COMMONWEALTH OF VIRGINIA

DEPARTMENT OF HEALTH

OFFICE OF EMERGENCY MEDICAL SERVICES

STATE EMS ADVISORY BOARD

IN RE: EMS ADVISORY BOARD MEETING

HEARD BEFORE: CHRISTOPHER L. PARKER

CHAIRMAN OF THE EMS ADVISORY BOARD

FEBRUARY 8, 2019

CONFERENCE CENTER

EMBASSY SUITES HOTEL

2925 EMERYWOOD PARKWAY

RICHMOND, VIRGINIA

1:03 P.M.

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APPEARANCES:

Christopher Parker, BSN, RN, CEN CPEN, NRP, CCEMTP, Presiding
Chairman of the EMS Advisory Board

Amanda Lavin, Esq.
Office of the Attorney General
Board Counsel

Parham Jaberi, MD, MPH
Public Health and Preparedness
Deputy Health Commissioner

EMS ADVISORY BOARD MEMBERS:

Michel B. Aboutanos, MD

Samuel T. Bartle, MD

John C. Bolling

Dreama Chandler

Valeta C. Daniels

Kevin L. Dillard

Angela Pier Ferguson

Dillard E. Ferguson, Jr.

Jason D. Ferguson

R. Jason Ferguson

William B. Ferguson

Sudha Jayaraman, MD

Lori L. Knowles

John Korman

Matthew Lawler

Julia Marsden

Richard A. Orndorff, Jr., Mayor
Strasburg, Virginia

EMS ADVISORY BOARD MEMBERS (con't.)

Jeremiah O'Shea, MD

Jethro H. Piland

Valerie Quick

Gary Samuels

Thomas E. Schwalenberg

Gary Wayne Tanner

Sadie Jo Thurman

Allen Yee, MD, FAAEM

Gary P. Critzer

VDH/OEMS STAFF:

Gary Brown
Director

Scott Winston
Assistant Director

George Lindbeck, MD
EMS Medical Director

Tristen Graves

Wanda Street

Irene Hamilton

Jackie Hunter

Stephen McNeer

Karen Owens

Adam Harrell

VDH/OEMS STAFF (con't.):

Marian Hunter

Deborah T. Akers

Chad Blosser

Chris Vernoval

Cam Crittenden

Tim Perkins

Luke Parker

Ron Passmore

David Edwards

Wayne Berry

Paul Fleenor

Rich Troshak

ALSO PRESENT:

Kate Challis
Coordinator
Central Virginia Coalition to Stop the Bleed

Valeria Mitchell
System Improvement Committee

Karen Shipman, Chair
Injury & Violence Prevention Committee

Brad Taylor, Vice-Chair
Pre-Hospital Care Committee

Margaret Griffen, MD, Chair
Post-Acute Care Committee

ALSO PRESENT (con't.)

Mark Day
Emergency Preparedness & Response Committee

Greg Woods
Regional EMS Council Executive Directors

Brian McRay
Richmond Ambulance Authority

Michael Player
Virginia 1-DMAT

AGENDA

(The EMS Advisory Board meeting was called to order at 1:03 p.m. The Pledge of Allegiance was recited by the Board and the gallery. A quorum was present and the Board's agenda commenced as follows:)

MR. PARKER: For those members seated at the table, I've been asked to make sure that you speak into the microphone. We do have a Court Reporter. Make sure your microphone is on and make sure you speak clearly.

On the agenda, we have the approval of the November 7th meeting minutes. The minutes were sent out. Are there any corrections or adjustments to the minutes?

BOARD MEMBER: Mr. Chairman, on page 12, line -- starting off the paragraph on line 23. It references John Bolling retired fire chief for the City of Bristol. Bristol is misspelled.

It actually looks like Richmond. I would ask that that be corrected to spell Bristol.

MR. PARKER: So noted.

BOARD MEMBER: Thank you.

MR. PARKER: Any other corrections? Hearing none, do I have a motion to accept the minutes as amended?

BOARD MEMBER: So moved.

MR. PARKER: Second?

BOARD MEMBER: Second.

MR. PARKER: All in favor?

BOARD MEMBERS: Aye.

MR. PARKER: Meeting minutes approved. You have it in front of you, the agenda for this meeting. Do I have anything that needs to be added to the agenda? Hearing nothing, may I have a motion to approve the agenda?

BOARD MEMBER: So moved.

MR. PARKER: And the motion's been seconded. All in favor?

BOARD MEMBERS: Aye.

MR. PARKER: The agenda stands. On the chairman's report, as I mentioned this morning in the TAG meeting, this is an exciting time for the Commonwealth.

The last two days have been filled with meetings, not just of the previously standing committees of the Advisory Board, but the new six committees that fall under the Trauma Branch, as we've decided to call it.

I met for two hours with OEMS staff Wednesday afternoon. And we kind of phrased that as the Branch to make sure we can kind of keep some of this in line.

And you'll hear more about that as we go through today. In moving back in the history and thinking about the ACS site visit that we had here in Richmond, the

100 people -- over 100 people that were in the room, this is a very positive exciting time in seeing where this is moving forward in the Commonwealth.

It's been a lot of work and you'll hear more about that today. And that's all I have for the Chairman's report. Vice-chair.

MR. D. E. FERGUSON: I don't have any report at this time. Thank you.

MR. PARKER: Okay. Deputy Commissioner's report, Dr. Jaberi.

DR. JABERI: Good afternoon. Just want to thank you again everybody for taking the time to come out today. I had a chance to introduce myself the last time.

Joined the Department of Health in October. This being my second Advisory Board meeting. It's nice to see a couple familiar faces. I want to thank a few of our folks here in central Virginia partner who've invited me out to their

facilities to show me their trauma systems, the landscapes, some of the concerns with regards to patient transport.

Specifically where whether trauma triage guidelines are being followed and how that's being enforced. So I'm beginning to learn a little bit about that.

Obviously, we've been through some challenging times, and with this week I would say with what we're seeing in the political realm, what we did in the VDH -- Virginia Department of Health -- is had an agency-wide polycom to kind of talk about the lessons learned.

And what that means about the services we provide in the Virginia Department of Health, which is aimed and geared towards all citizens.

We realize there's a lot of scrutiny, a lot of concern and just want to acknowledge the -- the challenges and difficulty some of our staff have had with regards to implications of what does this mean for us as State employees. So it's been a tough time, but through the

conversations, I think we have brought about awareness just through discussions. We have brought about opportunities to remind ourselves when we talk about health equity.

When we talk about the services that the State provides for our citizens to insure that we do those in a way that's meaningful, that's understandable, and that our -- our citizens when they have questions and concerns, we can respond to it in -- in the most effective manner.

Again, I -- I really appreciate being part of the EMS Advisory Board. The amount of talent and commitment that's in this room is -- is next to none.

And I enjoy every interaction I've had with our Office of EMS staff who work so hard to prepare for this meeting and look forward to the comments ahead. Thanks so much.

MR. PARKER: Thank you, Dr. Jaberi. Office of EMS report.

MR. BROWN: Thank you, Mr. Chair.

First I'd like to start off with a couple of updates on personnel changes. Staffing updates in the Office of EMS. And if -- first of all, I'd like to introduce you to Rich Troshak.

And if he can stand up so I can properly embarrass him. Oh, keep standing. You're not off the hook yet. Okay. This -- Rich is our emergency operations specialist.

This is a position that was held by Ken Crumpler. Rich comes to us -- and there's a write up in the -- in the quarterly report to you guys. He has served as the director of emergency communications for Chesterfield County for over 10 years.

His other communications experience includes the DHS communications Megacenter bank center in Philadelphia, as well as 911 centers in Kansas, Michigan and Pennsylvania, but he saved the best for last. Right, Rich? Right here. So anyway, we want to welcome Rich to the Office of EMS staff. And he will also be staffing our communications committee of this Advisory

Board. And if you have a chance to, go talk to him. He's a pleasant individual. And we've got a lot of busy work for him to start on here in the -- soon as this meeting is over, actually.

So Rich, welcome aboard. We do have an opening also in the same division, our emergency ops planner position. We are now going into our fourth round of advertisement and recruitment.

We have had three failed attempts in terms of filling that position. So we are trying again. And we, quite candidly, are upping the salary range so we can hopefully attract qualified candidates for that position.

And we have had it categorized as a hard to fill position as well because, obviously, three failed attempts. It is a hard to fill position. So that is in recruit.

And then I'm sorry to report that Billy Fritz, who is our BLS training specialist within the Office of EMS has been lured back to Prince William County and will

be working in Prince William. And we really -- very, very sorry to see him leave because he's been very visionary and has really done a lot in his short tenure within the Office of EMS.

And he will be sorely missed. So that's it with updates. I do want to also echo what Chris had started off saying with regards to the new committee structure.

And I said this today in the trauma -- I have to look at my notes -- Trauma Administrative and Governance Committee. We refer to it as TAG.

And this -- it's really monumental, I think, in terms of what's going on here in -- in the Commonwealth with regards to the ACS consultative study and review.

And basically, the recommendations that came out of that national assessment. And then, how do you get your arms around the recommendations and how do you eat this elephant, so to speak. And the -- working with the chair of the Trauma System Oversight Management

Committee, which is now TAG -- Dr. Aboutanos and then the former chair, Gary Critzer. And -- and putting structure to that type of process and working through all the recommendations and categorizing them.

And then establishing work groups and so forth, it's -- it's been nothing short of -- of miraculous in many respects. And again, I said this in TAG this morning, I'll say it again.

The Office of EMS is very engaged in and very active on a national level, through the National Associate of State EMS Officials. And I am getting calls and emails on a routine basis.

And people -- they look up and they pay attention to what's going on here in Virginia. And they are looking at what we're doing in the world of trauma and critical care and integration of a true system, EMS trauma care system.

And they -- they really are asking how did we pull this off, how we -- we doing this. And they -- they are looking closely because it's really something that,

quite honestly, I haven't see it in -- anywhere else at the moment. And so, with the TAG Committee led by Dr. Aboutanos and then the six work groups which are now standing committees of the Advisory Board, under that.

And of course, that was done as a result of action taken at the November 7, 2018, Board meeting to amend the bylaws to recognize this, to really integrate the -- the system even closer.

It's really remarkable and I certainly welcome all of the new -- excuse me -- committee chairs. And I think they're under the TAG report.

I believe there's going to be some introductions by Dr. Aboutanos and maybe some updates and so forth. So we're really happy about that.

This time of year, too, you know that we -- the Office of EMS -- we send out a weekly legislative grid and report. And it's bills that we are tracking that are of interest. I will have to admit this -- this year legislatively has been the

lightest year in my career with regards to legislation that we are lead on and having to develop legislative action summaries and fiscal impact statements and -- and also attending committee meetings and testifying.

But nevertheless, there's a lot of bills that -- that do have an impact on EMS. And so, hopefully you've been getting them, that we post them weekly on our web site as well.

And so, you can follow those bills. You may wonder why some of the bills that are on the grid and report are there. They're all there for a reason and even including bills that may have action that would lessen the impact of suspending a driver's license, thus eliminating a reinstatement fee.

The reinstatement fee is what -- it feeds into the Trauma Center Fund. So every bill that we list is there for a reason. I don't put commentary on those bills in our reports. But expect that you would look at those bills as you find interest in them. And read them and know

about them. And if you -- if you have any comments yourself or you want to talk to your local Delegate or Senator, that is your prerogative to do so.

With that, I'm going to actually turn it over to staff now because we do have a couple of special presentations that I want to make sure that we include as the Office of EMS report.

And one that came up actually earlier today in TAG that -- a special presentation on Stop the Bleed, and then another presentation. And so I will defer anything else I would have and look at Scott and then Dr. Lindbeck.

MR. WINSTON: All right, thank you, Gary. I, too, would like to extend my warm welcome to the -- the Trauma System community.

It's nice to see you all participate in this process. You've been a member of this community and we've recognized that. But now we have formalized that involvement and that commitment to the

trauma care patients. So we appreciate the hard work that you're doing. Secondly, I'm going to put a plug in for cardiac care, to kind of save the dates, if you will.

The first one has to do with the Mission Lifeline EMS Recognition Program. For the last five years, the American Heart Association has celebrated achievements of pre-hospital providers and their designated hospital specific to STEMI patient care.

You can be recognized for your contribution as a vital member of that STEMI team by putting in an application. A number of agencies have applied already in past years and been recognized.

There is a process for -- for those that have prior applications or those that wish to apply for the first time. The deadline is April the 2nd of this year.

And I would encourage agencies interested in doing that to do so. The second item has to do with the Virginia Heart Attack Coalition. And this is a group of individuals and physicians who have

gotten together and have been meeting for a number of years, looking at providing education and training to help improve the outcome of cardiac care patients.

Dr. Pete O'Brien from Lynchburg and Dr. Mike Kontos from here in Richmond are great guys to work with. And we had a conference call this -- earlier this week.

The Virginia Heart Attack Coalition has an annual meeting. May the 17th it will be held at Chesterfield County Fire in their training center. And I encourage you to -- to attend if you haven't been before.

The web site for the Virginia Heart Attack Coalition is virginiaheartattackcoaltion -- all spelled out -- .org. So please take a look at that. And we'd like to see you at that meeting in May. Thank you.

DR. LINDBECK: Just a brief comment. The EMS Agenda 2050 document was released last month, so it's only been out

for two or three weeks. But I think it'd be worth taking a look at and reviewing. It's available at ems.gov for download if you want to take a look at that. That's it.

MR. BROWN: That was great coming from you, George, the medical director. Just administrative stuff, huh?

DR. LINDBECK: Yeah. I love it.

MR. BROWN: Okay. I'm glad George brought up the agenda 2050 because the original EMS Agenda for the Future, released in 1996, actually had a big influence on us in Virginia.

And we implemented a lot of what was in that document. And we actually structured organizationally this Board based on the 1996 EMS Agenda for the Future.

And the 14 attributes that were identified to -- for states to have an effective and efficient EMS system. And we do have all -- we do address and cover all of those 14 attributes. So the 2050 agenda

is very important. In 2016, NITSA -- which produced the first Agenda for the Future in '96 -- did go out on national bid to develop a document of direction and vision for EMS in the country for 2050.

So you'll be hearing more about that. And it helped segue me into something I forgot to cover. And I will ask Chris Vernoval on our staff to cover that. And that's the update to the State EMS plan.

The Code of Virginia does require that we have a State EMS plan. And that that plan is reviewed and updated tri-annually and approved by the State Board of Health.

We last did that in 20 -- March of 2017. And so therefore, we've got a target date of March of 2020 that we have to take it back before the Board of Health.

And one of the things that we did need to look -- as we go through that -- and tasking each committee to update sections that are applicable to them or include sections that may not be there now. It's also look at federal documents such as

the Agenda 2050 as well. So Chris, with that, if you would come forward and kind of give some more details on what everybody's homework assignments are going to be.

BOARD MEMBER: Is there a microphone for the public? There is not. You want to step to one of the sides so that you can be picked up by the Court Reporter.

MR. VERNOVAL: All right. So, thank you. All of the committee chairs and EMS office staff to those committees have been emailed out every -- all the information, the guidance documents that we already have on it.

So a lot of the communications that we've had over the last couple days have also included some of the communication that we need with this.

The guidance documents, the time frame and everything that we need to have everything done. The plan has to come back -- we have to have everything done and completed so that we can complete it at the

August and then approval for the November Advisory Board meeting. And then we'll go through for the Board of Health to actually have the final approval in March.

So it's a lot of stuff's going to have to happen over the next year. So part of your meetings are probably going to have a little bit of extra work alongside of your -- your normal load that you're used to.

Just -- you know, again, we ask the committees take a look at your relevant sections of the -- of the plan, review them.

And again, as -- as Gary was saying, please take a look at that Agenda 2050 and see how the Agenda 2050 is going to be relevant into our current State plan and how it's going to move forward for our next three-year plan.

And one of the things that we're looking to do as well is as we get the plan in place, as we're moving forward to have -- when we have our quarterly meetings and everything to have a committee chair

report reporting back into the Advisory Board as to how our plan is actually working. And in the action items and how everything is going with those committees moving forward in the future. So any questions on the plan?

MR. BROWN: Thank you, Chris. Appreciate it.

MR. VERNOVAL: You want me to do Workforce while I'm up or --

MR. BROWN: Let's save that for the --

MR. VERNOVAL: I'll wait.

MR. BROWN: -- the Standing Committee report, I guess.

MR. VERNOVAL: Okay.

MR. BROWN: Also this year is our 40th anniversary of our statewide EMS

Symposium. And so we're -- we're planning a lot of big things, big activities. Our Program Committee meets again this coming Tuesday for us to start going through over 1000 calls for presentations to select from for our Symposium.

However, if you or anybody in this room would still like to submit -- and you have an idea, you have a great instructor's name in mind or so forth -- please get in touch with us right now.

Either -- you can send me an email or Debbie Akers, who's handling that for the Office with the Program Committee. Any ideas that you would -- you would have in terms of what you'd like to see offered at the Virginia EMS Symposium.

Basically, we'll still accept it even though we've closed officially the call for presentations online. But if you -- if there's really something that you would like to make sure that we cover, please let us know. We'll do our best to accommodate that. Also, just moving very quickly -- Kate, if you'll start coming

forward. And I'm going to let you introduce yourself. But Kate gave a presentation on actually a -- a national effort called Stop the Bleed.

And it is -- it was so impressive that after she got finished this morning presenting it to TAG, Chris and I kind of look at each other.

Said, well, if she's willing to stay over for the afternoon, we'll give her a nice lunch. And we'll put her early on the agenda to make this presentation. Because we felt that strongly about it.

And it was such a good presentation. And we need to get this word out and this awareness, even wider than we have.

And we also -- this was an emphasis point at the past Symposium as well in terms of train the trainer for Stop the Bleed campaign. So Kate, if you don't mind introducing yourself and then --

MS. CHALLIS: Can somebody more technologically inclined than I am --

MR. HARRELL: Just touch your computer. It should all wake up.

MS. CHALLIS: There you go. Can you all hear me or do I need to pick up a microphone?

COURT REPORTER: Pick up a microphone, please.

MS. CHALICE: Hi, I am Kate Challis. I am -- oh. I told you, no technology here. I'm Kate Challis. I'm the trauma program manager over at Johnston-Willis and I got suckered into being the coordinator of the Central Virginia Coalition to Stop the Bleed.

When they looked around the table, I was the one left to be in charge. So they asked us to come here this morning and speak to you all about what we've been doing in Central Virginia to bring the Stop the Bleed Program out to the public and to our communities. So we wanted to explain it to you all. In Central Virginia, all the

trauma centers gathered together and sat at a table and said, we're all teaching the same program. We should be teaching it together.

There's really no competition here and there's all sorts of competition among trauma centers for all sorts of market share. But not on this one. On this, we all had the same message.

Wanted to get it to the same people. So we gathered together and we started to bring in other people on an ad hoc basis.

Z-Medica has been a great supporter and has offered a lot of training equipment, and helped us out financially quite a bit.

Then the Office of EMS and the EMS-C also because one of our target vulnerable populations was, of course, children. But we meet monthly.

We started at the end of 2017 at Johnston-Willis. And we decided that we would be very intentional about collaborating for large courses, especially

when the sort of crossed different geographical areas and locations. And as a result, we were able to -- as early as February -- teach the entirety of the Richmond Airport.

And now if you were to look around in the Richmond Airport, they have wall-mounted trauma first aid kits that include Quick Clot and tourniquets in them as well.

And then we started gathering other groups to -- this is another example. We taught at a high school and taught -- I'm sorry, middle school and taught the entire staff of the middle school.

So in a span of about an hour and a half, we were able to reach 125 people. And then one of our largest classes to date has actually been in New Kent.

And in the span of about three hours, we taught roughly 400 people. Again, because we all came together to sort of join forces for that. We joined underneath the -- or branched out the ODEMSA's professional development committee because we were able

to sort of leverage the pre-existing 501-C-3 status so that we would have the opportunity to apply for grant funding as we needed it.

And also because it was a -- already built in network of EMS agencies and intentional community outreach that already existed. So we sort of just rode their coattails for a little bit to do that.

We considered -- we also considered instead using the Central Virginia Health Care Coalition because it was a group of hospitals.

But we felt there was better relationship already there with EMS agencies and with the community using ODEMSA's branch instead. Some successes or things that contributed to our success.

We have unified buy-in. Every one of the program managers went to our facilities -- and this is three major competitors in particular coming together.

We went to our facilities and requested support, and they unanimously gave it. And we also were intentional about having a single location for our data

registration, for our course registration. We drive them through VCU's Center for Trauma and Critical Care Education, so the university side of it, because they have the personnel and the programs and the ability to collect the data.

So that the smaller centers, for example -- myself, our center is much smaller. But we can use that same data and everyone can collaborate for it.

We also created our own logo because at one point we discussed having a -- a shirt or design that incorporated everyone's logos.

And then the marketing and legal implications got started that -- it just wasn't even worth the fight. So we went with creating name and a logo that you see there, very, very advanced.

And we had our own shirts and we stayed away from any sort of company involvement in any logos. Instead it was that one collaborative mission. Where we have seen that we would have a lot of opportunity is we would love to have more

financial support. We're currently expanding legislative support -- exploring, excuse me, legislative support.

There is some grant funding opportunities that we've bounced around, whether or not we can apply for them. We also discovered that we've had varying EMS support.

We've had some EMS organizations that are really willing and excited and show up in mass to help us teach. And we've had others that sort of said, no.

It's -- it's not really anything that we're going to do and get into. There also was not a[n] instructor course. It still doesn't necessarily exist. Supposedly, ACS is coming out with it this year.

We haven't seen it yet, so we had to create our own. But by doing that, we were able to have one of our other bigger successes, which was to at EMS Symposium in this past year, we trained over 250 EMS providers in a train the trainer format. So

that we have 250 new instructors to add to our instructor cache. And they are from across the State. We're also creating a school nurse tool kit so that the school nurses can help us teach it as well.

We'll talk more about that in just a minute. But one of the things that centralized data repository, we wanted to spread the message to you all is that VCU has offered to house that data for the entire state.

And we will get the message out, probably via email, in the next six weeks or so how we are actually going to organize and structure that.

But that way, everyone can make sure that the data is being collected on where we are actually teaching. Because right now, even in the last TAG meeting, we discovered we can talk about where there are gaps.

But turns out maybe an EMS agency is teaching that. And we just aren't speaking -- didn't know it. So we can have that central data repository that will tell

us where it's being taught. And also, if you were to need instructors, that will include a component that has a centralized instructor pool.

So that if you, all of a sudden want to teach a class of 100 people but don't have anyone to help you, you can send an email to those instructors and say, who's around on this date, this time that can help teach this class.

We looked at whether or not we should form a State coalition. And there were really two paths that we saw in how to do this. Either base it geographically on the EMS councils or base it geographically on the health care coalitions.

And there are advantages and disadvantages either way you look at it. If you look at the first option with your EMS regions, if you overlay your hospitals that are trauma centers over top of that, you've got some pretty good representation across the State and pretty good, sort of, spearheads to kind of deliver that message. There are, however, two fairly large gaps

there, Shenandoah and the far southwest region that don't have a trauma center. If there is one near by, it is across a border. So there is not one in Virginia right there.

If you look instead at the hospital coalitions -- the health care coalition regions -- then you start overlaying your trauma centers in there. And you've got less of a gap, but still that one big one that's out -- far southwestern Virginia area.

So we decided instead that perhaps the way to go about this is a -- a version of a hybrid so that each geographic region needs to sort of explore within themselves how they form a coalition that is similar to what we've done in Central Virginia.

And already we know that there is some exploration in southwestern Virginia and also in the Tidewater area. But there has to be those open lines of communication that haven't necessarily existed before. I'll tell you that from the trauma program manager perspective, we are very fluid with

offering referrals back and forth. I get requests on a daily basis for teaching classes from across the State. And my staff can't do that, so we send them on instead.

We'll send them to Mark in Tidewater. We'll send them to other places, wherever is appropriate. Because this isn't about me and my company. This is about getting the message and getting this course out to the public.

Also we're going to have it be a standing -- Stop the Bleed is a standing discussion item at both the Trauma Program Manager Group on a quarterly basis and also the Injury and Violence Prevention Trauma sub-committee.

So we're talking about it on a regular basis in these open forums. But the real answer and ultimate issue is that trauma centers are a short term solution to what we want to be common knowledge.

We want this to be as common as CPR an using AED. So instead, one of the things we're looking at is -- also, not instead, excuse me -- in addition to is

using public school system to help teach our students and teach our kids so that over the next many years, we're going to have a community that actually has that education.

The whole idea is to create an actual self-sustaining program that doesn't rely on trauma centers or EMS agencies or any operating in a silo. Instead, it's able to be brought to the entire public.

So the way that we are proposing that we do that is that the trauma centers will come in and teach the school nurses. And we've already begun part of this.

School nurses can also help to teach other people in their building that are going to be -- either have a passion for it or have some sort of exposure to it.

Whether that's an athletic trainer or school resource officer or each school has its own safety team who is designed to respond to any kind of an accident or instant that would happen inside. They create a training team and that training team is able to teach the

teachers, staff, coaches, the people that would be in the school around the kids. And then that results in that smaller microcosm that knows the Stop the Bleed curriculum.

Looking long term, the school nurses are going to teach the health and PhysEd teachers, not gym teachers. Don't make that mistake. I did. Health and PhysED teachers.

They're going to offer it in ninth grade when they have their first aid curriculum. And then the kids are going to learn it then. And then in 10th grade, they're going to have a refresher.

And we've piloted how you would do that refresher. I'll explain that in just a few minutes. But at the same time, the school nurses are still working with that training team, because they're going to maintain a staff competency that's going to need to be done and repeated regularly. And that's going to create that baseline Stop the Bleed in the community. At the same time, your trauma centers are there to help support the school nurses and

the rest of the community, so that eventually everybody knows it and knows how to help if there were ever to be an incident.

One of the things we have begun to do in the trauma center community is we've created a tool kit for these school nurses.

It'll go out to them in July about how to teach the class, how to get funding for it, how to get the supplies in the school.

Because the supplies is another big -- the cost of the supplies and the logistics of getting them there are very sort of -- that's a very big obstacle for them.

But the first thing we did is we have gone out already and taught some of the school nurses and then athletic trainers.

And sort of helped them discuss and bounce around how they would create this team within their school. And this process started in the fall and it is

continuing and will probably continue for the next 12 to 18 months. We will bring them a train the trainer at the same time if they would like that, to go ahead and develop that team right then and there.

We'll do it because it only adds on 30 minutes. And then we've developed a scenario-based training. We piloted this with some school nurses. We did it and had some great success.

They went through three evolutions where they had to do sort of a one on one and then a small team environment, and then a large team environment from true mass casualty.

And what we discovered when we did that was that all the teachers and the school nurses that participated said, Stop the Bleed class is not sufficient. They need reinforcements, a refresher.

And that that scenario-based training was absolutely the way to go. That they believe that sort of gave them a practical application that took it from being theoretical to actually real, that

they could do this to help somebody. They also felt that they had sort of been empowered by doing it and that they felt more competent in doing it, and willing to help if anything were to happen.

Moving forward, the next steps are to help them develop their own training team and bring it out -- teaching -- they're doing the teaching. We're not doing the teaching any more.

We're sort of that supportive role. And that is coming up in the next spring time. The State of Georgia has done a similar model. They had $1M grant from their State government.

And they actually put one kit in every single school. They have numbers for -- so that you are aware -- their numbers are fairly comparable to Virginia's.

So 2300 schools is a rough ballpark of about where we would sit. They had $100,000.00 grant for training supplies that they used to get out to those schools. But they were using PVC pipe and Styrofoam pull noodles. So not quite the level we

would hope for, but still a realistic possibility. Because, again, in the large way that it can be cost-prohibitive -- that training supply.

They also trained small teams within each school and their results were, after they got most of their schools trained, they had four actual appropriate documented children's lives saved because they used a tourniquet that was provided by the Stop the Bleed program.

Or by this Georgia governmental grant. So looking and thinking about applying that to Virginia, this really, we feel like is the way to go.

And we feel like we've got a pretty good system and plan in place. What questions do you all have? None? All right, then.

DR. ABOUTANOS: I'll just say great job for presenting and -- I just think this is -- I mentioned this at the TAG. I mention this again. This is -- that's why we asked Kate to come and -- and present to

the TAG. Just showing how various health systems can come together for something that's incredibly essential. And that we, as a State, should come together and achieve -- achieve this.

This is a national movement. And that we -- that does make a difference, especially if we have any kind of, you know, mass casualties. But also in regular ability of the average citizen to stop the bleed.

And so I applaud all the -- the efforts and the -- and I think this, what she put on, has together of how this should move.

There are various different regions that also have their own efforts beside Central Virginia. And how can we come together and come up with a centralized common efforts and make sure that we geo-map the whole thing.

And any desert that doesn't have that, educate in those various different deserts. Especially in places that don't have trauma center, don't have

a[n] EMS system that can get to you within seven to 10 minutes. So those are very important things that -- that this -- we have the formula. Just a matter of now how to move it forward.

MR. PARKER: I'm going to echo what Dr. Aboutanos said, and thank you, Kate, for being here.

MR. BROWN: Kate, thank you. We really appreciate it. Last, I would like to ask Gary Critzer to actually update the Board on some activities and projects that are going on in OEMS.

MR. CRITZER: Thank you, Mr. Brown. Yesterday at the Executive Committee and at the Regional Council Executive Directors' meeting, I was asked to give an update on some ongoing activities at the Central Shenandoah EMS Council. I'd like to acknowledge, before we start, that one of our Board members is also on this Board -- Mr. Lawler representing Augusta County is a

CSEMS Board member. And Jeff Michael, the deputy chief from Rockingham County Fire and Rescue is also with us and has actively been involved with our Board in -- in -- over the past many years.

So I don't know how many of you are aware of what's been going on with us over the last year, year and a half. But a number of events have occurred that have impacted Central Shenandoah EMS.

For the last many years, to be quite honestly, and it's been sort of spiraling effect for -- for a while. As you know, Central Shenandoah for years was one of the -- what I would like to say was one of the strongest EMS councils in the Commonwealth, especially with relationship to the amount of training that it provided in our region simply because we did not have a community college that delivered advanced EMS education.

Central Shenandoah filled that void. We also have a mix of rural and suburban where, over the years, that -- our system has evolved from one made up

predominantly of volunteer EMS to one that are now -- now a number of career combination systems that are operated by fire rescue organizations at local governments.

So the structure of -- of CSEMS has changed pretty dramatically over the last 30 years. As it has, quite candidly, throughout the Commonwealth.

Our board was formerly made up -- and don't gasp, they did that twice yesterday. Our board formerly was made up of 72 members. Every licensed EMS agency in the region had a seat.

Every hospital that served the region had a seat. And every local government in the region had a seat. There were days, believe it or not, 20 years ago where we would fill a room with a number of people when we would have a quarterly board meeting.

But not so much in the recent past. We would have a very limited attendance and it was always pretty much the same people. Until you tried to change the

bylaws to downsize the board and then you would get people coming out of the woodwork you hadn't seen in five years because they didn't want to lose their seat.

Nevertheless, our biggest event started when our funding was impacted. We, through the years, had a number of -- what I would like to say were very successful funding opportunities.

Back in our early years with our first executive director, Tom Schwartz. Some of you may know Tom. Tom was pretty visionary when he looked at alternatives for providing funding for CSEMS.

And our first funding source was a 45 cents per capita funding from all of our local governments. Then came One for Life and followed subsequently by Two for Life and Four for Life, and Four and a Quarter for Life.

But with One for Life, he developed a funding strategy that -- that got all of our agencies that received Four for Life funds to do a 35% share with CSEMS. We held the funds in escrow. And when

someone needed to withdraw money to pay for allowable equipment or training, they would come to the board and we would send them -- they would request it with an invoice.

And we would reimburse them for their expense. We were allowed to hold that money in escrow and use the interest off that account as part of the administrative -- to operate the council.

And we also used EMS training funds in the old model extensively. Matt was our EMS education director, excuse me. And we used those monies extensively to help provide EMS education.

The -- if we look back at that now, one could say that we -- we probably made a good mistake, if there is such a thing. We were able to provide very affordable EMS education to a lot of people.

We got often asked how are you doing that. You're charging $400.00 for an EMT Intermediate class or $495.00 or whatever it was. We were teaching EMT for $195.00 a student. We actually got criticized for that. I think now we can

look back and say, well, while we did a lot of good with it, maybe the criticism was a little bit due. Because about three or -- well, it's probably been longer than that.

Probably about four years ago now, the Attorney General's Office ruled that EMS Councils could no longer be direct recipients of Four for Life money.

And when that happened, we had to return all that money that was in escrow back to our agencies. And they had the option of sharing that money with us through paying for training.

But needless to say, there were a lot of them who always shared just because it had been the thing they did. And when they got that money back and saw that they could use it locally, it just was not available to us any more.

Followed within a year was the change in the EMS training funds structure, which in total hit our budget for about $140,000.00. Which, quite candidly, started this downhill effect that we could not easily recover from. We put together a

funding program called Building a Stronger Future that really looked at a lot of -- it was based on how much an agency provided was what their training costs would -- would be.

And it was based on a formula involving the level of responses that they did during the year. And that program was never really successful.

And where we found out that we made this mistake with -- with subsidizing EMS training was that it suddenly became, wow, it's all about money.

Your costs for an intermediate class or an EMT class are now, you know, $1800.00 and 30 some hundred dollars respectively -- respectfully -- anyway, you know what I mean.

And it -- it became an argument about, well, you all are just trying to make money. And we realized that we just couldn't continue in that route.

About the same time, we lost Mr. Lawler to Augusta County, to their benefit. One of the -- probably the finest EMS educators in the Commonwealth. And I

don't say that lightly and I'm not saying that because he's sitting there. But he produced a lot of really good EMS providers. And we lost Mr. Lawler to Augusta County.

Shortly behind that, we lost our CTC coordinator when she had another child. Shortly behind that, we lost one of our training coordinators, Mandy McComus [sp].

And then shortly behind that, Chad left us and came back to the Richmond area. And we were void of an executive director. So we did the thing that we'd always done for years and we went out and we hired an executive director.

That -- and that relationship didn't end up as successful as we would've liked for it to have been. And we found ourselves five and a half short months later without an executive director again.

Which prompted a discussion. And that discussion was that what did our future hold. We realized that we were continuing to do a lot of work that was -- quite candidly, some of it has been around

since the days that -- the original EMS councils were formed over 30 years. Work that was designed during a time when the regional EMS systems were much different than they are today.

So we realized that it was an opportunity to look at how we do business and the work of the council to try to make sure we were performing tasks that were truly needed in our region.

So many of our -- our agencies that once were volunteer are now part of career systems. The career systems have their own training staff. They do their own performance improvement.

They do their own infection control plans and their own MCI plans. And we found that a lot of the planning that we did as a regional council really wasn't needed any more.

That's a discussion that we've had to have with the Office of EMS, is that we're doing work that really doesn't make a whole lot of sense. We do a lot of other good things like trauma performance

improvement. We do trauma triage plans. We do regional protocols. We do STEMI and stroke plans and guidance, which are very important and we should continue to do.

But the other discussion we had is what about our leadership. Our board really needs to change. It's time. It's overdue. We drafted bylaw changes and were successful in getting those through and reduced our board from 72 members to 15.

One from each political subdivision, one appointed by VHHA for one of the area hospitals, and two EMS provider seats that are appointed by the other 13 members of the board.

At the same time, we had a discussion about what about our -- our staff leadership, our executive director. And we had three options.

One of which was to maintain the status quo and hire -- try to recruit another executive director, and continue on the path that we had been on with a new board. When we hired Chad's predecessor, we had no applications from our local region.

And we had maybe -- Matt, you can correct me if I'm wrong -- maybe two from the -- the Virginia. And the majority of them were from out -- from out of the Commonwealth.

One was actually from Alaska, if I remember correctly. And we hired an individual that was from outside of the Commonwealth.

And as -- again, as I referenced, that relationship -- regretfully -- was not entirely successful. So we talked about let's hire another director. We talked about should we think about partnering with another region.

And we quickly said, you know, we need to keep it local. We need to keep it where we're at the grassroots level and we're insuring that our local agencies and providers and hospitals have a voice.

No disrespect to any other region, but we didn't want to have to work with a region that was 100 miles away or even 50 miles away. And our other idea was to engage the Office of EMS about a new model. A hybrid, so to speak -- that seems

to be the buzzword today. But a hybrid model with the Office of EMS and a board structure that where the board continued to direct the work of our -- our region.

But that the staff would actually be staff that worked for the Virginia Department of Health, Office of EMS -- much like the Advisory Board is.

This Board sets the work plan, puts the work to task and the Office of EMS staffs committees and helps to carry out that mission. So we -- I want to make sure this is clear.

We, as CSEMS Board, felt that was the direction we wanted to at least investigate. And we approached the Office of EMS and engaged them in discussions, which started late last spring like in the May-June time frame if I remember correctly.

They went on all throughout the summer into the fall. And in January of this year, after we'd seen a couple of -- we met with them. We had some rough drafts. We looked at a -- we appointed a work group to look at a memorandum of agreement between

the Office and the region. On the 24th of January, our board voted unanimously to endorse a memorandum of agreement with the Office of EMS to become a hybrid regional EMS council. So the work is ongoing.

We're meeting again next week to start look at -- looking at position profiles for staff for our program manager. That will be the equivalent of an executive director.

And for the other staff that will then be support staff from training and education to quality assurance and performance improvement, administrative support, etcetera.

That -- that work is yet to be done. It's a work in progress. But we believe, and we stepped back and looked -- looked at it, that if we continued with the status quo that it wasn't a matter of if we were going to cease to exist.

It was simply a matter of when we were going to cease to exist. Our local governments had, all but with an exception of maybe one or two, had withdrawn all of

their local support financially. All of our agencies, with the exception of one or two had withdrawn their local financial support because they really -- to be candid -- weren't sure what they were getting for their money.

We hope to turn that around. We have a new board, we have a new vision, we have a new day. We have a new partnership with OEMS and we see down the road that this will hopefully open a lot of new doors for us.

Some examples of that are with relationship -- for example, our medical director, Dr. Brand, is very engaged in wanting high performance quality improvement.

But under the old model, it was a struggle to get the data that we needed out of -- out of ImageTrend and out of the Trauma Registry to be able to do really robust PI. It took a lot of work. There were a lot of holes. Matt did that data collection for a long time and can tell you it was a struggle getting all the data

that we needed. In this case, that will now be a staff member of the Office of EMS who, not being a contractor, will have greater access to the Trauma Registry and ImageTrend to provide the -- the robust data that we need to do high quality performance improvement.

We determined that we were no longer going to be able to maintain our accreditation as an intermediate or advanced training site. Fortunately in the last year, Blue Ridge Community College has come on board.

They have recently met all of their requirements and they'll be offering a paramedic degree program and certificate program starting with the fall, I believe -- if I'm saying that correctly.

They also will be doing advanced EMT programs, as well as a lot of our localities have -- are working to become accredited advanced EMT training sites. So we're going to continue to try to work for BLS education, especially in the area -- the rural areas that don't have a lot of EMS

educators. But funding's been an issue since the EMS training funds went away. Well, a good example of that is being a hybrid council that's part of a State organization.

That funding structure's a little bit different. So our board, which will have -- insure that our local representation drives the work of the region.

It'll be just like it is today. There will be a designated regional council. We'll have our own medical director. We'll have our own board.

And we'll continue to have a seat on this board as long as the -- the context of the board stays as it is. So we'll remain our -- have our autonomy. We'll still be a 501-C-3.

We'll still have our own community training center for American Heart. But that trainer, if -- for example, I'll pick on Augusta County since he's here and he can throw something at me. But Augusta County determines that they need to

teach an advanced EMT class. And they've got 30 students. There's a void in the number of providers in the region and they can demonstrate that need.

They can come to our board and say, hey, we need support on getting this done. We need instructors, we need -- we need resources, we need funding, we need money.

And we can approach the Office of EMS and because we're now a hybrid office, instead of the scholarship program, that money can flow -- if it's approved -- directly to the program and can offset some or all of the costs of the program.

So it changes how we do business. We look at it as an opportunity to grow, as an opportunity to change the way we do things, and open a lot of new doors.

We -- while this will be a work in progress, we see this as something that is going to evolve. We have a -- our MOU is for five years with one-year renewals. And the ability at any point to come back to OEMS and have addendums to that

MOU if we find there need to be changes or modifications. So it's going to be very hands-on, work in progress as we go forward.

Working with the State and then working with us to insure what I believe is the hallmark of Virginia EMS, which is that the grassroots provider, agency-level involvement is still there.

They're still going to be driving the work of the region. But we're not going to have to worry about how to pay staff, where their health insurance is going to come from.

Open new doors to State programs and services. We -- we own our building very proudly. It's debt-free. If you've never been there, we have a -- a very nice state-of-the-art facility.

We are going to enter into a lease agreement with the State where we provide them a lease-free building. In exchange for that, they will assume all the utilities, all the maintenance, all the upkeep. They'll bring in their -- VITA's IT infrastructure and operate all those things.

So when -- you know, we did a pro and con list with our work group before we went back to our board. And quite candidly, the pro's outweighed the con's almost tenfold.

Correct, Matt? We are very excited about this opportunity. The Office of EMS has been very engaging and very involved. There has been no pressure from the State to make this happen.

We approached them, they did not approach us. But again, we believe that the future of -- of regional EMS is that change is inevitable.

We need to -- and we hope that we can be the catalyst for change. And we're excited about our future. I want to thank Gary and his staff.

This has been all the way to the Commissioner's level, so Dr. Jaberi and the Commissioner for their engagement and their support of stepping into new ground, so to speak and taking a chance. We want to make this work. We're committed to making this work. We're willing to share our experiences. We're willing to tell you how

this goes in -- in hopes that it can be beneficial in some way to -- to other regional councils in the State as a whole. So we look forward to that.

And I don't think I would be doing my job if I didn't ask Matt if he had any comments he would like to make about the process or if I've missed anything. Or -- I think it'd be important for you to throw your hat in the ring there.

MR. LAWLER: Thank you, Gary. That was a -- a comprehensive report. And I'm not sure that I can add a lot of new information to that.

However, let me say that I think in -- in our region there were, you know, some agencies that felt like the -- the regional EMS council system had, you know, passed its heyday and really didn't have a lot to offer to the region.

And I can tell you as an administrator for an EMS department in the region that's not true. There were a lot of services that -- that the council provided

that have, due to the disfunction that has existed in the council over the past couple of years, have kind of fallen by the wayside.

And -- and quite frankly, the region is suffering in a -- in a lot of areas. And that -- that includes protocol development, performance improvement.

And there are a lot of local training programs that -- that we relied upon that the council administered. So I think that the regional EMS council system is there to serve a role.

And I think that it needs to continue to exist, but it needs to evolve like you said. One of the things, having been an employee of that regional council for 16 years that -- that was always a struggle is that we spend a lot of our time worrying about and running the business side of the EMS council when most of us were there to serve the region rather than, you know, run a business. And I think that this model allows us to -- or the folks that work there to be freed up from a lot of those

responsibilities that the State will now bear the responsibility of. And allow them to better serve the region and do the things that they're -- they're in place to do.

Historically, at the council we had a difficult -- very difficult time attracting quality employees to -- to work at the EMS council.

Primarily because we were challenged to offer a competitive salary and a competitive benefits package for -- for our employees. And this will address that -- that problem as well.

So -- and in the end, I think that -- that, you know, this sounds almost too good to be true, but I think that it is. And we have spent a lot of time working with the State on this MOU.

And one of the things that we really strive for from the local perspective is some sort of ability to govern and direct the employees. And in every turn when we asked for something, they gave it to us so that they could have -- or that we could have the -- the oversight and direction so

that we could, you know, have programs that serve our region the best. So again, I thank everybody that was involved in the process, too. And I think this is going to be very positive for our region.

MR. CRITZER: Matt, thank you very much. Again, as Matt said, I know that was a long drawn-out report. But I think, for those of you who don't know our region, you needed to understand the history, where we've been, where we are and where we're going.

And that's why I wanted to take that time. It is change. And change to some people is fearful. There's suspicion, etcetera. I will assure you that this is been all on the up and up.

And that this is being done for all the right reasons. And we really believe that it's going to open a lot of doors for our region and be a good thing. So we encourage you, if you have questions you don't want to ask today but you want to ask them off-line. If you want to know six

months from now how it's going, I'll assure you we'll be telling you. We'll make sure this body is up to date. We'll make sure the regional executive directors are up to date.

I -- I just -- again, I believe that we have stepped into the -- to the right direction. And we're excited about what the future holds. So Gary, if there are any questions or --

MR. PARKER: Any questions for anyone on the Board?

MR. BROWN: That would conclude our report, Mr. Chair.

MR. PARKER: So at this point, we've been at it for about an hour and 10 minutes. And I've seen a lot of people up and out.

So we're going to take about a 10- to 15-minute break. We still have a lot of work to do. And I figure if we don't stop now, there'll be people leaving in the

important parts of the committee reports. So it is seven minutes after 2:00. So we'll start back at 20 after, so that's 13 minutes.

(The EMS Advisory Board meeting went off the record at 2:07 p.m., and resumed at 2:21 p.m. The taking of testimony resumed as follows:)

MR. PARKER: All right. So we're going to get started back. We're down to Amanda, Attorney General's Office.

MS. LAVIN: I don't have anything. The snacks are good.

MR. PARKER: Okay. So following the agenda, we're down to the Board of Health report. Gary.

MR. CRITZER: Thank you, Mr. Chairman. The Board of Health last met on the 13th of December. We had a number of action items on our agenda for -- everything from water advisories to swimming pool

regulations and disease reporting and control. We also approved Virginia's plan for well being for the year. Our next meeting will be on March the 7th at the Perimeter Center in Henrico County at 9:00 a.m.

I encourage you, if you're interested in the work of the Board, to come. It's very broad and very in-depth, much more than I could've imagined.

So it's -- it's interesting work but a lot of work that, if you really stop and think about it, indirectly comes right back to the work that we do.

Disease reporting and control, they're all potential patients of our EMS system. So I'd encourage you to come, learn more about the work of the Board of Health. Any questions? Thank you.

MR. PARKER: Excellent. Thank you, Gary. We're at the point of the agenda for the Standing Committee reports and Action Items. And the first one up is the Executive Committee. The Executive

Committee met yesterday. We discussed heavily the flow of the meetings for this week heading into the six new trauma committees, plus the change-over from the TSOM to the TAG, adding an additional meeting.

We discussed the way that the meetings flowed with the ability for the coordinators to attend the different committees that fall under them as well as the chair and vice-chair to attend the meetings.

Historically, we've had the Executive Committee meeting and it occurs during some of the time frames of other committees. And we would like to be able to participate in the new trauma committees or at least attend those meetings.

So we've had some discussion related to that. So I and the rest of the Executive Committee will be working with the staff over the next few weeks to kind of streamline some of the line-up of the different meetings, as well as the meetings that occur simultaneously with the Advisory

Board committees in order to make it flow a little bit better. Due to some changes with the bylaws from November, we now have a new coordinator position, the trauma system coordinator.

The Executive Committee voted to move Dr. Aboutanos to the trauma system coordinator position from the patient care coordinator position. This now leaves vacant the coordinator -- the patient care coordinator position.

And according to the guidance document that's been posted on the EMS -- OEMS web site, that was approved by the Advisory Board some years ago. It states that the patient care coordinator should be a physician.

The OEMS staff have reached out to Dr. Yee and the Executive Committee has approved Dr. Yee to this position. So he will now be the new patient care coordinator. The Executive Committee, in conjunction with OEMS staff, will be working on updating that governance document. In fact, Adam Harrell has started working on

some of that to kind of streamline the staffers that report to the different committees.

This document will be sent out to the committees to have them look at the seats, the positions on the committees to see if there needs to be any restructuring.

In that guidance document, there -- and in the bylaws it states that the Executive Committee should approve every year the make-up of the committees.

And we feel that that hinders the ability for the committees to start working. Because the first meeting of the Executive Committee is usually in February.

And you've missed about two months' worth of work. So we're going to restructure that guidance document to allow the committees to report up through their patient coordinators.

There will be some other info that comes out on that. And that concludes the Executive Committee report. FARC Committee, Kevin.

MR. DILLARD: Thank you, Mr. Chairman. The Rescue Squad Assistance Fund spring cycle is now open. We have a March 15th deadline at 5:00 p.m.

And for the fall grant cycle, we received 105 grant applications requesting over $14M in funding. And we were able to fund 70 requests out of the 105 grant applications that came in.

And I want to announce that we're going to have a Rescue Squad Assistance Fund technical assistance webinar on Friday, March the 1st, from 1:00 until 3:00.

And that offer was sent out to all the agencies and available on the web site. Thank you.

MR. PARKER: Thank you. Administrative Coordinator, Mr. Henschel.

MR. HENSCHEL: I have no report as Administrative Coordinator, so I'll refer to the appropriate committee chairs. Rules and Regulations met yesterday. We discussed the

process of the revision for Chapter 32 of the regulations. It's currently at the beginning of Stage II. The intent, at this point, is to have a draft presented to the Board of Health in June of this year.

This is a lengthy process and if you wish to -- to see how that flows, you can find it in your quarterly report. We discussed a little bit about fingerprinting.

It's now going to be outsourced to Fieldprint. So we're hopeful that this will streamline the background process for agencies and clean up some of that process.

State EMS plan was discussed briefly. We did take a look at the sections that pertain to Rules and Regulations. All of those have been addressed and are currently part of the revision that we're undergoing.

We don't have any action items at this point to bring before the Board. And that's my report.

MR. PARKER: Thank you.

Legislative and Planning, Gary Samuels.

MR. SAMUELS: Yeah, we met -- Legislative and Planning met this morning. We had some good discussion on the strategic plan, the timelines.

We've got some items we're going to be bring back to the Executive Committee to -- to help make the strategic plan more operational.

But that's just going to be some guidance back to the Executive Committee using the EMS Agenda for the Future for 2050.

We reviewed the legislation and reported -- reports on that piece of the -- of our committee. But other than that, I mean, we -- we welcomed two new members to the committee.

That was approved by the Executive Committee yesterday. And we're looking -- right now, our current meeting structure is going to stay the same through August. And then we may revamp our meeting structure to allow us time to be on time

with the schedule of legislation and those items that are brought for the next General Assembly since it's a long session next year.

MR. PARKER: Thank you. Infrastructure Coordinator, Dreama Chandler.

MS. CHANDLER: As coordinator, we have no action items at this time. But I would like to defer to the committee chairs if they have anything informational that they would like to share with the group.

MR. PARKER: Transportation committee, Eddie Ferguson.

MR. D. E. FERGUSON: Transportation Committee has not met. We didn't have any business -- present business, so we just cancelled our most recent meeting. We'll be meeting again looking into the future. Thanks.

MR. PARKER: Thank you.

Communications Committee, John Korman.

MR. KORMAN: Yes. Communications Committee met today. Discussion including welcome Gary Tanner from Virginia Association of Counties to the committee as well as Richard Troshak as OEMS's emergency operations specialist to work closely with the committee replacing Ken Crumpler.

Tom Krabbs [sp], who is the Statewide Inter-operability coordinator within the Governor's Office, advised of an updated strategy for communications inter-operability plan from 2013.

The intent is to minimize delay and maximize effectiveness of response. He also shared there's a recommendation to completely refresh Virginia's Comlink radio system and offer ongoing training with that.

And that system is Virginia's radio network that interfaces with radio systems in Virginia, allowing for multi-jurisdictional radio inter-operability communication. The good thing is there were

no first cuts to the governor's 2020 budget, so that looks to be solvent for that initiative.

We're looking to develop an online directory so agencies know how to communicate with one another -- with another jurisdiction in times of an emergency incident, as well as a planned event.

President Trump signed Kari's Law. That was a measure that requires businesses to enable direct dial access to 911. That stemmed from a case where a woman was murdered in Texas in a hotel room.

The child called 911. She did not know she needed to dial nine to get an outside line, and then 911. So the FCC rules propose allowing calls to be completed to 911 with or without a prefix, namely from businesses that have a multi-line telephone system or a PBX-kind of telephone system in place.

The good thing is a lot of the systems out there today can be reconfigured at little to no cost. There was an annual report by the FCC on 911 fees that were

collected. Actually, Virginia's in good shape as far as not diverting fees for other initiatives at the State level. So kudos to us.

We want -- the committee is also working to strengthen the EMD -- emergency medical dispatch -- accreditation and re-accreditation process for 911 centers as well as the Office of EMS.

Finally, the last two things I have, we're looking to develop training objectives for 911 centers relating to information gathering and dispatching for fire and EMS calls, the Department of Criminal Justice Services.

The Virginia Organization has training objectives already for law enforcement, so looking to mirror something like that.

And finally, Virginia Delegate Mike Mullen introduced House Joint Resolution 646 to designate September 11th, 2019, and each succeeding year First Responders' Day in Virginia, which includes fire fighters, EMS providers, emergency

management professionals, Virginia National Guard and 911 dispatchers. End of report.

MR. PARKER: Thank you, sir. Emergency Management Committee, Tom, and you'll have to say your last name for the record.

MR. SCHWALENBERG: Schwalenberg, sir.

MR. PARKER: Thank you.

MR. SCHWALENBERG: So Mr. Chairman, the Emergency Management Committee met yesterday. Lots of discussion about some ongoing things.

We have completed our survey where we sent out to the jurisdictions and localities asking about MCIA training, preparedness, what they understand.

We've decided, based on those survey results, to focus on mass casualties as our first topic area. Predominantly looking at providing templates and guides

for those agencies that may need that additional planning help. Based on that, we're also looking at putting together a leadership, sort of, program if you will -- class reaching out to our other partners at VEMA, VAVRS, Virginia Fire Chiefs, on the planning aspects of mass casualty planning -- not so much the operational aspects.

But how to put your plans and training events together. There was some discussion over the changes in regulations for the number of triage tags that are going to be carried as is proposed in the new regulations.

There was some discussions over that. We're not making it an action item at this time. But there was -- there was some concern about the numbers and the lowering of those numbers in the proposed regs.

Last -- last thing that we had was looking at two bills, Senate Bill -- correct me -- 1220 is the school emergency planning, language about the involvement of localities in school emergency planning.

Again, lots of localities are, but certainly there's localities where it's still silo' d in those gaps.

And then House Bill 1870, which is long term care facility preparedness and its interaction with local -- localities reviewing and approving those plans. That's it for the report.

MR. PARKER: Thank you. Professional Development Coordinator. Jose Salazar could not be with us, so we'll head to the committees. Training and Certification Committee, Jason Ferguson.

MR. R. J. FERGUSON: Thank you, sir. Training and Certification Committee met on January the 9th. Billy Fritz updated us that the high school EMT curriculum has had several changes and will be coming out in the near future.

As I mentioned in the past, we've had some work groups that we've established that will finally start in the coming weeks. The first will be to review

Chapter 32 to evaluate its items related to education and training, as this document will eventually guide the revision of the TPAM.

And we want to insure policies and procedures reflect current and best practices. The second, we'll look at the psychomotor exam related to EMT testing for its effectiveness and any need for update.

And the final group will review the TR-90A, which is the competency-based form for EMT programs. We'll be working with OEMS to acquire some data to make these requirements more evidence-based instead of just arbitrary numbers.

Jason Ferguson of the -- chair of the Medevac Committee came and was gracious enough to present for adding a component to initial EMT education in relation to air medical services for utilization, safety landing zones.

And he and his work group are going to kind of come up with the final product and maybe bring that back for us to look at at the April meeting. The Education

Coordinator work group that's been working hard presented to the committee with the following recommendations.

To remove the psychomotor exam requirement for the EC process, to add administrative time of 20% of the overall hours or 10 hours, whichever is greater, to reduce the required percentage related to EMT hours to 50%, and to implement and affective domain evaluation form, a mentorship objectives checklist and evaluation instrument to use at the EC Institute to get internal feedback regarding the process.

So this brings me to Appendix C in the quarterly report. As you guys have reviewed, the -- the TCC approved the first three items and tasked them with completing the -- the final three and bringing them back at the April meeting for approval.

MR. PARKER: If you'll turn to your quarterly report, Appendix C reads as follows, there is a motion. The TCC moves to amend the education coordinator candidate

process by removing the psychomotor testing requirement, adding in an administrative component to the mentor program representing 20% of the required teaching hours or 10 hours, whichever is greater.

And change the amount of time required to teach an initial EMT program from 60% to 50% of the total mentored hours. Considering this comes from a committee, it does not require a second.

Is there any discussion from the Board? Hearing no discussion, we'll call for a vote. All in favor?

BOARD MEMBERS: Aye.

MR. PARKER: Any opposed? Motion carries.

MR. R. J. FERGUSON: Okay. Also as you and I discussed, there are nine positions on TCC excluding the chair. So effective this year, we'll be appointing three positions per year to allow for continuity. And the TCC chair will make

recommendations to the Executive Committee at the November meeting to -- for changes to take place at the January TCC meeting. And also, we've been in discussion about the two vacancies we've had.

We will be -- I'll be working with you to fill those over the next couple weeks. And lastly, I'd like to thank Billy Fritz. His time with us was brief, but as a new person to the committee and with him being new, he was very beneficial.

And I really appreciate him and wish him the best. And our next TCC meeting will be April the 3rd at a location to be determined due to construction at OEMS.

MR. PARKER: Thank you. Workforce Development. We'll ask Chris from OEMS.

MR. VERNOVAL: All right. So first of all, the Stop the Bleed program is -- was brought forward earlier. OEMS had worked with Office of Health Equity. We then received a grant and received a number of

the Stop the Bleed kits for training. And all of those kits have been distributed to 10 of the regional councils. We have one more that's still ordered and will be coming in in the next few weeks.

So all 11 of the regional councils do have training material, including the injured appendage, per se, the tourniquets, the packing gauze as well as some training books and the posters to go with it.

They're also going to have some upkeep stuff as it goes along in the future as well. The EMS officer program, we are doing a few more final revisions on that from our symposium class.

We've taken a lot of the data, a lot of the feedback that we've got. Some of the stuff -- the online video portions were said to be too long, so we've broken those down into the chapters.

So out of the three -- three-hour -- three one-hour programs, they're 10-minute to 15-minute programs, each one broken out so it's a little bit easier to go

along. Revamping some of the homework and also creating the instructor guide and creating an onboarding program for additional instructors as well.

So we hope to -- after -- we have a schedule. We're going to be teaching a class over at the Caroline County Fire School in the end of April.

And we're hoping to do another class or two before the August meeting. And by that point, we hope to actually be able to roll out of this pilot phase and start moving forward with the Officer II.

But as we progress with that, we'll be able to have a little clearer idea. The standards of excellence program, we have a number of revisits to be doing this year. And I believe we have about four new visits to be doing.

So we've got somewhere in the area of 10 to -- 10 to 12 so far. And we do hear some more rumblings of some more applicants coming in. So we'll be busy out doing some visits throughout the Commonwealth this year as well. Other than

that, no other -- other than the committee is also moving forward with the State EMS plan. Other than that, no other information to report. Any questions?

MR. PARKER: Thank you.

MR. VERNOVAL: All right, thank you.

MR. PARKER: Provider Health and Safety, Lori Knowles.

MS. KNOWLES: Thank you, Mr. Chairman. Provider Health and Safety Committee met this morning. The mental health campaign is still moving forward. Office of EMS has hired a marketing company to further push out information.

The company will be sending out advertisements through various social media networks and venues that will direct people to the OEMS web site. They will also be sending out various print materials to every department in Virginia for each

station that their department -- their department has. We also had quite the discussion concerning bloodborne pathogens exposures from the recently deceased.

The issues is there's -- there are no labs in Virginia that can validate cadaver testing at this time. So what happens is that should a provider have -- experience a bloodborne pathogen exposure, they would have to take that sample and it would have to be sent to the Mayo Clinic.

This is going outside the federal 48-hour notification rule, so it causes another scope of -- of problems here. Committee's going to begin looking in to which hospitals would be willing to conduct validation testing on these -- on these samples. So there'll be more to come on this. That's all I have.

MR. PARKER: Dr. Jaberi, can I ask you to take that info back?

DR. JABERI: What's the name?

MR. PARKER: The info related to what Lori talked about with the labs not being able to test the blood. If there is anything that can be done from the Health Department aspect.

DR. JABERI: Sure. I'm not sure if you engaged the Office of the Chief Medical Examiner, but that's another one of the offices under us.

I'm sure -- you may have spoken with him, but we can speak to them -- can speak to our State epidemiologist and our DCLS partners. Thanks.

MS. KNOWLES: I'll let Valerie talk a little bit more about that.

MS. QUICK: Yeah, if I can -- if I can add on that. We actually sent a specimen to the OCME to get tested. And they -- their legal counsel looked back at it and said that they do not have an obligation to test it, and refused to do anything about it. They also don't have the

testing -- the validated testing. So they did offer to give the specimen back. We did take that blood sample and we tried to bring it to North Carolina, which also has a lab there.

There are three labs in the United States that actually can do cadaverous blood testing, which is something that I think a lot of hospitals didn't know until some of this opened up.

So it -- it really requires that we not only figure out where to validate tests or where we can draw -- or not draw, but actually run those tests.

UVa has looked into that process and has agreed to go ahead and start the process to validate those. But that's going to take quite a few months. So we still have this gap in time where we may not be able to turn things around.

The other concern is that if you have -- if you're trying to get those labs pulled from the cadaver, whether it's on-scene or at the funeral home, there are some issues with the OCME as to how that

process would occur. I know that there are some jurisdictions that actually go to funeral homes and actually pull the -- and I've done that myself -- and pulled the blood.

And we -- we found out that that -- that may not be the right kind of process, too. So we have to figure out a process to get the blood drawn.

And then we have to be able to validate it. Rob Bell did introduce a bill that I think was just tabled two days ago that would require the OCME office to actually look into this.

DR. JABERI: Thanks so much.

MS. QUICK: Mm-hmm.

MR. PARKER: Patient Care Coordinator.

BOARD MEMBER: I know we just voted or just appointed, but --

MR. PARKER: Dr. Aboutanos, do you want to --

DR. ABOUTANOS: I defer to Dr. Allen Yee.

DR. YEE: I knew this was coming. I've no report as coordinator being I just got appointed five minutes ago.

MR. PARKER: Medical Direction Committee, Dr. Yee.

DR. YEE: So Medical Direction last met in January. We have two action items. One of which is in your quarterly report. So the first action item is Medical Direction Committee changed the -- it continuously works on the scope of practice.

In the -- in the newest -- in the version that we're proposing today, there are several changes, and there's some confusion on the first change. So the first change is that we removed essentially sedation only intubation. And the language

here is drug-assisted intubation. It does -- that does not include RSI, rapid sequence induction or rapid sequence intubation. So what -- we're talking about giving Versed for the purposes to intubate.

That -- that -- we got rid of that -- removed that. Non-invasive ventilation was also simplified and approved at the EMT level.

It also allows -- we took out whether it's got to be fixed or adjustable. Again, another action was -- because sedation for intubation was removed, we had to change some other language.

Local anesthetic was added to the A-EMT level essentially for the purposes of starting an interosseous infusions. And then the fifth and final change was color-coded epinephrine administration for medication was added at the EMT level for epinephrine.

Essentially for allows that EMT's to give epi for anaphylaxis. And they can draw it out of the syringe using a color-coded system. That -- that's one

action item. Another action item we have is the Medical Direction Committee universal -- unanimously endorsed the NITSA document for the safe transport of children, which includes the child restraints in the back of an ambulance. So those are the two action items. We also have two informational items.

MR. PARKER: All right. We're going to stop for one second. So the first action item, as amended, the Medical Direction Committee moves to endorse changes to the Virginia EMS scope of practice as follows. Which line do you want inserted related to the --

DR. YEE: It was just a clarification. So drug-assisted intubation, DAI slash, we'll probably --

MR. PARKER: Gotta change that one. That was the confusion or the issue was -- Jason, if you want to speak.

MR. R. J. FERGUSON: Yeah, that's what I asked about. So DAI/RSI are two terms that are used in relation to the same process. We're talking about drug facilitated intubation.

So maybe wording it like that. And then clarification on the sedation part since sedation is used in conjunction with the DAI and RSI.

DR. YEE: We can -- we can change it to drug facilitated intubation.

MR. PARKER: Thanks. So the scope of practice as follows; drug facilitated intubation was removed from the scope of practice. Non-invasive ventilation was simplified by removal of the word adjustable and approved to the EMT level.

Sedation for intubation was removed based on the removal of the medication facilitated intubation. Local anesthetic by infiltration was added to the A-EMT level, and color-coded epinephrine administration systems for medication

delivery was added and included to the EMT level. Coming from committee, this does not need a second. Is there any -- any further discussion? Hearing no discussion --

BOARD MEMBER: Mr. Chairman.

MR. PARKER: Okay.

BOARD MEMBER: Dr. Yee, with regard to the color-coded epinephrine administration system, is there any latitude for other types of syringes?

For example, a syringe that's marked, you know, with numbers and letters like adult and pediatric dosing. Or -- or is it restricted to color-coded systems only?

DR. YEE: We just -- we discussed systems that actually clearly demarcated dosing. So whether it was color-coded or other methodology, whether you say this is for Peds. But I'll defer a little -- to the opinion of Dr. Lindbeck.

DR. LINDBECK: Yeah, we tried to stay away an individual product. So one product might be Certa Dose which is out there. But there have -- that's sort of rapidly expanded now to fill the market.

Just for background, the issue behind this is that epinephrine auto injectors, particularly Epi Pen, have become fantastically expensive. EMS agencies, fire agencies want to keep those stocked.

They very frequently go out of date before they get used. And having those available on all of your units can be cost-prohibitive.

There's been a movement to have EMT's be able to draw up epinephrine out of a multi-dose vial and administer it for acute allergic reactions. It has been held that dose calculation and med-mass skills are not part of the EMT curriculum.

So we have probably debated this for about two years now. And this time around, the Medical Direction Committee agreed that color-coded dosing systems could be used. We would also accept a system that

used a mechanical dose limiter. Those of us who have been around for a while remember the old Ana-Kit that had a physical stop on the syringe to -- to give the dose.

That would be acceptable as well. The -- we did not talk about systems that -- where the syringe was marked in myriad other ways. I mean, could you put tape on it?

Could you mark it with a Sharpie? Could you -- again, the list goes on and on. But what the MDC approved were color-coded dosing administration systems for anaphylaxis. Does that make sense?

MR. PARKER: Yes. Any other discussion? Hearing none, is there a motion to approve? Actually, it doesn't need it. So all in favor -- it's been a long day.

BOARD MEMBERS: Aye.

MR. PARKER: Any opposed? Motion carries. Next motion that you had was?

DR. YEE: Medical Direction unanimously endorses the NITSA document for the safe transport of children, which does include stipulations for child restraints in the back of an ambulance.

MR. PARKER: Okay. The motion is on the floor. Any discussion? Hearing none -- oops. Dr. Bartle.

DR. BARTLE: The -- I think -- just share with the background of what's going on with this. The -- this year's General Assembly, there was a proposed bill in both the House and the Senate, House Bill 1662 and Senate Bill 1677, that police, EMS, fire can transport kids without the appropriate child restraint.

Which kind of goes against what the whole idea of what we're supposed to be doing. Especially through EMS-C and safe child transportation. So I applaud Dr. Yee and his group for supporting that. So this is -- and it's still not quite final yet what's going on in the General Assembly

with it.

MR. PARKER: Okay.

BOARD MEMBER: Mr. Chair, can I ask a point of clarification?

MR. PARKER: Yes.

BOARD MEMBER: What does this motion do? Does this mean the EMS Advisory Board endorses that entire document? Or does that mean the EMS Advisory Board endorses child restraints in ambulances? Or does it mean we endorse the -- the Medical Directors endorsed it?

DR. ABOUTANOS: We endorse the endorsement.

MR. PARKER: We -- we endorse or we support the endorsement of that document.

BOARD MEMBER: I just -- I have not read that document. I'm not familiar with

it. I don't know if others have read it in its entirety.

DR. YEE: It has been a little while since I've looked through it. It was actually published in 2012. But it was a NITSA project on safe transport of children specifically in ambulances.

It's available on EMS.gov., for those who want to look at it. But the -- but the idea is that having a child transported in the arms of a provider or a parent is not adequate or safe methods of transportation.

MR. PARKER: Is there any other discussion?

DR. BARTLE: The -- can I give a further background? A lot of the work that's been done to this -- to this date has come from that recommendation.

And the fear is that if you start having a recommendation that's okay not to follow it, it's counter -- not only

is it counter-productive, it's -- it's not very thoughtful, to put it nicely.

MR. PARKER: Okay. So it's time for favor, aye.

BOARD MEMBERS: Aye.

MR. PARKER: Any opposed, lights on. Okay, motion carries. Dr. Yee.

DR. YEE: We have two other informational items. Out of Medical Direction Committee, we actually have two work groups.

One of which is working on how do we define critical care transport in Virginia. We have brought together some agency representatives, some hospital representatives.

We -- we're going to invite a critical access hospital representative and some -- and a trauma center representative. Because we, quite honestly, have a difficult time defining what is critical care, let

alone how do we execute critical care transport. So we can move sick and injured patients across the State to where they need to be.

We have a second work group that's working with Mr. Perkins on mobile integrated health care community paramedic. That -- that meeting -- we've accelerated our time table.

We plan to meet monthly or bi-monthly to create a platform to refine the legislation that was proposed this year. No action items from either of those work groups.

MR. PARKER: Okay. Medevac Committee, the other Jason Ferguson.

MR. J. D. FERGUSON: Medevac Committee met yesterday morning. We had a very prompt meeting. But ultimately, the House Bill 1728 work group continues to work on addressing the different priorities identified in that document. As you heard, we've started to reach out to the other

committees that would be involved to make sure that we're engaging and -- and moving forward. And no action items or other information to report.

MR. PARKER: Okay. EMS for Children, Dr. Bartle.

DR. BARTLE: Yes. We last met on January 3rd. We don't have any action items to present. We do want to say -- to thank the Office of EMS for creating a pediatric track in the symposium for this coming year.

Part of what we've been doing is actively recruiting speakers for this. And currently developing a pediatric boot camp to kind of share the information that the National EMS-C has for -- that can be used here in Virginia.

We've discussed that -- looking -- possibly considering looking at some pre-hospital guidelines for certain pediatric conditions. And most of the time was spent on the -- the bill of -- for safe transportation of kids. And just -- the

last word I heard was that the Senate and House Bill has been approved with the amendment of only in exigent circumstances that they can transport kids without appropriate child support -- or child restraints.

MR. PARKER: Okay. Trauma System Coordinator, Dr. Aboutanos. And if you'll go ahead and give your TAG report.

DR. ABOUTANOS: Thank you, Mr. Chair. I -- so this is marked the first time for the trauma system coordinator on this committee, so this is an important step.

And I want to begin it by the -- by the two most important word[s] which are thank you. A really big thanks for -- especially for this committee for being -- for opening up for the -- a need that we -- we saw for the State and for the -- for the injured. And the ability to have a plan that is integrated. And I know this took a lot -- a lot of work and I want to

specifically thank the Office of EMS also for their incredible amount of support in this entire process.

And -- and also thanking -- and Gary for -- Critzer for just phenomenal way of navigating us through this -- through this system. I think lot of this is due to your -- your diligence and your patience.

And asking us to be patient as well. So -- and I'm confident this process will -- will continue. But just on the way from the ACS site visit in 2015 to the development of the Trauma System Task Force by the Executive Committee for us to do that.

And incredible work that has happened that led to development of trauma system plan. Then to the bylaws approval on November 7 by this Advisory Board.

And then the approval of the membership yesterday for the -- for all the committees. And the inaugural trauma system committee meetings today, which all happened yesterday and -- and today with really impressive presentation and commitment by so

many new members. And members who have been involved from the very beginning to make this process move forward.

So an incredible amount of work has -- has been done and getting ready to be -- to be continued. And so, again, a big thank you for -- for all of this.

And the Trauma Administrative and Governance Committee, we mainly discussed the processes of how things would be handled and how the -- the action items will come out of the various committees, then have to pass through the Trauma Administrative and Governance before they come to this EMS Advisory Board.

That was one of the main -- main aspects. And we discussed mainly logistics for now with regard to every committee.

But then, I will defer the -- the presentation to the rest of the committee chairs. So first one will be system improvement.

MR. PARKER: System Improvement,

Dr. Safford.

MS. MITCHELL: My name is Valeria Mitchell. I'm reporting for Dr. Safford who's out of town attending a conference. We had our first System Improvement Committee this morning and we spent a little bit of time trying to determine -- we have three slots that need to be filled.

And we feel very confident we'll be able to get them filled. We've got some -- we were able to get some really good suggestions from the members. It's a couple of things that we talked about.

We talked about identifying databases that are available and trying to find out which -- what -- where they are and what -- what information they contain, which may actually be information that we can use in our committee so that we don't end up duplicating work.

We talked about the process of validating -- the need to be able to validate data that we're putting into our registry. The new epidemiologist from the

Office of EMS gave us a copy of the fourth quarter trauma report. And we also looked at the table of contents for the Ohio State registry report, which Dr. Safford feels may be a tool that can help us as we determine -- develop a registry report that he hopes to have published by the end of the year. Thank you.

MR. PARKER: Thank you. Injury and Violence Prevention, Karen Shipman.

MS. SHIPMAN: We met yesterday. And just a little history about our committee. Our committee was -- our work force was composed of injury prevention coordinators from throughout the trauma centers throughout the State.

We've been restructured to where we'll be bringing in members of the community, so we're very excited about that. So we'll have members of the judicial system, State Police, epidemiology, VDH. In addition to that -- to our seated positions, we're also looking at formally inviting

about 30 to 40 organizations throughout the State to attend as liaisons. Because injury prevention is so big and there's so many different patterns throughout the State.

And we want to make sure that everyone has a seat and a voice when we start planning things for -- for our State. The other thing we talked about is, obviously, beginning to pull data to look at these trends throughout the State and see what's going on in those areas.

MR. PARKER: Okay. Thank you. Pre-hospital Care, Brad Taylor. Mike Watson.

BOARD MEMBER: He left, so Brad Taylor will do it.

MR. PARKER: Okay.

MR. TAYLOR: We met yesterday and made Mike Watson Chair, so I'm now vice-chair. We have two openings that we're looking for a trauma survivor. We're going

to reach out to some of the hospital systems to see if we can't find that. Pretty much, we're just getting the foundation going right.

There's a lot of new members on there. We're trying to figure out each other and -- and our roles and answering some of the questions that Dr. Aboutanos has for us.

And we look forward to getting some work done. So far, we haven't -- we didn't do much yesterday.

MR. PARKER: Okay.

MR. TAYLOR: All right. Thank you.

MR. PARKER: Thank you. Acute Care, Dr. Young.

DR. ABOUTANOS: So Dr. Young is not here and he asked if I can give the report for him. So the Acute Care Committee met yesterday and they had -- they formed the three work groups who want to work mainly on

the updating the trauma manual. And another work group to work on the criteria for trauma center designation report.

And the other work group that developed may need to look at the acute care facilities in the trauma system and their engagement. The -- there was one action item that came out of the -- the Acute Care Committee.

And this action item relates to the proposal for physician acute -- excuse me, an advanced providers for their trauma CME changes. Just to give a quick -- quick background.

American College of Surgeons has lessened the requirement for CME's for demonstrations for mainly the trauma physician and the -- the physician except for the trauma medical directors and the ED medical directors.

And this makes it a lot easier during the site visit. So the proposal came in, should the State do the same as American College of Surgeons. This has been debated heavily. And then -- this is an action item

that came out of the Acute Care Committee. Basically, that states with regard to trauma medical director -- trauma medical director shall be board-certified.

General surgeon or pediatric surgeon maintain certification in ATLS as a provider. Instructor shall have 30 hours of CME's every year -- three years.

Similarly, for the emergency medicine medical director, the emergency medicine medical director or designee has to be board-certified in emergency medicine or pediatric emergency medicine, and shall maintain certification in ATLS as provider or instructor.

The main change came with regard to the emergency medicine physicians. All emergency medicine physicians shall be board-certified for board-eligible in emergency medicine or pediatric emergency medicine.

And shall have successfully completed ATLS at least once. So it does not state the -- the CME requirement. Emergency medicine physician, board-

certified in a specialty other than emergency medicine or pediatric emergency medicine must maintain board certification, maintain ATLS certification as a provider or instructor.

And shall have 30 hours of Category I trauma critical care CME every three years. With regard to surgeons taking trauma call, all surgeons taking trauma call shall be board-certified or board-eligible general surgeons or pediatric surgeons, and shall have successfully completed ATLS at least once.

And therefore, does not state the CME requirements. And finally, with regard to advanced care practitioners, physicians assistants and nurse practitioners responding to the trauma activation must be board-certified, maintain ATLS certification as a provider or instructor, and shall have 30 hours of Category I trauma care CME every three years. So this action item came out of the Acute Care Committee. It was approved by the TAG Committee for this to be presented

here for this Board to discuss and -- and approve of. And that's the report for Acute Care.

MR. PARKER: Okay. So we have an action item from the Acute Care Committee and a point of clarification. This was not presented to the full Advisory Board prior to today. So this will need a second from the floor in order to vote on. Is there any discussion before that?

BOARD MEMBER: Can I make one question? Dr. Aboutanos, I was at the meetings and I agree with this in concept. I'm concerned that as this document is written, criteria 3.1 says that all emergency physicians shall be board-certified or board-eligible, which I don't think was the intent of the discussions yesterday.

I think it was to say that emergency physicians who are board-certified or board-eligible in emergency medicine or pediatric emergency medicine fall under the

requirements listed in 3.1. And separating those from emergency physicians who are not board-certified in that specialty.

DR. ABOUTANOS: So you're making the distinction of saying who are instead of shall be?

BOARD MEMBER: Correct.

DR. ABOUTANOS: I think we could accept that as a modification.

MAN IN GALLERY: Sorry, that was -- that was the intent. That if you're caring for trauma victims, they have to be board-certified.

LADY IN GALLERY: Or board-eligible.

MAN IN GALLERY: Or board-eligible.

DR. ABOUTANOS: I think you're saying the same. Instead of shall be, but

who is. Right? Is that --

MAN IN GALLERY: No, because that means then if -- if it's a family practice doctor -- you know, if you're caring for trauma victims, you have to be board-certified or eligible.

LADY IN GALLERY: And then -- or they fall under the other guides.

DR. ABOUTANOS: Yeah. I think maybe I misunderstand the words shall be versus be. So if shall be means that you are, yes. That's the same thing. Just the way the English word, I think.

BOARD MEMBER: I guess the clarification I'm looking for is, does this mean that an emergency physician who is not board-certified in emergency medicine but is board-certified in family practice could not care for a trauma patient?

MAN IN GALLERY: Yeah. He -- he

then falls under the --

DR. ABOUTANOS: The second one.

MAN IN GALLERY: -- the next one --

DR. ABOUTANOS: 3.2.

MAN IN GALLERY: -- that says then you have to have current ATLS and do the CE.

BOARD MEMBER: Okay. The way it's written it -- it is confusing to me that it implies it -- because it both says emergency medicine physician for both of those.

I think the intent of the first one is to classify those emergency physicians who are board-certified or board-eligible as different from those who are not board-certified or board-eligible. And are board-certified in a specialty.

DR. ABOUTANOS: It says that. It says emergency medicine physician, board-certified in a specialty other than

emergency medicine.

BOARD MEMBER: This is the part I'm confused -- emergency medicine physicians shall be board-certified or board-eligible in emergency medicine. So I would -- I would recommend that we amend shall be, who are --

MR. PARKER: Why don't we just put --

BOARD MEMBER: Shall be to who are.

MR. PARKER: All right.

MAN IN GALLERY: I see that.

DR. ABOUTANOS: That's all we're saying. Or saying all emergency medicine physicians who are board-certified in their specialty or board-eligible in their specialty. That's shall be board-certified in their specialty, in emergency medicine. And actually, it says that. In emergency

medicine, in emergency medicine. If you continue the sentence, it says it. It specifies -- okay.

DR. LINDBECK: One more point of clarification. I think -- isn't the appropriate term to be board-prepared?

BOARD MEMBER: It's board-eligible.

DR. LINDBECK: If I recall correctly, ABAM does not endorse the term board-eligible. It's now board-prepared. If I recall, it goes back 10-15 years.

BOARD MEMBER: Eligible's the word that's used in the current medical language.

DR. ABOUTANOS: Yeah, we use it -- and it's also less -- yeah. That's what we use -- always use in the manual.

DR. LINDBECK: If you look at ABAM, I believe they've removed all reference to eligible. It may be -- they removed all

terms of board-eligible and now say board-prepared. It may have to do with the Daniel lawsuit from a few years ago.

BOARD MEMBER: I think they did change that language, although other specialists and other groups may continue to use it.

DR. BARTLE: In pediatrics, they do board-eligible as opposed to prepared. They repeat prepared throughout the training. They become eligible once they finish the training.

BOARD MEMBER: I'm on [unintelligible] and that's eligible.

BOARD MEMBER: I have a question just to make sure it's clarified. We're breaking out between physicians who are board trained or eligible to be trained in emergency medicine from those who aren't formally trained. But they have to keep up with --

BOARD MEMBER: Certified, trained.

DR. ABOUTANOS: We didn't -- we didn't ask that. It's actually to take away the CME. This will be replaced with more. The fact that now the trauma program managers don't have to spend thousands of hours chasing everyone to get their CME requirements, which have not been proven to make any difference.

Except they kept those -- that certain criteria for the medical director and on both the trauma and emergency. And they did not -- we didn't change much with regard to everything else. So --

MR. PARKER: And this mirrors the ACS, correct, what --

DR. ABOUTANOS: This mirrors the ACS. We're a little bit more stringent when it comes to the advanced care practitioners where we're asking that they -- they get ATLS and their CME's. Otherwise, it mirrors the ACS.

MR. PARKER: Okay. Any other discussion?

BOARD MEMBER: One other question. The way it currently is now, is there -- taking out the requirement for CME, does most places meet this? Meet the same criteria, the ones that -- the trauma centers now.

DR. ABOUTANOS: They meet it more because they don't -- they don't have to have the -- you know, so it's going back to the fact that you are -- they're putting emphasis on the board.

If you're really a board-certified physician, then by definition, you've kept up with all of your thing to remain board-certified. They took away the fact that -- that aspect.

And then also remember that the -- every trauma center, the trauma program, the trauma medical director is ultimately responsible [for] making sure that the trauma care's appropriate.

Everybody's caring for the -- for the patient that center have the appropriate credentialing, etcetera. So that's why they're giving credit back to that -- to that part.

DR. LINDBECK: If I might just -- excuse me -- just interject. From doing these site reviews, I would say that probably 95% of the physicians are board-certified in EM.

There's probably only five to 10% that aren't. The -- it really reduces a burden on the trauma program coordinators who had to try to corral all of their emergency physicians, which could be 20, 30, 40 doc's in some cases.

And -- and not just ascertain that they had adequate CE, but that they had adequate trauma CE.

MR. PARKER: Mm-hmm.

DR. LINDBECK: And it was very burdensome. And the -- the added quality

measures were highly debatable.

MR. PARKER: My whole in trying to get across is that it's not really changing what's out there now. It's just making it less burdensome.

BOARD MEMBER: Yes.

DR. ABOUTANOS: Yeah, exactly. Making it -- if the American College of Surgeons making theirs less burdensome, should the State do the same.

And it would be tough to kind of have two separate criteria where we're more stringent in the State, less for the...

MR. PARKER: Is there any other discussion?

BOARD MEMBER: So is that amendment acceptable? Do we need to vote on the amendment?

DR. ABOUTANOS: It would be

acceptable to us. I mean, who are board-certified or board-eligible instead of shall be board-certified. I think -- think the word -- the way I understand it, the word shall be is intended to say who are.

It just said -- as a -- it's almost like a -- a God statement, you know. Thou shall be, you know. So that's how I see it.

MR. PARKER: And that's in the minutes. Oh, boy.

DR. ABOUTANOS: We're invoking divine powers here.

MR. PARKER: Because it hasn't been seconded and you're still working on it, we're going to go with that. So it's -- it's presented --

DR. ABOUTANOS: Yeah.

MR. PARKER: -- and it's finalized. Okay. So now do we have a second for that?

BOARD MEMBER: Second.

MR. PARKER: Okay. The motion's on the floor. All in favor?

BOARD MEMBERS: Aye.

MR. PARKER: Motion passes. Point of clarification we just -- I just discussed with Gary Brown. This will have to still go through the -- the Board of Health for approval.

So that way the trauma program managers can't run out today and start this process. So just wanted to clarify that before I start getting text messages. Okay. Anything else from Acute Care?

DR. ABOUTANOS: That concludes the report. Thank you.

MR. PARKER: Okay. Post-acute care, Dr. Griffen.

DR. GRIFFEN: Having just heard the

discussion, I just want to make a plea to get it approved before November when our next site visit is so I can go back and give my trauma program manager some relief. My name's Maggie Griffen.

I'm from Inova Fairfax. I'm the trauma acute care surgery director up there. Post Acute Care, one of the things that we've quickly learned, for those of you some background -- in order to figure out about quality care for the trauma patient across the State.

Right now, any data related to the care of those patients end when they leave a trauma center. Because that's where the data ends. The registries are great, they have lots of data.

And then it's like they go to the wind. We don't know where they go -- well, we do know where they go. We don't know how they do.

We don't know did they get back to work. We don't know, did they get back to school. We don't know if they go to a rehab, how they do in that rehab. If they

go to a skilled nursing facility, how do they do. If they go home, how do they do. So the biggest thing for us is data.

In fact, the first part of the data is we don't even know how many centers for all of these things to provide post-acute care in the Commonwealth of Virginia exists. Because there is no list anywhere.

For all the skilled nursing facilities, for all the rehabs, for what they do, for what they provide. And then, the information that they then provide back about those patients is varied and it's to various agencies.

So the biggest component of what we discussed yesterday in our meeting -- and I can't even tell you how great it was to have all these people from all across and from PT and OT and all over the place that we invited to come be part of this.

And how energetic they were and enthused about the opportunity to have a place to have this discussion and go forward -- because they have all wanted the same sort of thing -- is to be able to find

the answers to the initial question. What's out there, what does everybody do, where are they located so that we can come up with a map across the Commonwealth of what's available for our various patient populations at the various centers, and where they can go.

And that's going to take us I don't know how much time. So everybody's gone back to look for where they can find data and bring it together. And we will let you all know what we find and where we put it and move forward from there.

But it's going to be a huge task, but it's a major component to then be able for us to come back and say that what we're doing on the front end is really accomplishing what we think it is on the back end.

For kids getting back to school when they've been injured, for people getting back to work when they've been injured. We have a mortality for when they leave a trauma center. We know what our mortality is for the Commonwealth. We don't

know how many of them die two weeks later in a rehab or in a SNF. We don't know how many die six months later. We don't know the answers to those questions.

And for quality review, we really have to have the answers to all those questions. So I can't thank you all enough for the opportunity for us to all do this.

We really are dedicated to improving this care for our patients and having the quality data that we need to review it. So I appreciate it very much. And that concludes my report.

MR. PARKER: Thank you. Emergency Preparedness and Response, Mark Day.

MR. DAY: Good afternoon. This has been a long time coming. And Tom, I've looked very closely to working with you. This part of disaster is not just general disaster. We're looking at -- at taking the trauma centers, trauma education at, you know, adults and burn and pediatrics. And getting disaster education to our centers,

and melding that trauma education with EMS and fire around the State. So we're very much in our infancy. Today we had our first meeting.

We brought the coalitions together and looked at what their assets were. And like I said, today was our first meeting.

And I really look forward to getting this off the ground and meeting Dr. Aboutanos's expectations with this. Tom, we'll be working really close with your group. And anybody have any questions?

MR. PARKER: Okay.

MR. DAY: Thank you.

MR. PARKER: Thank you. That concludes the committee reports. Regional EMS Council Executive Directors, we're going to ask Greg Woods.

MR. WOODS: Thank you, Mr. Chairman and Board members. The Regional Directors

group met yesterday. Our morning session included an informational work shop related to information technology. And that was followed by our regular meeting.

We did agree to implement monthly tele-conferences specifically related to IT, but also to foster greater collaboration in strategic planning among the various regions.

We also put together a work group to gather information related to MIH and community para-medicine programs in our respective regions. And to collaborate more fully with other groups who are working on this as well.

Our next regular meeting will [be] held in conjunction with the next Advisory Board meeting. I'm happy to answer any question that you may have, but that concludes my report.

MR. PARKER: Thank you. Now we're down to public comment period. Is there any public comment? Adam, do you have the clock?

MR. HARRELL: No, we don't need one.

MR. PARKER: Okay. Just making sure.

MR. MCRAY: Mr. Chair, members of the Board. My name is Brian McRay. I'm the safety officer for the Richmond Ambulance Authority. I just want to take a moment to thank you for endorsing the NITSA thing about pediatric transport.

Dr. Yee and I have a ongoing discussion about adult transports and the problems that it presents. One of the things that my agency looked at recently was the pediatric -- specifically the newborn -- transporting newborns.

The reality is in my community and our service area, our populations don't necessarily always have the resources or the opportunities to have the appropriate child safety carriers available. And so we found on many occasions having to figure out how to transport the newborn in a method that

was safe for everybody. I want to thank Dave Edwards from the Office for helping us out and providing us with some equipment ideas so that we can look forward.

All that being said, I would encourage you to potentially take on some education for the pre-hospital provider on -- on this particular topic. It's great to endorse the concept, however, we need to push the message.

I would also ask that Financial Assistance Review Committee consider some sort of special initiative as that equipment is not cheap, especially to cover what we're talking about, the newborns and the, you know, really -- not -- for the kids who don't necessarily fit the standard equipment that we have today. So thank you.

MR. PARKER: Thank you. Any other public comment?

MR. BROWN: Mr. Chair, I'd actually like to solicit one public comment and I hate -- I haven't had a chance to talk to

him. I hate to put him on the spot, but Commander Player, I would like for you to brief the Board real quick on the 15th anniversary of Virginia 1-DMAT coming up.

But I would hate for that to slide by this Board and it will have occurred before the next Board meeting.

MR. PLAYER: Okay. I'm Michael Player, Commander of Virginia 1-DMAT. We are having our 15th Anniversary on March 9th in Virginia Beach. We've had more than 200 deployments in our 15 years, serving the citizens of the United States.

And many of our best providers and practitioners in Virginia have been members of the team, many in the -- on the committee right now are or have been members of the Virginia 1-DMAT in the past. Thank you.

MR. PARKER: Thank you. Any other public comment? Any other public comment? Hearing none, any -- is there any unfinished business to come before the Board? Any

unfinished business to come before the Board? Hearing none, is there any new business to come before the Board? Any new business to come before the Board? Hearing none, is there a motion to adjourn?

BOARD MEMBER: So moved.

MR. PARKER: Meeting adjourned.

(The EMS Advisory Board meeting concluded at 3:23 p.m.)

CERTIFICATE OF THE COURT REPORTER

I, Debroah Carter, hereby certify that I was the Court Reporter at the EMS ADVISORY BOARD MEETING, heard in Richmond, Virginia, on February 8th, 2019, at the time of the Board meeting herein.

I further certify that the foregoing transcript is a true and accurate record of the testimony and other incidents of the Board meeting herein.

Given under my hand this 22nd of February, 2019.

Debroah Carter, CMRS, CCR
Virginia Certified
Court Reporter

My certification expires June 30, 2019.