment to research, prevention, and education. Level III centers demonstrate an increased commitment to trauma care, managing moderately injured patients and rapidly resuscitating and transferring more severely injured patients. Undesignated hospitals must recognize, resuscitate, and transfer most trauma patients.

All hospitals whether designated or not should make every effort possible to participate in and to improve the trauma system. Due to the unexpected nature of injury, trauma patients and their families cannot choose their location of care. It is incumbent upon the healthcare system to provide these patients with the most optimal care possible regardless of location and

circumstances. The purpose of the designation process is to assure consistent performance of entry-level trauma and trauma/burn centers and to promote continued improvement and development of experienced centers.

I. Record Keeping

Overview: The trauma system in Virginia is dynamic. Centers change in response to pressure of the healthcare environment and criteria and processes for evaluation change as trauma and burn care evolves. Maintaining records consistently over a period of time achieves several purposes. It provides a series of system snapshots over time. It allows centers and VDH/OEMS to refer back to actions taken in the past. Finally, it allows a summation of trauma and trauma/burn center performance rather than a series of unrelated and disjointed episodic views. In order to accomplish these goals, the records must be identifiable, consistent, accessible, and maintained in a predictable fashion.

a. Documents and revisions of documents will be numbered and maintained by the VDH/OEMS. This process is put into place to avoid confusion with regard to which version of a document is in use during the site review. When a trauma or trauma/burn center is scheduled for a review, the Trauma/Critical Care Coordinator will provide the title and effective date of the documents to be used during the review. These will include the trauma and trauma/burn center criteria and the administrative and interpretive guidelines, as well as any other documents considered to be pertinent.

b. Each trauma or trauma/burn center will have a file maintained for a period of not less than ten years after the most recent trauma review. The file will include:
    i. Records of each site review to the institution with the following information:
        1. **Designation Items:**
            a. Written preliminary report and suggested remediation by site review team,
            b. Written documentation of remediation,
            c. Closure of remediation,
            d. The final report of the site review team, including specific findings and remediation, and
            e. Copy of written action by the Commissioner (designation).
        2. **Site Review Documents:**
            a. Site Review Agenda,
            b. Site Review Team Roster, and
            c. Version of (by revision date) of trauma center criteria used for site review.

3. **Written Application Including:**
    a. Acknowledgement that the VDH/OEMS trauma designation file has been reviewed (signed),
    b. Trauma Center Code of Conduct,
    c. Trauma Center Capabilities,
    d. Current Organizational Chart,
    e. Impact Statement,
    f. Checklist,
    g. Questionnaire,
    h. List of physicians,
    i. Trauma team alert criteria (roles, responsibility, and policies),
    j. TMD job description,
    k. Trauma Nurse Coordinator job description (include an organization Chart),
    l. Trauma Registrar job description and evidence of CME requirements (as applicable),
    m. Performance improvement plan,
    n. Performance improvement process flow diagram,
    o. Verification renewal letter, and
    p. VSTR audit.

ii. Any records pertaining to any voluntary or involuntary withdrawal of designation.

iii. Any additional communication pertaining to designation status between the center and VDH/OEMS or the Commissioner.

iv. A summary of activity related to the center (a list of dates, nature of actions and resulting status of center.)

c. A copy of the current trauma center file will be sent to the TPM and to the TMD at the time of request for verification or designation. These individuals will review the information contained for accuracy and provide written confirmation to VDH/OEMS.

d. Management of records during review:
    i. Each member of the site review team will receive a copy of the trauma center file in its entirety at least two weeks prior to the review, and
    ii. Team members will receive electronic or written application material at least two weeks prior to the review.

e. Preliminary report of findings may be made available to the center prior to the time of departure of the site review team:
    i. The center may receive a written copy of preliminary report listing issues of concern, strengths and areas for improvement; and
    ii. The team may also provide specific preliminary suggestions for remediation in writing at time of departure.

f. The team leader will provide written confirmation of preliminary findings and remediation or amended findings and remediation within one week of finishing the site review.

g. After any conditions of remediation have been satisfied, the site review team leader will provide VDH/OEMS with written notice of closure of remediation.

II. Application for Review

a. Six months prior to the date a center is due for site review, the Trauma/Critical Care Coordinator for VDH/OEMS will notify the TPM and provide the following:
    i. Application to be completed,
    ii. Copy of trauma center file on CDROM, and
    iii. Copy and version number of Criteria and AIG to be used during review.

b. Application will include:
    i. Signed Trauma Center Code of Conduct,
    ii. Completed Trauma Center Capabilities Form,
    iii. Current Organizational Chart describing the relationship of the trauma service within the hospital organizational structure,
    iv. Impact Statement: the impact statement describes the role of the trauma center or proposed center in the system it serves. The statement acts as an argument for the existence the center and its essential contributions to the community,
    v. Level I, IB, IP, II or III Checklist for appropriate level requested (electronic form provided),
    vi. Completed Trauma Center Questionnaire,
    vii. Current complete list of emergency physicians and mid-level providers,
    viii. Current complete list of trauma surgeon's performing trauma call,
    ix. Current complete list of nursing staff members that serve as the primary trauma team nurse in the trauma bay/room. The list of trauma team nurses should include whether the nurse possesses active TNCC, ATCN, or CATN,

x. Copies of current TNCC, ATCN, and CATN should be made available to the site review team,
xi. Trauma team activation/alert criteria for your hospital,
xii. Trauma team roles and responsibilities policy,
xiii. Trauma alert policies,
xiv. TMD job description,
xv. Burn Medical Director job description (as applicable),
xvi. Evidence of TMD's board certification(s), current ATLS, CME, and national conference attendance (as applicable),
xvii. TPM job description (include an organizational chart),
xviii. Burn manager/coordinator job description (as applicable),
xix. Evidence of TPM's TEH and national conference attendance (as applicable),
xx. Evidence of the Burn Manager/Coordinator's burn education hours (if applicable),
xxi. Trauma registrar job description and evidence of TEH requirements (as applicable),
xxii. Emergency Medical Director's board certification(s), CME and current ATLS or the identified designee's current ATLS,
xxiii. Copy of the program's PI plan,
xxiv. PI process flow diagram includes how issues get reported to its highest level,
xxv. PI tracking sheets, and
xxvi. Other documents as requested.

III. Prior to Review

a. Prior to review, the site review team shall have:

i. Complete copy of trauma center file,
ii. Full copy of pre-review application,
iii. Current status of center with regard to VSTR provided by VDH/OEMS, and
iv. List of any trauma related issues requiring investigation by VDH since last review, along with resolution.

IV. Site Review

Overview**:** Without trauma and burn patients, a trauma center cannot demonstrate the consistency and effectiveness of procedures and protocols put into place at the time of its inception. However in a well-developed system with a strong trauma triage element, severely

injured or burned patients will be directed toward existing designated trauma or trauma/burn centers. A paradoxical situation develops; the center should not be designated until it demonstrates effectiveness, yet cannot demonstrate effectiveness until receiving patients as a trauma center. To remedy this situation, first time institutional reviews will be to survey for a provisional status.

Although it is important for a center to demonstrate its level of performance, the public must not be put at risk for suboptimal care. Therefore, the second review following a short interval will be held for full designation. The interval will allow the center to put its documented plan for trauma care into action. In addition, the institution will have an opportunity to correct any deficiencies identified by the original site review team. At the time of the second site review (the first designation review) the center will either pass or not pass. Any identified critical deficiencies will result in a mandatory period during which the institution will re-evaluate the trauma service prior to beginning the designation process over again.

a. Provisional center – one year period
    i. At the provisional review, the center must demonstrate that all required mechanisms to meet criteria are in place. The team will confirm that there is a resource, policy, or procedure that addresses the criteria and that it represents a practical and effective approach.

    ii. The team will identify the following:
        1. Critical deficiencies
        2. Non-critical deficiencies
        3. Potential areas for improvement

    iii. The presence of critical deficiencies will be cause to withhold provisional designation. The center must re-evaluate its program and if desired, begin the application process again after a period of not less than one year.

    iv. When non-critical deficiencies exist or in the absence of deficiencies, the program will receive provisional status for a period of one year. During this time, it will function at the identified level and remedy any non-critical deficiencies identified at the first site review.

b. Designation: A second site review will occur at the end of the hospitals one year provisional status. The hospital does not have to submit a full application, but should submit an interim report describing any changes since designation as a provisional center, status of non-critical deficiencies noted

during the first site review, as well as a trauma service summary from its trauma registry.

The modified site review team will consist of a surgeon team leader and a trauma/critical care nurse reviewer. The surgeon team leader or OEMS may add additional members to this team as deemed necessary.

Any critical deficiencies identified at this time will result in the center not receiving designation as a trauma center. The hospital will not function as a trauma center if this occurs and will re-evaluate and revise its current program for at least two years prior to beginning the application process again.

c. Verification**:** Following designation, a center will undergo verification review every three-years having become designated, an institution must continue its developmental process. A progressively sophisticated approach is expected of more experienced centers and is reflected in a number of the criteria. This is particularly apparent in the area of quality assurance. Continuous improvement means continuous change. An experienced program is expected to demonstrate ongoing evaluation of the trauma care system, presenting enhanced approaches to existing problems or efforts at solving newly identified problems. For this reason, it is unlikely that an experienced program will be successful if unable to present progress and changes over three verification cycles. Verification reviews follow a successful designation review and should document ongoing development of the center and responsiveness trauma system issues.
    i. A full application will be submitted for each verification review.
    ii. In the absence of critical deficiencies or persistent non-critical deficiencies the center will be confirmed at its current level of function.
    iii. If a non-critical deficiency has been identified for the first time it will be noted in the team leaders' summary. However, if a non-critical deficiency is identified in two out of three sequential reviews, the center will be asked to submit a plan of correction to VDH/OEMS within three months. At the next site review, the center will provide evidence of having implemented the plan and improvement in the area of deficiency identified.

V. Withdrawal

Overview**:** As an advocate for quality trauma and burn care, a trauma or trauma/burn center should be able to identify situations in which it no longer meets criteria required for its current level of designation. If this occurs, the center should notify VDH/OEMS requesting a temporary withdrawal, permanent withdrawal or request for re-designation (either upgrade or downgrade). Identification and self-reporting of the problem is more advantageous than waiting for an adverse result of a verification review or complaint resulting in involuntary withdrawal.

a. Temporary: A hospital may request a temporary withdrawal from the system if unforeseen and uncontrollable circumstances prevent the center from functioning at its designated level and if the period of time is expected to be longer than one day and less than three months. Requests for temporary withdrawal greater than three months will require a site review team review.

Examples include death, disability, resignation, retirement, etc. of key individuals on the trauma service, or an internal disaster such as a fire or flood. A representative from the hospital will notify VDH/OEMS regarding the request for temporary withdrawal by phone or e-mail as early as possible. Initial notification shall be followed by a written report outlining the circumstances, the plan to correct the circumstances, the anticipated length of temporary withdrawal, and any arrangements to maintain trauma care within the system (e.g. memorandum of understandings with other hospitals, notification of VDH/OEMS) within 14 days. Once the problem has been corrected the trauma or trauma/burn center will notify VDH/OEMS. A site review is not required for re-instatement. If the center is involved in remediation for critical deficiencies at the time of request for temporary withdrawal, the timeline for remediation is not altered and no extension is applied.

b. Permanent**:** If a hospital wishes to discontinue its role as a trauma or trauma/burn center it may request a voluntary withdrawal. The institution is not required to provide a reason for this although VDH/OEMS may request information to facilitate evaluation of the trauma system. The hospital should provide the request for voluntary withdrawal in writing. Included with the request should be a copy of the most recent impact statement and suggestions for changes in the system to allow for accommodation of gaps in trauma coverage. Following voluntary withdrawal, a center may apply for re-designation at any level desired after a period of not less than one year. The center will arrange for notification of the public and EMS agencies regarding the change in status. Only one voluntary withdrawal is permitted within a ten-year period of time.

c. Re-designation (upgrade)**:** The hospital requesting an upgrade in level of trauma center designation will be required to undergo a full site review at the level of re-designation being requested. The site review must occur prior to functioning at the requested level of re-designation. Since this is a new designation a verification review will be required in two years.

d. Re-designation (downgrade)**:** If a hospital requests a downgrade in level of designation, a modified site review will be performed to assure the hospital is functioning at the level of designation being requested.

e. Involuntary**:** An involuntary withdrawal occurs when a center fails to remediate critical deficiencies as outlined by the site review team, or if a review by a site review team or VDH/OEMS representative determines that further function as a trauma center would be a risk to patient safety or extremely detrimental to the system. If this occurs, the center has the option of an appeals process outlined below. At the time of an involuntary withdrawal, VDH/OEMS will provide notification to the public and to EMS providers in the area. Following the first involuntary withdrawal, an institution may request re-designation after a period of not less than three-years. After any subsequent involuntary withdrawals the institution will not be permitted to apply for re-designation sooner than five years.

VI. Appeal

If a hospital, whether designated or attempting to be designated, has a grievance with findings relating to the enforcement of the Virginia trauma center criteria by VDH/OEMS, a site review team leader, a site review team member, the TSO&MC, or any subcommittee formed from the TSO&MC has the right to file an appeal the finding(s).

The appeals process will follow the Administrative Process Act (APA) of Virginia § 2.2-4000. Notice of intent to appeal should be documented and submitted to VDH/OEMS as stipulated in § 2.2-4000. Failure to follow the APA guidelines can result in the appeal not being heard.

VII. Variances and Exemptions

Any designated trauma center that wishes to request a variance or exemption from any of the criteria or procedures required by the trauma center designation process shall do so in writing. A variance provides the hospital with temporary relief from a criterion or procedure and an exemption provides permanent relief from a specific criterion. All variances and exemption become void upon implementation of a revised Trauma and Burn Center Designation Manual.

To submit a request for a variance or exemption the designated trauma center may file a written request for a variance with the VDH/OEMS Trauma/Critical Care Coordinator. The following additional requirements apply:

1. The written variance or exemption request shall be submitted by the hospital's administrative leadership.
2. The request shall be submitted to the VDH/OEMS Trauma/Critical Care Coordinator.
3. The request shall clearly state:
    a. The criterion that is the focus of the variance/exemption.
    b. A detailed description of why the request is being made.
    c. A detailed impact statement describing any alternative action that will occur to mitigate the effects on patient care or operational procedures.
    d. Describe how the regional trauma system will be informed if applicable.
    e. Provide any transfer agreements and transfer policies as applicable.
    f. Provide any supporting facts or data that support granting a variance or exemption.
    g. Provide and letters of support from regional hospitals, EMS agencies, or others as applicable.
4. The VDH/OEMS Trauma/Critical Care Coordinator will review the request and make a recommendation to approve or disapprove the request to the State Health Commissioner.
5. The VDH/OEMS will provide the State Health Commissioner with any facts such as national standards that relate, either positively or negatively, to the request.
6. This process may take 2 – 8 weeks.

VI. Site Review Team Member Roles, Training and Recruitment

a. Site review team member roles (refer also to site review checklist for more details)
    i. A surgeon team leader officiates over the site review team and provides a written summary and recommendation upon the application to the Health Commissioner. The surgeon team leader will review the surgical capabilities of the hospital and determine if they meet essential criteria for the level of designation/verification being sought.
    ii. An emergency medicine physician will review the ED's response to trauma patients. This would include whether there is an appropriate team response to trauma patients, the care provided during that response and the availability of ancillary services during the initial phase of trauma care.
    iii. The trauma/critical care nurse reviewer will review all phases of nursing care provided by the applying center. This would include assuring there is adequate staffing and equipment available, as well as quality nursing care

provided during the trauma team response, within the critical care department and inpatient areas.

iv. Trauma nurse coordinator's role within the trauma service will also be evaluated by the trauma/critical care nurse reviewer.

v. A hospital administrator role will also be utilized to evaluate the overall commitment that the hospitals administration has to the trauma service.

b. Training - VDH/OEMS and the TSO&MC may provide a training program, suited for both classroom presentation and self-learning which will assure the site reviewer's knowledge of the current criteria and their role as a site review team member.

c. Recruitment –VDH/OEMS and the TSO&MC will assure that there are an adequate numbers of site reviewers. To qualify as a site review team member, the individual will be required to observe a minimum of one site review, receive the site review training, and be approved by vote of the TSO&MC.

d. VDH/OEMS will maintain records on individual site reviewer activities including dates, locations and outcomes of reviews.

e. VDH/OEMS will solicit evaluations of site team leader performance.

BURN PATIENT CRITERIA

Burn injuries that should be referred to a trauma/burn center for assessment:

The American Burn Association has identified the following injuries that usually require referral to a trauma/burn center.

- Partial thickness and full thickness burns greater than 10 percent of the total body surface area (BSA) in patients under 10 or over 50 years of age.
- Partial thickness burns and full thickness burns greater than 20 percent BSA in other age groups.
- Partial thickness and full-thickness burns involving the face, eyes, ears, hands, feet, genitalia or perineum of those that involve skin overlying major joints.
- Full-thickness burns greater than five percent BSA in any age group.
- Electrical burns, including lightning injuries; (significant volumes of tissue beneath the surface may be injured and result in acute renal failure and other complications).
- Significant chemical burns.
- Inhalation injuries.
- Burn injury in patients with pre-existing illness that could complicate management, prolonged recovery, or affect mortality.
- Any burn patient in whom concomitant trauma poses an increased risk of morbidity or mortality may be treated initially in a trauma center until stable before transfer to a burn center.
- Children with burns seen in hospitals without qualified personnel or equipment for their care should be transferred to a trauma/burn center with these capabilities.
- Burn injury in patients who will require special social and emotional or long term rehabilitative support, including cases involving child abuse and neglect.

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