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VIRGINIA DEPARTMENT OF HEALTH ADVISORY BOARD

MEETING

AUDIO TRANSCRIPTION

FRIDAY, AUGUST 6, 2021

APPEARANCES

COMMITTEE CHAIRPERSON
VICE CHAIR VALERIE QUICK
GARY BROWN, OFFICE OF EMS, DIRECTOR
DEPUTY COMMISSIONER BOB HICKS
KEVIN DILLARD, RAPPAHANNOCK EMS COUNCIL
J.C. BOLLING, SOUTHWEST VIRGINIA EMS COUNCIL
MARY KATHRYN ALLEN, BLUE RIDGE EMS COUNCIL
AMANDA LORETI, CENTRAL SHENANDOAH EMS COUNCIL
LARRY BIRD, CENTRAL SHENANDOAH EMS COUNCIL
DR. GEORGE LINDBECK, OFFICE OF EMS, STATE EMS MEDICAL DIRECTOR
ADAM HARRELL, OFFICE OF EMS ASSOCIATE DIRECTOR
GARY SAMUELS, VIRGINIA PROFESSIONAL FIREFIGHTERS
DR. MICHAEL ABOUTANOS, AMERICAN COLLEGE OF SURGEONS, TRAUMA SYSTEM COORINATOR FOR STATE EMS ADVISORY BOARD EXECUTIVE COMMITTEE
DR. ALLEN YEE, VIRGINIA COLLEGE OF EMERGENCY PHYSICIANS, PATIENT CARE COODINATOR FOR STATE EMS ADVISORY BOARD EXECUTIVE COMMITTEE
DR. JEREMIAH O'SHEA, VHHA REPRESENTATIVE
KRYSTAL SANDERS, ASSISTANT ATTORNEY GENERAL
JON HENSCHEL, ADMINISTRATIVE COORDINATOR, OFFICE OF EMS RULES AND REGULATIONS COMMITTEE
JIMMY BURCH, OFFICE OF EMS

JOHN KORMAN, ASSOCIATION OF PUBLIC SAFETY COMMUNICATIONS OFFICIALS (APCO), VIRGINIA CHAPTER, OFFICE OF EMS COMMUNICATIONS COMMITTEE

THOMAS SCHWALENBERG, EMS ADVISORY BOARD, EMERGENCY MANAGEMENT COMMITTEE

DR. JASON FERGUSON, EMS ADVISORY BOARD, TRANING AND CERTIFICATION COMMITTEE

VICTORIA "TORI" SMITH, VIRGINIA EMERGENCY NURSES ASSOCIATION/VIRGINIA NURSES ASSOCIATION, OFFICE OF EMS MEDEVAC COMMITTEE

DR. PATRICK M. MCLAUGHLIN, AMERICAN ACADEMY OF PEDIATRICS, OFFICE OF EMS EMS FOR CHILDREN COMMITTEE

GREG WOODS, REGIONAL EMS COUNCIL

PRESENTERS

MIKE COURT

ALEX DEE

CHRIS FRENCH

DR. BRENT MYERS

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ATTENDEES: I pledge allegiance to the flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

CHAIRPERSON: Okay, the first item on our agenda is the approval of the May the 7th meeting minutes that were sent out from the Board. Do any of the Board Members have any additions or questions to the minutes that were sent out?

ATTENDEES: (No audible response.)

CHAIRPERSON: Okay, hearing no comments, the minutes from the May the 7th meeting are approved for submitting. Next we have the approval of the August 6th meeting agenda, does anybody have any changes to the agenda?

ATTENDEES: (No audible response.)

CHAIRPERSON: Okay, hearing none, the agenda is approved. Okay, I want to start

off with my report, the Chairman's report, and I really have some good news I wanted to bring up, and I want to recognize the person to my right, Gary Brown. As of last month he's got forty-one years of service with the Commonwealth of Virginia.

(WHEREUPON, applause.)

CHAIRPERSON: I think it's amazing all the great work that Gary has done for us over the years. I want to give an example of something that Gary took the lead on that has recent real-life implications, and that's dealing with the EMS contact. So recently one of the other states, Wyoming had a little bit of an emergency going on where they had a 911 provider that was pulling out of the service area, and in a short time period a new EMS 911 system had to be set up. And in order for them to make it through the first month, they reached out to Virginia, and we sent nine providers out to Wyoming and helped get the system started. And they were able to do that because of his EMS contact, so it was about seven, eight years ago that Gary started talking to all of us about the Replica, and the EMS contact, and Virginia was

the third state that signed on to this, and then we had to get a certain numbers of states, I don't know if its twelve or what it was, ten?

MR. BROWN: Ten.

CHAIRPERSON: Ten to make it go into effect, so it's up and operating today. The twenty-first state just came on in October, which was Louisiana, so I just want to thank Gary for all the work that he did on (XXX 2:25.9 17091) and all the other many things that you have done, so thank you Gary.

MR. BROWN: Thank you.

CHAIRPERSON: All right, we're going to continue on with our report, and I'm calling on Vice Chair Valerie Quick.

VICE CHAIR QUICK: I have no report at this time.

CHAIRPERSON: All right, thank you. All right, welcome to our Deputy Commissioner today, Bob Hicks. Anything you'd like to report on, sir?

DEPUTY COMMISSIONER HICKS: I'd like to say thank you, I'm glad to be with you here, and I hope that I can help continue in the good work that Gary and all you have done for

(XXX 3:02.5 17091), you know, I've been around a long time, I'm in my fiftieth year, so. But the good thing was that most of it was in the local health departments for about thirteen years, which I think has taught me a lot about how the Central Office should operate. But the local government and you all, I mean you know things get done, and you know, the teams, we've got to get together to get things done. Over the last year and a half obviously you all have played a great role in helping us fight this pandemic, and yeah, I want to really thank you all for that. I think it has opened our eyes to things that have worked well, but more importantly those things that didn't work well, and how can we do better to reduce those things. And so already worked with Gary's and trying to increase the (XXX 3:51.0 17091) from across the agency to where we (XXX 3:51.8 17091), so thank you for allowing me to be with you guys.

CHAIRPERSON: All right, thank you sir. Okay, at this time we will do the Office of EMS report, so I will call on our Director, Gary Brown.

MR. BROWN: Thanks. Thank you,

Mr. Chair. As you know, we have sent in our quarterly report to each of the Board Members and those that are on our distribution list. I haven't personally checked our website unfortunately, I'm not sure it's been posted yet, if not it will be posted either by the end of today or early next week, so I apologize I did not check on it sooner. But as you know, the quarterly report drives this meeting with the, with the discussions under all the standard committees, and also in that, for those you got the quarterly report, I did put information, and in fact it was the very first thing with Mr. Hicks appointment as Deputy Commissioner for Public Health and Preparedness. And I've known Bob for decades now and he is a man that is very reasonable, very friendly, he makes things happen, he is a great achiever, but also a person that is very reasonable and common sense, and you get a really, builds bridges and works well with everyone, and I'm very excited that the Office of EMS and myself, we report to you, Mr. Hicks, I think it's a great, it's going to be a great partnership. And I do appreciate him being here with us today. Also, I will bring you up to date

on some personnel matters within the Office of EMS. As you know (XXX 5:56.1 17091), Deputy Secretary Senior, and Executive Secretary to this Board retired earlier this year, and so we have finally gone through the personnel process and we had interviews on Tuesday of this week to select a new executive senior and we're winding up that process and an announcement will be coming soon. Also, I think we have, well we have a new employee in our trauma program, a manager position. This position has been open for over twelve months, and so we have finally filled that position. Her name is Mindy Carter, is Mindy in the room? Oh, she's in the back with her hand up. I think a lot of people know Mindy, she has attended these meetings over the years and been very active in the trauma world, and I have a little bio here, I hate reading stuff, but I just wanted to make sure that I give her her due. Mindy is a registered nurse with a long history of experience in emergency and trauma services in the Commonwealth, starting in the volunteer EMS system in Blacksburg, she has been an advanced EMS provider, bedside registered nurse, and a manager, director for a number of trauma programs

in Virginia. While leading those programs she was also responsible for developing and implementing EMS outreach programs that provided improved collaboration in the EMS agencies and hospitals. Mindy has held a number of professional certifications, including trauma, Certified Registered Nurse, and she was recently asked to join the Trauma Nurse Leadership Council for the American Trauma Society. So anyway, we want to welcome, officially welcome Mindy to the OEMS team and she is going to be a great asset for the system and all of the EMS, so welcome, Mindy. Also along the trauma spectrum, we, the Trauma Program Director position is open, we finally have interviews for that position this coming Monday. And also we, through the allotment of FTE's that was approved by the General Assembly, we're now able to start meeting that commitment that we have with our hybrid regional EMS Councils, so for Shenandoah, Blue Ridge EMS Council, and the Rappahannock EMS Council, and we have many positions actually in competent classroom (XXX 8:32.4 17091) they are actually recruits, anyway we're finally able to meet those commitments and get the personnel in

there. And since the Chair is one of those hybrid councils, and as the President knows, the Rappahannock, EMS Council asked Kevin if he has any comments.

MR. DILLARD: Okay, thank you Gary. So as Gary said, the Rappahannock EMS Council became one of the regional councils and is working very well for us. But I wanted to call on the president of Southwest Virginia EMS Council because they are looking into the process, and I would ask if he could make a few comments, so Mr. Bolling?

(WHEREUPON, technical matters were handled.)

MR. BOLLING: Thank you. Thank you, Mr. Chair. We will, and I apologize.

UNKNOWN FEMALE SPEAKER: That's okay.

MR. BOLLING: We will improvise, adapt, and overcome, that seems to be our mode of operation in Southwest Virginia for quite some time and we have been very good at it. A wise fire chief once told me, if we always do what we've always done, at best you will be lucky to get what you have always gotten. Our Board of Directors asked that we look at our need, and how

the best way to proceed forward. We studied several different models, we looked at forming alliances with other councils, we looked at forming a partnership with councils becoming one super-council. We look to continue doing business the way we have done it, and we talked to OEMS about the possibility of becoming a hybrid office. And out of all those, making a long story short, the most logical sense would be for us to enter into an agreement with OEMS to become a hybrid office. We certainly in our discussions have the same mission, and that's taking care of the needs of the localities and EMS agency providers in our area. So it makes perfect sense being that we be part of one team. There's a lot of duplication that can be eliminated, there's greater effectiveness can be had going forward. And I am not saying we were ineffective in the past, I would say hats off to our council, we've done the most with the least for quite some time, and I will tip my hat to our Director, Rick Woods, for being the leader to get us through all the previous years. And going forward, I think this is going to be even better, this is another chapter certainly in the

Southwest Virginia EMS Council, a positive chapter, and we certainly look forward to forming a relationship and become a hybrid office with the Office of Emergency Medical Services. Thank you, Mr. Chairman.

CHAIRPERSON: All right, thank you, J.C. Gary?

MR. BROWN: Along those lines, we have several new members of the hybrid councils, I see Mary Kathryn, do you have anyone to introduce possibly from BREMS?

MS. ALLEN: No, she's actually on vacation, so.

MR. BROWN: Okay.

MS. ALLEN: It's just me.

MR. BROWN: Just you, well that's good. How about Rappahannock? Nope, no one here? Okay, then Central Shenandoah, any?

UNKNOWN MALE SPEAKER: Gary, Daniels Linkins is on vacation, the Regional Office Director, but we do have two members of the staff that are here and I will introduce you to Amanda Loreti, Amanda you're performing performance improvement within the region, working closely with Dr. Asher Brand and looking

at data, and looking at plans and evaluation in terms of improving services within the region. And then we have Mr. Larry Bird, he's back there, and Larry is one of the Technical Resource Specialists within the Central Shenandoah EMS Office, so we're very pleased to have you onboard and look forward to working with you. And no, Larry Bird has never heard the Larry Bird jokes, so. Okay, thank you.

We are also planning this year, after four years straight of having the Virginia EMS Symposium, obviously we had to cancel last year. We are planning the Symposium for this year November 3 through 7 in Norfolk. And registration opened this past Monday morning, and as of Wednesday I have looked at the registrations and we were a little over three hundred at that time. So I tell you this because with what's going on across the nation and with the variant, we are continuing to plan and go forward with the symposium, I'm hoping that it won't be derailed, but we never know, we will keep an eye on that. If it is anything that comes out from the Governor's Office or CDC that would require us to alter course or even cancel,

we will have to do that. I did get a question in our Legislative and Planning Committee this morning, you know, what time frame would we be looking at if indeed that happened? I don't know the answer, the only answer I could give was I hope it's sooner than later, because if we have to cancel like a week or two before it starts, that is more troublesome than if we cancel a month or two months in advance, so stay tuned and we'll let you know as quickly as we know anything, but in the meantime we are moving forward with a full slate of courses. I think it's about three hundred classes that we're offering over a five day period of time, four and a half day period of time. We obviously are curtailing social events in the evening. We will have the annual Governor's EMS awards program on Saturday night at the Symposium.

Also this Board for years now has met in consultation with the Symposium in November, but we, and as we were planning the symposium for this year we were looking at reducing the risk as well, and we will not be having the Advisory Board or any committee meetings held at the, in conjunction with the

symposium like we normally do. The Advisory Board is scheduled to meet the week following the symposium, we are working with this hotel to negotiate a contract, but its scheduled for Friday, November the 12th, so if you could put that date on your calendar, that's the next Advisory Board meeting. And of course we'll be reaching out to look at the schedule for Thursday, and then Friday other committees will potentially be.

I also have received some questions since we have had this in conjunction with the Symposium for many years, we would obviously cover travel for the Board to attend the Advisory Board meeting, and we would also waive the registration fee if you wanted to attend the meeting, so we're going to continue that courtesy, that if any Board Member wants to attend the symposium, the registration fee is waived for you and we will still cover one night's lodging for you, so if you want to attend, we certainly encourage that, its good times and be around the movers and shakers and the leaders within our EMS system in the Commonwealth, I think, and also for them to get

to know you as a Board appointed by the Governor that impacts so much that goes on in the EMS system across the Commonwealth. With regard to the Board, the appointments have not been announced by the Governor yet. My last discussion with Shawn Soares, who is Deputy Director for Gubernatorial Appointments informed me there were two organizations that they had not heard from at that point, and that's AFCO and ACS, American College of Surgeons, and I think they're trying to make all the appointments at one time, and they were still waiting on nominees from those organizations. They were very well aware of the dates of this meeting, and it was somewhat of a goal to get those appointments done before today, but that has not occurred.

And again, you as a Board Member, you may have come to the end of your serving your time on the Board if you served two consecutive terms, which all Members continue to serve on the Board until either, well until replaced. So it could happen by November the 12th may come and appointments may not have been made, I don't know, but you will continue to serve as an appointee of the Governor until replaced. And

with that, we're going to yield most of our time, as you see on the agenda, a special presentation of the EMS Patient Care Information System, before I do that though, I will ask, go around their side and Adam and Dr. Lindbeck if they have any update before we get into the special presentation. So sir?

DR. LINDBECK: Gary, I'm going to yield my time and I may have remarks as we go through the agenda, okay?

MR. BROWN: Adam, anything or it will be in the presentation?

MR. HARRELL: The majority of my updates will also come during the special presentation.

MR. BROWN: Okay, all right. George?

DR. LINDBECK: I don't have any specific report, I would like to point out I'm a lot younger than these guys.

(WHEREUPON, simultaneous speaking.)

UNKNOWN MALE SPEAKER: We've had multiple events this week Gary, we're going to have to terminate his contract.

MR. BROWN: Okay, with that,

that's all I have on my notes at the moment, so I'm going to turn it over to Adam to kick off our presentation of the EMS Patient Care Information System in Virginia, what's going on, what, how it has occurred, why we are where we are, and we have many people in the room with us to help us out here. So Adam?

MR. HARRELL: Thank you, Gary. So as Gary said, this is a presentation. The first part of this is going to be from the project team, so with a project of this scope and scale, you have to think about this is, for the Patient Care Registry, the Trauma Registry, the Direct Entry Patient Care Reporting System, as well as having to contend with multiple vendors. We have engaged a project team outside of the Office of EMS to assist us with this. Part of that team is housed as part of the Clarion Corporation, who is under State contract to assist us with this, as well as bringing on a contract staff to assist with this project. So the two individuals that will be presenting the project status to you today at the front table are Alex Dee, and that's all I'm going to do because I will murder his last name, from Clarion, and then Mike Court who

is the project manager on staff with us to assist with this project. So they're going to kind of give you a run through here of conception to current, as well as some future State information, as well as some of the statistics that we have encountered thus far. So with that, I will turn it over to Mike and Alex.

MR. COURT: Ladies and gentlemen, thank you so much for the opportunity this morning to speak to you about the Patient Care Reporting System transition. We have been in this project in the actual delivery phase for about five months now, and the pre-work that was done regarding the RFP, the inception, concepts and requirements for some time longer than that, and my partner here Alex will go through that. But when I first came on the project, I started doing some research because while I do have a background in medical/surgical, I don't necessarily have a background in EMS, so I wanted to learn what the spirit of what we were trying to achieve was.

And I found this quote in EMS World and I hope that's appropriate for this, but I thought it was striking, and I wanted to just

read it for the group, because I thought it really underscores the challenge that the entire EMS community is going through when they try to put a solution like this in place. "Data provides evidence that EMS is central to the healthcare system and the community at large. What is quantifiable is valued. Attention is given to problems that can be demonstrated with data. We know EMS performs extremely valuable services every day. With data, these services become visible to the rest of the healthcare system and the community as a whole. EMS holds unique knowledge and experience the rest of the care community needs. EMS personnel see things other building-based providers simply do not see. With data sharing, EMS can communicate this perspective and receive the credit due to it for the expertise it deploys every day. Data can also show when EMS is doing work that it was not originally designed to do that would be better addressed by other parts of the healthcare or social service systems."

I found this an incredibly remarkable quote, I wanted to preface what we're trying to do as a challenge statement. Thank you

for allowing me to share that. Our project objective statement is pretty cut and dry and to the point. With Virginia's EMS system, the Western Virginia EMS Council has partnered with ESO and Image Trend to build a comprehensive state-wide network to collect and track healthcare, public safety data from EMS agencies, fire departments, and hospitals. And like I said before, this process took its inception long before we started the project delivery, and I would like Alex from the Clarion Corporation, who was a stakeholder in this process, to go through the RFP process at a summary level.

MR. DEE: Thank you, Mike. Can you all hear okay? Good. So very quickly, first of all my name is Alex Dee, and it's a pleasure to be with you all today and thank you for having us. This has truly been a partnership, I mean if I could sum up the amount of work that has gone into this it's been a true partnership amongst many organizations to get us to where we are today. I think Virginia is uniquely positioned in this space, having gone through a long-term contract with a vendor in this space, and so what we wanted to do was make sure that we brought the

best of breed to Virginia, and brought the best solution possible for the EMS system.

So as you see on the screen, and I won't go, I mean again, our goal is not to go through each of these slides line by line. But we identified vendors that were NEMSYS compliant, we created functional and technical requirements and specifications across several factors. We worked with EMS, we worked with vendors, we had questions and answers that were created. Sixteen of the organizations submitted questions when we put the RFP out, there were hundreds of questions, each was answered, documented, and distributed back to all of the vendors to insure that everyone got the same information. At the end of the day, three organizations submitted inquiries and in February, ESO was awarded, and in April, Image Trend was awarded contracts to support this new initiative. I think one thing out of this slide, if nothing else, is that the awards represented a lot of work by both BDHEMS, Western, and the organizations involved, and I think the awards also represent a phenomenal solution to insuring that we are meeting the needs of all agencies and all stakeholders

throughout this process. At a very high level, I just want to touch on a couple of the things that have happened with initial engagement and OEMS response.

As Adam has mentioned previously, this is a significant undertaking and I also want to say that we are, you know, continuing to hone the process and to take feedback from you all, knowing that there are always things you could have done differently, done more effectively, et cetera, but we wanted to make sure that we continue to take the feedback from you all, individuals, agencies, et cetera to make this the best possible. So in the top section here, this is the initial engagement. We announced it publicly, we held town halls, we actually had a needs assessment that went out, a survey that went out to insure that agencies understood what was needed and we understood what agencies needed to make this as (XXX 26:49.8 17091) as possible. We went through outreach, we had regional council engagement, and then we also had these weekly transition update webinars. Again, each of these was to really hopefully help people meet them where they were, recognizing as well this is a

significant change after being in one direction for many, many years, also recognizing we probably stormed this a bit more, which in hindsight was positive because we have many people on it, but I also recognize that could have created some challenge for individuals with multiple people contacting them and making sure they were where they needed to be. And so I think we have address that and will be addressing that in the near future as well.

On the OEMS response side, we've had equipment grants, the first cycle was already completed. Sixty-five, or ninety-seven percent of the applicants were awarded those grants to help them with equipment. The Image Trend contract was executed, the ESO contract was amended to include additional functionality. And then also just for awareness, there is a second equipment grant that started the 2nd of August, it will go through September 3rd, just for awareness as well, so there is a second equipment grant that is open currently that will close on September 3rd to also assist with agencies who need assistance.

MR. COURT: I just want to add to

that that OEMS did respond as well with emergency grants for integrations as well as some people saw that as an unplanned expense, so Adam and his organization responded in kind, so I think OEMS was very responsive, listening to the needs of planned and unplanned requirements from the different agencies and developing mechanisms to streamline.

MR. DEE: Okay, going to the agency migration status on the EAHR's. As you know, we have a lot of agencies, almost six hundred, that are ultimately in the scope. When we first started, we wanted to go with a pilot-type, low risk release, and we went with a small group of about six, and we were able to keep them at a hyper-care status, where we were able to listen to their concerns once they went live, and respond very quickly to things that they were not familiar with, or it had legitimate requirement issues, and turn it around. In release groups two, three, and four, and you will see the Cadence pick up, as more agencies are coming online with their setup files and they are actually working with the ESO implementation teams, we are seeing greater velocity and

agencies that are enthusiastic about coming onboard to ESO. We are also being very accommodating to agencies that are not fitting in specific groups and working with them so that they can have off release dates based on their needs. We understand that the agencies have a core competency, they have a job to do every single day, they are in the life saving business, so we are going to work with them, you know, and be serving as leaders for them and make sure that this is not an encumbrance to them, and we continue to work with each and every one of the regional directors and agencies to make sure that we're making this as seamless and painless as possible. I talked about hyper-care, and I think it's really important to call out ESO and the Office of EMS for being incredibly responsive to the agencies when they do have questions, when they do have concerns, or even recommendations, and getting answers back to them as quickly as possible. I think that their feedback grows our intellectual knowledge on how the system is going to live in its life cycle in this state. Go ahead.

MR. COURT: Because change is hard

and because technology can be daunting, we thought that training was going to be a pivotal foundational leg in the chair of us being successful. ESO did a phenomenal job with their training program on a couple different levels, they have their on-demand training, on-demand learning that is self-paced webinar training that anyone can sign up for and take. ESO also partnered with the Office of EMS and did in-person training at four locations last month, so we were able to hit four different locations and actually conduct in-person training where people were able to bring their equipment, sit down, have one to one organized conversations and forums with the ESO trainers, and go through and basically take a train the trainer type instruction. Finally, there is admin and user training that is virtually instructor based that happens on Cadence at a regular time per week. And I wanted to call attention to some of the metrics up there, not going through, but you can pretty much see the saturation rate that we're seeing within Virginia on the training, it's pretty impressive. We did get quite a lot of participation and we think that our economy of

familiarity is going to, you know, bear fruit with this training, so I can't underscore ESO's efforts in helping us build this training strategy.

MR. DEE: And Mike, the only thing I will add to that as well is that we also understand that the EMS world is a bit transitory, and so people are going to come and go throughout the process, and so I think that ESO has done as well as create a process that will support new individuals as well, right, so it's not a once and done, it's not okay well if you miss it, okay. I think the positive here as well with the on-demand learning and with the virtual instructor based is that there is a Cadence for new individuals, there's a Cadence for folks that will be joining our ranks and transitioning into our ranks as well.

MR. COURT: So concurrently, what is happening along with the HR onboarding as we have continued to work with the data migration timeline and you know, we had some very, very interesting comments and questions that we were able to field for the trauma program managers yesterday about when will data be available, when

can we actually expose all the historical data back in the ESO timeline? We just received an update today, less than thirty-five minutes ago that our data box, which contains all of our data is ready to be shipped to Microsoft, where we will start the remainder of the process of extracting and unloading the data, and moving towards our milestone of having it available in the ESO. And the Office of EMS has been also accommodating to agencies that need historical data, I believe Brian Hodges and his team can actually accommodate pulling some data on special needs cases, so that's where we are with that at this time, on schedule largely. Adam, do you want to add anything to that?

MR. HARRELL: The biggest thing is it's a question that we are routinely getting is when am I going to be able to access my data, when am I going to be able to access historic data? George and I were actually whispering about that over here while you were talking, so one thing I do remind people is you have to think about the size of the data that we're dealing with that would have to be migrated, approximately seven terabytes is what had to be

migrated from Virginia servers. So we're in the process of migrating that now. That data is going to go back to Image Trend initially, it's going to be available to all EMS agencies hopefully within the next seven to ten business days, pending no issues with Microsoft or Azure. And agencies will be able to do self pulls. We had some requests right now that we're working on diligently with Image Trend to prioritize for agencies, for legal purposes and et cetera, but these agencies will have access to their historic data in the Image Trend cloud. Once it's back in the Image Trend cloud, we'll begin working with both Image Trend and ESO to migrate all data into ESO, so that agencies later this year or the first part of 2022, will have access to all of your data in ESO. And when we do that migration, understanding that agencies want the data in a single point for QA, QI, QDEM processes, we're actually going to migrate data from the most current back, so that agencies can start using the analytic functions and the reporting functions in the ESO as soon as possible.

MR. COURT: Thank you, Adam. Additionally in our communications plan we do

always update our online resources, which are available to all of you and to all the agencies. We have a robust online transition site that has FAQ's technical documents, town hall webinar recordings, if you happened to miss avenue and you want to go back and review it, their available timelines and project contacts are also available on those sites. Additionally, videos, ESO town hall recordings are also available, onboarding documentation, and FAQ's that are ESO-specific.

Listening to the Regional Council, early on we did, we were able to leverage technology to actually take our Agency Tracker, which gives real-time updates on where individual agencies are as they relate to the regions, where they are in the process, and we update that every single day, and we were able to expose that to the Regional Council. A lot of the regional directors and their staff have taken advantage of that and have actually started a wonderful dialogue with us, helping us cleanse information. Our communication registry was not entirely up to date and we were able to clean that very quickly with their help, and thank them for that. But we

keep this Agency Tracker and we keep implementation data board through Monday.com, that they are able to interact with us on, they are able to leave comments and we scrub that every single day, so we actually have a working dialogue with the people that are closest to the agencies to improve the data, give them real-time status, put any risks out there as they may be identified, and work just so that we do not create an impediment to their success. And this is all of the players that are involved in the front line that are helping you make this a successful transition. It is quite a complex endeavor with a lot of moving parts, and that is why we have so many resources that are reaching out, there are a lot of different segment handoff points in this project, ultimately it would be nice for everything to come through one bottleneck, but it's just would not work with the way that we're developing and implementing this solution, so.

We will have this information available for everybody to see, but as always, I'm the project manager, things will escalate to myself and Adam, and Alex, and we will work with

every one of you to insure that your requests are handled in a timely manner. We are working tirelessly with the agencies, which are working tirelessly with the regional councils to insure that we're smoothing that curve as quickly as possible. We understand as well that this has, the only chance this has of success is if all of us are involved, if we're invested, and we're advocating for the solution.

MR. DEE: Thanks. Yes, the only thing I would add to that is I think, please keep your feedback coming, right, so while we are well into the process and into the project, your feedback and continued input is critical. So if we, you know, we'd like to hear from you on what is working and what is not, because we can only improve if we heard about those things as well, but please don't hesitate. I don't want people to say well, you know, it's already gone, or oh the ship has passed, please keep the feedback coming, because we want to make sure that we are meeting you all where you need us to be and making it as effective as possible or you all. I know there's been plenty of conversation in the past about that as well, and we are continuing to

refine and augment our processes, but please keep that feedback coming, not just for our sake, but for yours as well.

MR. COURT: Adam, would you like to offer any closing comments before we go to questions?

MR. HARRELL: No, not at this time. I mean we do, like Alex and Mike said, we want feedback, we want to know what's working for you, what's not, what we can change. In addition to what Mike and Alex have provided, we also have ESO presence, they want to talk to us about some other offerings and some capabilities within their system, so I would ask if anyone has questions or comments for the project team.

CHAIRPERSON: So Alex and Mike, I'd like to thank you all for that presentation and can we make your PowerPoint available to the Advisory Board's attendance?

MR. COURT: Absolutely, certainly.

CHAIRPERSON: I know this is not normal, but I will ask are there any question from the audience as well? Or comments?

ATTENDEES: (No audible response.)

CHAIRPERSON: If not, I will

change direction here and bring up the staff from ESO that are present.

MR. COURT: Thank you all.

MR. FRENCH: All right, thank you. My name is Chris French, I am a Vice President over Hospital & State Business at ESO and with me is Dr. Brent Myers, who is our Chief Medical Officer, and we really just want to say thank you for having us today, we really appreciate the opportunity to have a partnership with the Commonwealth of Virginia. As you're going to see on our next slide, our mission and our vision at ESO, it comes up here, there we go, is we want to make a difference. We believe in improving community health and safety through the power of data.

Our founder was a paramedic seventeen years ago, he is still our CEO at ESO, Dr. Brent Myers has spent extensive time in the industry and the hospital space as well, and many of the folks that work at ESO have clinical background from both the hospital and EMS, and Fire industries, and so when we first started working with Virginia it was very clear to us that you all have the same mission and vision for

your Commonwealth here. We work with a lot of states across the country, we talk to a lot of different hospitals, a lot of different EMS agencies and fire departments, and I can truly say that you all have a great hospital system, great EMS and Fire system, and great leadership at the EMS Office, so it's very exciting, and you all should be very proud of what you're building here. So thank you for letting us be a part of that.

One of the things we've been talking about throughout this project with many of your hospitals and your EMS agencies is something we call our Health Data Exchange, and it's a way for those EMS records, regardless of the EPCR or EHR documentation system they use out there in the community, to get their full legal record into the hospital systems in a seamless and very real-time manner so it removes a lot of those, you know, barriers as far as getting faxes and scanning and all that fun stuff you may be familiar with. And on the back half of that, it also then provides outcome information back out to your EMS and fire crews so that they know exactly what took place on that patient once

treatment was provided at that facility, which I'm sure you're all aware is very valuable information for those folks who are working as hard as they can on the front lines to keep patients safe and healthy. So that's what we really want to talk to you about today is again what we're doing at ESO here in the Commonwealth of Virginia, and then what that project could potentially look like, and just kind of update you on those conversations.

I thought this slide might be helpful to show our ecosystem, so everything you see up here is a product space that we offer at ESO. Obviously we got our start in that upper left hand bubble, which is that EMS space, offering different products to EMS agencies across the country, and we're proud to say we're a leader in that space. And then down on the right hand side you're going to notice the red Fire bubble, so that's something we over the last couple of years have started working in and building ESO fire products and working with different fire agencies across the country. Many of your agencies here in Virginia are either on ESO Fire or looking at that as well. And then of

course we have the hospital space, so this is something that we really started to blend into about seven years ago. We knew that in order to go achieve our mission at ESO we had to really go close that loop in the continuum of care, and in order to do that we needed to go provide some products and some solutions for our hospital partners.

One of those being our alerting solution, which is when an EMS agency is coming to your facility they can give you a real-time update of EKG's taking place in the field, how far out they are, what type of patient they are bringing that hospital, hospital is notified if they can see the live GPS feed of the ETA of how far out they are. But then they can use that tool to communicate internally with the response teams at the hospital. And I bring that up because as part of the partnership with Virginia, that is something that is a tool that is offered to any and all of your agencies and your hospitals, that they could utilize, so that's a very exciting thing for everybody in the Commonwealth. And then also we do have our Patient Registry for your trauma hospitals.

A few years back, ESO acquired three of the four leading trauma registries, DI, CDM and Lancet and the reason we did that is because we really had the vision of closing that communication loop, we wanted to make sure those trauma folks at the hospitals could get that information in real time from those providers in the field, but then also make sure that as those outcomes are coming back on the trauma patient, when they were discharged or sent to another facility of care, that we could close that loop and get that information back out to the first responders. And so we did acquire those companies and in moving on to the State bubble, it kind of ties in there. The Commonwealth of Virginia actually has our ESO Trauma Registry at the State level, which means all of your hospitals now have access to our ESO Trauma Registry as well to submit data to the State.

Along with that, as mentioned earlier, the Commonwealth of Virginia also now has the ESO EMS Repository as well for all the EMS records to go to the State level. So again, our vision at ESO is we want to go connect all these bubbles together, we want to take the

information from the very moment dispatch is called, all the way to the hospital and discharge, and reporting up to different State entities. And Dr. Brent Myers actually oversees our research team at ESO, and so if you could look at this slide and imagine just kind of a bubble around all of this, as we work with these different partners, we're taking that de-identified information and doing all sorts of great research work on that information so we can go make a difference in the community as a whole across the country and the globe. So to talk about our Health Aide Exchange, again we have probably talked now I think to almost every major health system in Virginia about our Health Aide Exchange, we've got a whole team back here behind us who have been working very hard at having those conversations and helping folks learn about this as well as many of the other products.

But to give you a quick overview of what Health Data Exchange is, again the idea here is that once that EMS provider arrives at your facility, there are a lot of different things that take place. There's a quick reg that happens so that patient can show up on your EPIC,

or your CERNER, or your Allscripts documentation system. At that point, when a patient encounter number is created, your EMS agencies can receive that encounter number and put that into their documentation system. Again, it does not matter if they are using ESO, Image Trends, ZOLE or any of the other vendors, it can work with all of those. But at that point, once that is captured, that EMS record will automatically flow into your hospital record at the hospital. And as we have been having conversations out there, you know, one of the things we commonly hear is that wow, we spend a ton of time hunting for these EMS records, because they come through via fax, somebody's got to pick that up, go scan that in, in the HIM Department, or sometimes we don't even get them because they get lost somewhere in transit, which is obviously a detriment to patient care. And so that would automatically take that EMS record and put it into the hospital system so that those clinicians can have real-time access to that.

And then the great thing about this, and I think one of the most important things, is it is bidirectional. So in that last

piece on the very right hand side, that means that your EMS providers would receive outcomes back once that patient has been admitted, discharged, or transferred. Those hospitals get to make the decision on what information goes back out to those agencies, it's your data, so you get to make that decision. And then that goes back and a lot of times that's both demographic and billing information, which is helpful for agencies to do their business pieces, as well as outcome information from a patient care perspective, so really truly closing that loop in the patient care for those patients. Let's see if my slide is going to come up, there it is.

So this just gives you a quick example of what that looks like when it comes into the hospital system. We actually, interestingly enough, this is the screenshot from Bon Secours Mercy, we have a corporate agreement with them and this is from their Toledo hospital system where they just rolled this out in that market, and they decided to bring this into their EPIC system. We can send over that EMS record as a PDF that's viewable, but we can also send that

over as discreet data, so all of those vital signs or any of those data elements going in, in the field, can now come and live within those Cerner or those EPIC records for those clinicians to have real-time access to.

The other piece of this that we have, obviously getting that into that record is very important, but then on the back end of this we believe in making that data actionable, so we give the hospitals and both the EMS agencies a very robust reporting system to where your hospitals can go in, run reports on the data, those reports can be customized, they are all actionable, meaning if you want to go look further or deeper into one of those data elements, you can click on it and it will pull open that EMS record that's generating that. We will jump in here in a second and show you kind of what this looks like in real time, but again we have that both for hospitals and for the EMS agencies. And then the last thing to kind of talk about here on the slide deck before we jump in and show some of these reports, is our Trauma Registry integration.

So again, because the Commonwealth

of Virginia has our Trauma Registry across your hospitals and at the State level, if our Health Data Exchange were at your hospitals, that would mean we could take that EMS data flowing into your hospital systems and then take that through and automatically update your Trauma Registry as well with those EMS components. And that is something that it's always fun to have some of those trauma folks in the room when we talk about this, because they get excited about that because as you all probably know, that takes a lot of work and a lot of effort to go search for those EMS records and find those data elements and put those in. So that is something that we could automate as part of that project. So before I dig into the reports, Dr. Myers, do you have anything you want to add there?

DR. MYERS: Yes, just a couple of things. The first is, of course, you always have to make your disclosures. And my disclosure is that I am a twice Chapel Hill graduate, my father was a Chapel Hill graduate, he was there when Dean Smith first came and Dean Smith bitched, they're starters, which in our opinion is what allowed you all to win the first game in Chapel

Hill while Dean Smith was there, but I am a Tarheel, so I have to disclose that and I thank you all for letting the native Tarheel come up and have a conversation with you all.

The second thing is, we talked a little bit about the research and we'll talk more about that in a minute, but the research component is an elective opportunity with the data collaborative that we have. Seventy-five percent of our customers electively share their data for the, to be identified for the purposes of research and benchmarking. We will be jumping into that database in just a moment to show just a few quick highlights of how that works, but it also gives you an opportunity to see what reports you would have as an EMS agency, a State, and a hospital as it relates to the data exchange, so, and we'll come to that in just a minute, but thanks for having us.

MR. FRENCH: Yes, so just real quickly to show you again as part of that data, what you would have access to from a hospital perspective, from an EMS agency perspective, but then what's really unique about Virginia is you're all very well positioned to be a leader in

the entire country to where if we have this data flowing in from EMS agencies and the hospitals collectively, you could then go look at a State level, that de-identified data, to really look at how are we performing in EMS care based upon outcomes coming back from the hospitals in Virginia, which is really exciting. So this is an example of a couple of those reports. At a hospital I would have access to log into this, access the analytics package that we have here within ESO, I could click on my hospital reports here, and then we do have a variety of different reports. And the way we built this reports is we have about seven hundred hospitals now who use our Health Data Exchange across the country, we build partnerships with those service line leaders to say if we could get you that EMS information at your fingertips, what would you like to go look at from a core measure perspective and that's how we have built these, and so we're always adding and changing these.

But anybody can run these reports and go customize them to their own. But the first one I always like to show is our total transport volume by agency. So again if I'm a

hospital or a hospital system, one of the things we quite commonly hear is that, you know, it's really hard to know how many patients we're getting from EMS because we have twenty different EMS agencies and it's tough to collect that data. And so the very first thing we provide with our Health Data Exchange analytics is let's go give that hospital an idea of what agencies are they getting their patients from, how many are they getting from each agency, and then give that to them in a way they can go see any trends in that data. So what you're seeing here, obviously this is one of our, this hospital is never wait emergency room in our demo domain, but they have had forty thousand patients over the last hundred and eighty days. Any of our reports, you are able to go do a trend line on so you can see if that trend is going up or down.

And then as your scroll down, you're going to actually see those data elements that make up that report. So here I could see those agencies, how many they brought my facility, I would be able to go click on any of these data elements and it would take me directly into that EMS record to go view it from there.

So again if you're a system, we could give you these reports in a manner to where you could look at the hospital individually, or you could go look at your system as a whole to see all your data from all your facilities.

One other report I will show, just really quickly before we want to show you what it looks like from an EMS provider perspective. These are some of our clinical reports. So these are reports again, as working with hospitals that we have heard are important as we are looking at core measures and different timings of EMS care coming into your facility, but one of the ones we will show is our time to STEMI alert. So again, we're taking the data coming out of the EMS records, we're providing that up into this report, so now you can really go see how is the performance, you know, going in the field with those providers. And it will take a minute here because we got quite a bit of data in our demo environment, but as it comes up all of these reports will give you kind of an idea of what it is pulling in, so there is an information button in the upper right hand corner to clearly show you what that is.

There it is. So this is nice because you can see, you know, how many patients you have received, they came in with the STEMI alert, what was the average time to STEMI alert, so once they determine in the field that that patient was having a STEMI, you know, how long did it take then for that alert to occur into the hospital, and again you can see some of those important metrics for a facility. Again, if you wanted to know exactly what this report is showing you, you can hit that information button to get all the different criteria, patients over thirty-five years old, this was the primary impression in the field, these can all be set by the individual running this report. Again, we could probably spend hours digging through our analytics and showing you some of the power of this, but the idea here is that now that you have the data flowing like you have flowing in Virginia, you can do some really powerful reporting on that and through that with both you hospitals and your EMS agencies. So again the other part of this, oh I logged you out, I'm sorry, Dr. Myers.

DR. MYERS: That's okay, I'll get

back in.

MR. FRENCH: The other part of this is, it is bidirectional, so that gave you a glimpse of what it looks like to have the data at your fingertips at the hospital setting, but now Dr. Myers is going to log in and show you that bidirectional piece. So what would it look like for your EMS providers in Virginia to be able to know on every single transport what the outcome was on that patient, as well as then what you could look at from a QA or a Medical Direction level at that agency as well.

DR. MYERS: Great, yes, so thanks. So this did hit the time out in the background, and there's like fourteen million records in here, so give me just a second, it's going to spin as it loads back up. But what this is is looking at our datasphere which is the, all of those agencies that have voluntarily submitted their de-identified data. And just to show you how relatively easy it is to just create a report from scratch, rather than having these canned reports.

What I want to look at, and I'll just leave the dates in here as it is, but the

first thing you can do is just say all right, I want to see all the patients that have an outcome back from the hospitals. So I just want to know that that outcome exists, and say yes, and then I am wanting to know from a quality assurance perspective, who I transported as EMS agency that did not survive to admission, which used to be a phone call, and they hear about it, and the hearsay thing back from the hospital, but now you can just simply go in and go to outcome and go to ED disposition, and then just say, this patient did not survive through the ED. And this creates an automatic quality assurance report that you would want to run. And we can tell you, across the country this number is about 0.6 percent with very little variation of patients that actually don't survive through the ED.

But you can see there and we'll take the squiggly line out of the background and just go to moving average, you can see that this is relatively stable data. But underneath that are all of the runs, and this would be for your agency, every EMS chart for patients that did not survive to admission, that you could then create a quality assurance report based on it. And then

conversely, if you wanted to go back and say I want everybody that was discharged because I want to look at them for potential ET-3, right, and the opportunity maybe they didn't need transport at all if they were discharged. You can just change those filters back and forth and create those lists at the agency level in real time. We have found people get a lot of use out of that ability to do that. And then the other item, and are you showing sales on yours?

MR. FRENCH: Yes.

DR. MYERS: Just want to show the outcome card. So that's at the Medical. Director level, I wanted to just real briefly show what the medic can see, or what the EMT individually every time they transport their patient. We don't have those in the research datasphere.

UNKNOWN FEMALE SPEAKER: I have a question.

DR. MYERS: Yes, please.

UNKNOWN FEMALE SPEAKER: So let's just say like from a QA perspective, and I know that our crew took in a STEMI, how, obviously the hospital has to end up putting in the, the door to needle time, but how long after that can you

get that data, or does the hospital have to release that data?

DR. MYERS: Great question. So what we see, most hospitals send the data in real time, in other words, so our system in Raleigh was the first system where I was in that for twelve and a half years, we were the first system to engage with this product. Today, as we are sitting here, if a medic takes a cardiac arrest into the hospital, when they get back to the station, they log into see the first blood gas. I mean, it is back in their report that quickly. Other hospitals batch it and send it, so that's up to the hospital system, but we are capable of taking up, you know, minute by minute updated feeds and displaying them for the medic or EMT or Medical Director to see.

UNKNOWN FEMALE SPEAKER: Thank you.

DR. MYERS: Yes. So if you logged in as the medic, you wouldn't have all of these things at the top, obviously because you probably wouldn't have all of the fire hydrant, but maybe if you're a fire/paramedic you would, but you can see there's a little bubble to let you know you

have new outcomes on patients that you as an individual have transported. So all you have to do is just click on that and then the outcome cards display, so these are all patients that you would have transported. And so here's just one that, I use this one because it's just timely, you can see off to the left your incident number, where you went, and all of your dispatch information. And then to the right, you can see your impression, what the ED working diagnosis was, and then the hospital diagnosis is all right there, so that card is available to anyone. And then their local medical director can determine how much additional information they would like to release directly to the medic, verse having just available for them in the QA and from there you can see those outcomes. If you looked at the view outcome, then this is that detail that you were talking about that comes back from the hospital, so this is all of their ICD-10 codes, their insurance information, their bedside glucose, their troponins, all of their labs, et cetera, et cetera, et cetera. And again, that's all up to the hospital to decide what to release and up to the Medical Director to determine who

gets to see that within EMS agency. So that's what I have, Chris. Thank you all for your time.

MR. FRENCH: I don't have anything else.

CHAIRPERSON: Thank you so much for that overview of HDE and you know, kind of what we are looking at here is that, as you heard ESO say, they have been out, they have talked to a lot of health systems in Virginia, this is an available option but it's not currently something that we have contracted with ESO to provide. In evaluating this product, it's definitely within the project budget to include this, but we wanted to get some input from the Advisory Board on their thoughts on this product being available State-wide to every receiving facility. So I will open it up to the Board if there are any questions or thoughts relative to the Health Data Exchange?

MR. SAMUELS: Yes, Gary Samuels with Virginia Professional Firefighters. I've sat through quite a few of Chris's demonstrations with your work and everything, and I look at this as something that is very advantageous, as Virginia would be one of the first states to be

able to totally implement this across all of our hospital systems, but regardless if it's a one hospital, a small (XXX 1:04:41.0 17091) hospital somewhere, or if it's a big system. And my question, you know, there's a lot of pieces to this, but within the scope of the project, how, what, what parts are not covered for the hospital systems, within the scope of what they were offering?

UNKNOWN MALE SPEAKER: So currently under the current agreements here at ESO, we, the State and Western, we have covered the cost to the EMS agencies, should a health system decide to implement HDE, that's already built into the project. What we're looking at here, what I've been discussing with ESO was the potential for this project to also cover the Health Data Exchange cost to ESO. So the only remaining cost to the health systems would be their backend IT costs. So whatever it would take, I know that there's an HL-7 communication that's needed here on the hospital end, there are things that the hospital will have to do with their IT infrastructure that of course would not be covered as part of this project. But as far

as the components and the pieces within ESO to be able to provide this state-wide as a universal application and a universal platform for everybody, this doesn't, this is not just for the EMS agencies and Fire agencies that are using ESO, this is for everybody. That's what we're looking at here.

UNKNOWN MALE SPEAKER: Would a motion be needed for us to move forward as a State?

CHAIRPERSON: One of the things I would love would be a motion or something from the Advisory Board in support of this. This is something, you know, we have dealt with patient care repositories and everything else we have done with ESO up to this point historically, so we had a precedent, we had code language supporting it. This aspect is something new for us. So again, making sure that we come to the Advisory Board to solicit input to see what the Advisory Board thinks about it and then if it is something that the Board and the stakeholders would support.

DR. ABOUTANOS: I am just going to, I'm going to formalize it, a motion, for me I

think this is really excellent, this is what we've been thinking about for a long time, in line especially with the various responses at all levels, at the pre-hospitals, hospital, I think this would only, could all well, we just discussed partially because I heard yesterday at the (XXX 1:07:22.6 17081) Committee, and we all thought this was really an excellent, excellent idea. And its something that we would need only for, just for whether it's better for the, for the, any patient whether they are injured, uninjured, but that comes into our health system, that's managed at the various levels. And data is power, the more we have control of how we use it and use it appropriately with the system that's reliable, used in other places where things gets better together. And we used to, as you all know, present, we still do but not as often, present our report to what's happening to the injured and limited to the prehospital or time to work at the hospital. This would allow us to have a comprehensive presentation, here you are in the field and what happening to you, not just only what happens to you in the field across this, so my feeling this really should be

endorsed. If there's any kind of motion that you think we need to have, this is simply an endorsement, I could formally motion to approve for us to back it up from my point.

DR. YEE: Second.

VICE CHAIR QUICK: Third. What have the hospital systems said about this and their willingness to come onboard in that, the ease for that? I think, I mean, I think it's pretty clear that from our perspective, from the EMS perspective it would, it would certainly be a valuable thing. Currently for those of us that have really good interactions with our EMS partners, I think it's good but there's, you know, a whole system that also needs to get behind this, that we, we really can't speak for.

DR. ABOUTANOS: Can I ask a question, can I ask a question before that? Which hospital in Virginia has automated (XXX 1:09:10.5 17091) the ESO?

VICE CHAIR QUICK: Very few.

UNKNOWN MALE SPEAKER: Yeah.

UNKNOWN MALE SPEAKER: Yeah. So that answers your question quickly, so (XXX 1:09:21.1 17091) just using, using an example.

So yes or they, has it...

(WHEREUPON, simultaneous speaking.)

VICE CHAIR QUICK: We are, from a trauma perspective, but all the other kind of makes it, and like the STEMI, the STEMI has their own registries, you know, I'm sure there's other registries, but I know STEMI specifically needs EMS data and pulls EMS data out, and so I don't want to not have that focus too on the vast majority of other information that needs to get fed in. If it's just the trauma information that, that's great for the trauma system, but we also need to make sure that its insured for the rest of, of business, because I do think that that's valuable that they can look at.

UNKNOWN MALE SPEAKER: Yeah, and I would encourage everyone also to look at the system for its other potential, absolutely STEMI, stroke, trauma are important, but they represent what, two, three percent of our call volume? We, now we can look at the nine percent of the call volume, especially the low acuity stuff, and we can make operational decisions based on outcomes now, and what hospitals are able to do. You know, maybe we start doing alternative

destinations, alternative transports, telemedicine, and now get a true look at, well, not telemedicine, we're not looking at what hospital, but to truly look at outcome data and really change the face of EMS in out of hospital care, and integrational hospitals using a product such as ESO.

CHAIRPERSON: All right, so we had a motion by Dr. Aboutanos, and second by Dr. Yee to continue moving forward with the project with ESO. So obviously there' s a lot of excitement and I didn't get a chance to announce the motion and a lot of discussion going on, so is there any further discussion?

DR. O'SHEA: Can I ask a question?

CHAIRPERSON: Yes.

DR. O'SHEA: So it's Jacob O'Shea from the Hospital Association. Any time you start aggregating data like this one of the questions is who controls the data. Who in this model has responsibility and authority over this aggregate of data?

DR. MYERS: Sure. So two direct answers to that question. The first is the data between you and your EMS agency is controlled

directly by that EMS agency, just as they would any other record. It is a voluntary component for the data to be aggregated at the larger level for the de-identified portion of that for research and benchmarking. We have an external non-compensated research leadership group of nationwide representatives in the EMS research space that review every single proposal and make a recommendation about whether or not to release that de-identified data. It is an annual dataset that we scrub and only release it once a year to make certain that it is completely de-identified, et cetera. It's de-identified not only for PHI but also for region, agency, and hospital, so there's no way with the dataset that's released to even know what area of the country the data comes from. The third piece to say is obviously anybody can do an IRB and come to us with a full IRB with every participating agency, so if a region of Virginia wanted to do research and do identify the information through an appropriate IRB, we can release that, but that's an entirely separate enterprise. But EMS agencies and hospitals own their own data, the aggregate data is voluntary, governed by an external Board,

released only once a year, and then we can release data for the purposes of other research projects with specific IRB approvals.

DR. O'SHEA: Thank you. And is there any other way in which data is released by ESO other than sell it commercially, anybody to, any...

DR. MYERS: We do not sell data commercially, and, and the research dataset is made available free to everyone every year. The only, and then to be fully transparent, there are a few researchers that do not have the statistical wherewithal to actually analyze the data, and we do offer an hourly statistical assistance, but it's not related to the release of the data.

UNKNOWN MALE SPEAKER: So to address some of the questions you had asked Valerie, we, you know, as ESO has said, they, they have gone out and met with many, many health systems in Virginia, and some of those, the Office of EMS had been invited to and I participated with directly, and a lot of the feedback that we got was ultimately a subscription cost per agency, whereas if we could

approach it from a State level, we (XXX 1:13:49.0 17091). So that was, that was one effort. We, we received a lot of interest and input from hospitals and, not all of them, but quite a few, and to this point it has been solely based on the hospitals reaching out. From the support aspect of this project, it would be at that point that we would go out and actively start pursuing hospitals to say this is, this is something that is now offered, these are, you know, what is covered, this is what's not, this is a benefit, you know, are you interested, what can we do to help you? And then of course we would approach this as we have done in current projects with the phased approach, not trying to, you know, again eat the elephant all at one time, we're going to take it in phases. ESO already has relationships and agreements and input from, I believe you mentioned HCA and Mercy Bon Secours.

DR. MYERS: Yeah correct, at a corporate kind of nationwide level, not necessarily here in Virginia.

DR. HARRELL: Right, so that those are something we could start, you know, utilizing, we would definitely want it partner to

work with, you know, VHHA in this project as well. So I mean those are all components to this. Right now we're still at that, you know, feasibility of the project, interest in the project from the key stakeholders.

DR. MYERS: Adam, if I may just real quick? Just to continue that response, this is, I will get this link to everyone, but this is the public website that governs all of our research and describes the dataset, the leadership group, and gives a full bibliography of every single thing we've ever published either internally or with someone else using our data, so it's all available and transparent.

UNKNOWN FEMALE SPEAKER: Can I ask a question? Can I direct the question to ESO I suppose? From a rural area, realizing it's a small percentage, but from a rural area when we need to send those alerts to the hospital and we're in that last ten miles of lack of connectivity, how have you overcome that challenge?

MR. FRENCH: Yes, great question. So that's actually, so that would be a separate product than, than this one we're talking about,

that's our alerting product, which is something that was already included in this partnership, but a great question around the connectivity. Do you want to take that one?

DR. MYERS: Yeah, so there's a couple of things to say about that, number one, you are right, there's difficulty there. It will wait until it finds connectivity, but obviously if you never get connectivity, that alert doesn't automatically go through. So for the rural area, I will be very honest with you, we don't have a connectivity solution, you know, the radio report is still, I guess, you know, that the backup, I'm not, obviously people can tell by the accent I'm a native of North Carolina and I grew up in a little town calls Wilkesboro in the mountains, three thousand people and everybody's home. So I kind of know that space, right, and it is difficult. So we're, you know, they're, they're still on radio report in there. Within the hospital walls it is helpful still once you arrive because they can enter that data to get the time stamps and then press it on through the hospital. So the hospital collection of the data can be more accurate, but your point is well

taken. If you don't have connectivity at the time of the alert, it won't go, and that's a good point.

UNKNOWN MALE SPEAKER: Yeah, one of the things that the Office of EMS can do with that, we are, because technology is advancing and we know that broadband connectivity throughout the state is a difficult issue. If you reach out to the Emergency OPS Division, Sam Burnette, I don't know if he's in the room, I know he might be in the hallway, that's a project that we're also undertaking to help areas identify, you know, carrier issues, tower issues, and we work with other stakeholders in the State to be able to communicate that back.

CHAIRPERSON: Are there any other questions or comments from the Board?

ATTENDEES: (No audible response.)

CHAIRPERSON: Hearing none, we have a motion on the floor to move forward with the project with ESO in support the project. All in favor of the motion, signify by saying aye.

ATTENDEES: Aye.

CHAIRPERSON: All opposed, say nay.

ATTENDEES: (No audible response.)

CHAIRPERSON: The motion carries. Thank you gentlemen for your presentation...

DR. HARRELL: Thank you.

CHAIRPERSON: ... and your presence here today.

DR. HARRELL: Thank you.

MR. FRENCH: Thank you.

DR. HARRELL: Thank you all very much for your time.

CHAIRPERSON: Adam, do we have anything else?

DR. HARRELL: No sir, unless there are questions, that's all I have for today.

DR. LINDBECK: Mr. Chair, one thing I did overlook. One of the things that came up in the Legislative Planning Committee this morning was membership of the Committee and it looked, the short version is is that Gary Samuels as Chair of that Committee is going to reach out to Scott Winston, who is staff, and they will look at some, it's actually a ten year old document now, the Advisory Board guidance document that I have brought to your attention before, they have all committees look at their

composition based on that document and update it. And so, I think that was the best, quickest solution I've heard, it's just to have the Chair and staff get together and come up with recommendations on changing the composition, or there may be some organizations that aren't included in certain committees that you want to add, you may want to drop, I would encourage you to keep at-large membership, especially for the Advisory Board Members that are looking to serve on the Committee that we can place them on a committee that bump, you know, any organization or (XXX 1:19:28.3 17091), so.

I know Mr. Chair, you and I talked briefly this morning that we would have an Executive Committee meeting in November before the Advisory Board meeting, and I would bring that up because the bylaws say the Chair of each committee in consultation with his or her coordinator, and the approval of the Executive Committee will end with the membership of the committee. So we need to basically bring the closure to the committee composition and numbers on these committees, because the bylaws do limit each committee to ten, but over the years and we

would have to go back and do a search, we have voted to allow m if not most committees to exceed that ten.

But in the spirit of this, and since we haven't had an Executive Committee meeting, and I did get this from Dr. McLaughlin, he has indicated with EMS Seat Committee that earlier that he is now making Dr. Sam Bartle into the vacant position on the Medical Directors Committee for Pediatric Emergency Medicine/EMSC seat. And so I bring that to the Board because absent the Executive Committee meeting that before you get this, get the Board to approve that, at least that one venture, if we could.

CHAIRPERSON: All right, may I have a recommendation in support, do we have a motion to approve?

UNKNOWN MALE SPEAKER: So moved.

CHAIRPERSON: All right.

UNKNOWN MALE SPEAKER: Second.

CHAIRPERSON: We have a motion and a second. Open for discussion.

UNKNOWN MALE SPEAKER: So the previous memberships, we, I think we removed that seat.

CHAIRPERSON: Okay.

UNKNOWN MALE SPEAKER: We removed that seat. The EMSC no longer has a position on the, on the MBC. So we would be open to it, but I think we're, you know, talking to Patrick and their nominee, I think it's, we can go through the process like every other committee and make an addition.

UNKNOWN MALE SPEAKER: Well, therein lies the problem. That's the reason we need this, look all the committees that they order (XXX 1:21:36.9 17091).

(WHEREUPON, Simultaneous speaking.)

UNKNOWN MALE SPEAKER: Yeah that email was sent out and our committee met, and you know, I found Doc, he had sworn it and he said I, that was the, the ships gone. So he's going to start the ball rolling in the right direction to get that position reinstated at least an at-large, but an official position. I think it remained vacant for so long, and when we recognized that, now its, we're behind the eight ball, so yeah, get things going.

UNKNOWN MALE SPEAKER: Okay, well it sounds like its remains inappropriate not to.

CHAIRPERSON: Yes, I would agree with that, and it's appropriate that we continue our efforts to have the staff get together with the Chair of each committee and come back to the Executive Committee in November.

UNKNOWN MALE SPEAKER: Okay. All right, so we won't be able to make a motion for a stronger motion.

CHAIRPERSON: All right, anything else?

ATTENDEES: (No audible response.)

CHAIRPERSON: All right, thank you. Okay, Assistant Attorney General report, Krystal Sanders?

MS. SANDERS: Good morning. I don't have really a report, I just want to introduce myself. I will be serving as council for the Office of EMS. I joined the Attorney General's Office in December from private practice, doing primarily criminal and family law, so I'm getting up to speed on EMS laws. I anticipate being an expert in a couple of days. So anything that I can do to help you guys, and I look forward to working with you.

CHAIRPERSON: All right, thank

you. Terry Bright was unable to make the meeting today so we're going to the standing Committee reports. The Executive Committee has not met, but we will be meeting before the next Advisory Board meeting. Financial Assistance Review Committee, we did meet yesterday, we had no action items. I do want to announce that the fall grant cycle opened August the 1st and the deadline for the grant submissions will be September the 15th. Administrative Coordinator, Jon Henschel.

MR. HENSCHEL: There's no report from the Administrative Coordinator's Office on Committee Chairs. Rules and Regs met on July 7th, we did meet, we had a good dialogue, a lot of discussion about some things received from the Committee as we looked at Chapter 32. We do intend to review the material and bring that back to us so we can have an action item for the Board at the following meeting will be in January/February for now.

MR. SAMUELS: Gary Samuels. The Legislative Committee met this morning, we have no action items at this time for the Board. We had good discussion on the 2020 and 2021

sessions. We reviewed some of the special session budget items that were going, that are going through right now. And the discussion that Gary already mentioned on community composition, so that's all we have for right now.

CHAIRPERSON: All right, thank you. (XXX 1:24:39.0 17091) Coordinator, Jimmy Burch.

MR. BURCH: Good morning, thank you. The Transportation Committee did not meet as scheduled, we did not have the grants, no more grants to review, but we are adding a couple of new committee members to Transportation, Mr. J. C. Bolling, Mr. Matt Woodman are coming onboard as the Transportation Committee, and so we appreciate that. The other thing I will say is that it meets next on October the 18th, and we will be reviewing grants. In addition, I will call the other committees, I don't believe there's a lot of business to report, but we will defer to them, do we're doing Communications next.

MR. KORMAN: Hello, I'm John Korman, the Communications Committee met in April of '21 as well as this morning. Emergency

dispatchers are individuals who have the most responsibility, the very earliest in each and every case. Also EMS and the Committee reviewed and finalized telecommunicator CPR training standards, where PSAP's must provide training, in-telephone CPR to each dispatcher by January 1 of 2022. The spring cycle, as mentioned for RASF grants is open now, the EMV program for localities in Virginia is a priority funded item. Agencies who apply for electrical, I'm sorry, electronic radio equipment must provide an FCC license and this, or a memorandum of understanding, and this is verified by the Office of EMS on the FCC's website. VDEM, or Virginia Department of Emergency Management, their 911 Branch is transitioning PSAP's onto a next generation 911 platform. That means that more data will be received at the 911 Center when the 911 system is activated. That is dependent upon the agency and their equipment that is installed. The Virginia Office of EMS State Strategic Plan 2020 through 2022 supports accreditation for PSAP's, or Public Safety Answering Points operating with EMV standards, so the EMV accreditation is established by the Office of

EMS, is a voluntary compliance program for 911 centers in agencies that receive an RASF grant must, RASF grant for EMV protocols I should say, is required to apply for accreditation within one year of implementation. The Committee is reviewing and updating the EMV accreditation program for PSAP's, the desire is for PSAP's to file online through the EMS Portal for accreditation and reaccreditation. Lastly, the Code of Virginia states that by July 1 of 2024, each dispatcher of a PSAP shall have completed an EMV program that complies with standards set by the Office of EMS. The last thing I have regarding the Communications Committee is that the FCC has set agencies to set alerts through an emergency alert system, must be, those alerts must be accessible to persons with disabilities. And that's our report.

CHAIRPERSON: Thank you John. And we'll roll it to the Emergency Management Committee.

MR. SCHWALENBERG: Good afternoon, Thom Schwalenberg. The Emergency Management Committee did not meet this cycle.

CHAIRPERSON: All right, thank

you. Professional Development Coordinator, Jason Ferguson.

MR. FERGUSON: Thank you, Mr. Chair. As far as coordinator goes, that's our report there. I will do a report from TCC and TCC Trans-certification Committee met here on July 7th. We had a group update of the (XXX 1:28:26.4 17091) policy that's related to the remote learning for continuing education that will provide more flexibility for using that delivery methodology. Anticipating changes to the NEMSYS guidelines, we're also discussing specifically regarding EMT requirements for competencies, clinical, and field. So we will gather some data, there will be a survey from the Committee and some educators to solicit some feedback, and they will report on that by the next meeting. There was no other business, and no actionable items. The next meeting will be here on October the 6th, and Provider Health and Safety did not meet, and I will ask Valerie Quick to give her report for working groups.

VICE CHAIR QUICK: Good morning. We met on August 5th. We had no actionable items, however, we had a pretty robust

discussion, acknowledgement as a Committee, certainly as a Board, individual members and leaders about the impact of Covid has had to our recruitment and retention of providers in our area, and that was on top of an already stressed system. So one of the things that we had, it was certainly some of the training opportunities which we fed back to Jason Ferguson and support, also of other, of various initiatives to try to get training more accessible and more affordable to our community. We also brought back the EMS provider survey and EMS agency surveys. One of the things that is missing in the Commonwealth is a lack of really true understanding of what our demographics are in our system, there's nothing that's tied to individual certification that allows us to assess that. That's also going to broaden a little bit to be specific to providers as far as questions go on the amount of time that they spend at a primary job versus secondary jobs, and any plans in the future to either continue upon their career track in EMS, or to potentially leave that, so that we can properly address those. So that survey is going to go back to individual areas to make sure that we are

not duplicating any services in any other databases that are out there. We are also solidifying the agency survey that will hopefully be tied to the recertification or re-inspections of each agency. Last was just discussions of, or just awareness of where EMS Officer and Standards of Excellence classes that are out there, returning back in the fall with Symposium and various other things. There were no action items and we will determine later as to our next meeting.

CHAIRPERSON: All right, thank you for those of course. Patient Care Coordinator, Dr. Yee?

DR. YEE: I have no report as the Coordinator, I have confirmed that the Chairs of the Committee, which was taken from the Medical Direction Committee. The Committee met last month, I was unable to attend, so I discussed things with Dr. Lindbeck who was stepping in as Chair. We have no action items to present to the Board, but we have one awareness item, the Committee is working on a mechanism to identify critical care level medics, paramedics, so that will give the ability for billing for critical

care within Virginia. So we plan to bring that back to the GAB at our next meeting.

CHAIRPERSON: Medevac minutes, Tori Smith.

MS. SMITH: Good morning. The Medevac Committee met on June 29th and August 5th. On the 29th, we reviewed and revised some regulations. On the 5th, we discussed committee membership, with three vacant positions, Tim met with the Communications Committee this morning and we will have a representative by our next meeting. And we have no action items.

CHAIRPERSON: All right, thank you. EMS for Children, Dr. McLaughlin?

DR. MCLAUGHLIN: Hi, the EMSC for Children met on July 20th. Our only action item was briefly discussed earlier. But several awareness items you will find in front of you, most of you, if you can spread the word to enroll as the emergency care coordinator. Our goal is improving EMSC visibility, and that's going to be a running goal over the next twelve months. In order to do so, we need folks to be enrolled. And our twenty-four month goal is going to improve collaboration and creating efforts at

both the Symposium, although this year very limited, but thinking about running for next year. Thanks.

CHAIRPERSON: All right, thank you. Trauma System Coordinator, Dr. Abounatos?

DR. ABOUNATOS: Thank you Mr. Chair. We have only three of all committees have met, and three have not met. I will be presenting two of these and report, but I was going to ask if it was okay, to the Chair, that (XXX 1:33:51.7 19071) and responses report, then have to talk a little more extensively about that too.

UNKNOWN MALE SPEAKER: Is that okay?

CHAIRPERSON: Yes sir.

UNKNOWN MALE SPEAKER: Thank you.

UNKNOWN MALE SPEAKER: The Emergency Preparedness Subcommittee and the TAG met yesterday. We have no action items, but we do have a couple of information items for you. We spent some time on introspection about the role of the Committee and its membership, the way that the bylaws are structured for that particular subcommittee is that we do have term

limits and staggered terms, so we're going to have to work pretty closely with our membership to determine who is eligible to be reappointed, as most of the members do have their terms expire on December 31st.

We also, and I think Dr. Aboutanos will talk about this in a minute, we looked at some of our future priorities as it relates to the Committee and as it relates to the TAG Committee. And the role of this Committee, within the Trauma plan, as well as a review of some of the aspects of the report from the American College of Surgeons. And then the last thing we did was look at some of our priorities, and these include as we go forward, not necessarily exhaustive with this, but the role of the Transfer Centers in emergency preparedness, legal and ethical issues, trauma-related preparedness, such as Intella and HIPAA, those kind of things. Psychological first aid, or first aid for responders and providers.

And then, last but not least is the role of Telehealth, particularly within four components, pediatrics, burns, trauma, and highly infections diseases. So we'll be looking at the

State Telehealth plan that was recently submitted to see how we can re-interact with that. Plus, we're looking at a special project administered by the Department of Health Office of Emergency Preparedness later on that, providing corporations special capabilities that would be available to trauma centers and to the hospitals in disasters, for Telehealth applications specifically on a very emergent basis. So that would conclude my report, Dr. Aboutanos, unless you have something to add to it.

DR. ABOUTANOS: If you don't mind if I just correct one statement you have, it's a work committee, not a subcommittee that you have.

UNKNOWN MALE SPEAKER: Thank you.

DR. ABOUTANOS: It's just, it's an important point.

UNKNOWN MALE SPEAKER: Thank you.

DR. ABOUTANOS: Should I continue with the rest of the reports?

CHAIRPERSON: Yes sir.

DR. ABOUTANOS: Thank you. I will present the Acute Care Committee report, John cannot be here today, he was at, the committee met yesterday, so I'm giving a report on his

behalf. It was very active in discussion, and one action item from that committee.

The significant amount of work and discussion had with regard to the work of the Trauma Program managers, and the, we are looking at the Trauma Designation Manuals and make sure it will be online, and especially with all of the changes that happened about corrections that needs to happen, but most importantly also looking at a lot of the alignment with the American College of Surgeons, it's their verification. Not a significant number now of the trauma centers in Virginia are both American College of Surgeon verified and also State designated, especially at the Level 1 and now recently at the Level 2 status, so this is actually, it needs a lot of work in order to not have duplicate effort and in that way, so we are looking at the significant amount of work that's going out about program managers with regard to that. The Designation Manual is heavily based on the American College of Surgeons manual, I mean, that's what we use as a standard across the country with regard to this.

The action item is with result to

a specific discussion with regard to the ultimate pathway for a physician who was not, who are not Board eligible or Board certified. So that is a, it was a heavy discussion, but ongoing actually for, for a while with regard to this. Currently the American College of Surgeons have allowed physicians who are properly vetted in specific, pretty detailed criteria, that if they, for them to be able to serve on the Trauma panel, and respond to the trauma patient, and if they were approved they must go to the ultimate pathway. But we've had a discrepancy that came up both neurosurgery, orthopedic, and Trauma with (XXX 1:38:46.8 17091) the same.

You know, on the American Board of Surgeons I could actually approve this patient, this physician, but on the State I can't, so there was a little bit of a, so we noticed that when we first put the Designation Manual together we omitted that part. So, so the, there was a motion and we looked at it, and a motion to reintroduce the, to add the Designation Manual, the ultimate pathway for those physicians to be able to serve the patient and the Commonwealth. So basically aligning what already exists on the,

on those who are ASC certified. And so that was a, an action item coming out of that, of that committee to approve, and then have the action item on the modification, but an item that would not include the emergency physicians, since Dr. Amni just phoned up to me that doesn't actually exist on under the, the ASAP does not support that in the State.

The, so the motion is we need to ask to adopt into the criteria for the ultimate pathway for physicians who are not Board eligible, but who have provided specifically to you and you have the criteria in front of you, but I will summarize them very quickly. So the physician must have a (XXX 1:40:13.5 17091) from the Program Director attesting that the physician successfully completed the residency training program that is consistent with the U. S. training program. So he has to have exact similar training. Documentation of the resident status as a provider or instructor in an ATLS program, then you must have at least twelve hours getting done on the trauma-related EMS qualification, it's with CME's, and the documentation that the physician attend fifty

percent of the PI process and for, and that possible documentation of the membership attended some local, regional, and national trauma meetings, during the reporting year. And performance improvement assessment by the, by the trauma Medical Director of each center, demonstrating that the morbidity and mortality results on the patient treated by that physician compared favorably to the morbidity and mortality result of the other members of the Trauma Call Panel.

And finally, documentation that you have a Virginia license to practice medicine, and approval before the membership of the Surgical Committee, but the (XXX 1:41:17.7 17091) Committee. And so at least that's the process, we go through that currently, currently exists in Virginia for any, for any trauma center that has ultimate pathway, we have used it before. So the, the Acute Care Committee motion is to approve basically the same criteria that we have for, and this will apply for the general students, orthopedic, and the neurosurgeon, we will hold on the emergency motion.

CHAIRPERSON: All right, thank

you. So I have a motion for the Acute Care Committee, we do not need a second since it's coming from the Committee. So I will open the floor for questions and comments.

DR. O'SHEA: Hi, Jake O'Shea from the Hospital Association, I represent. The requirement for the letter from the Program Director, is that from ACS as well?

DR. ABOUTANOS: Yes it is. Sorry, not to the, but we have vetted this, we looked at it again. We actually used the exact same thing except removed the American College of Surgeons and put the Office of EMS instead, that's the only modification.

DR. O'SHEA: I asked already because we wanted John to get some of those dates and verifying people who have trained outside of the country is getting that verification back from their residency program? So but if it's a ways, yes, and we'll support that.

DR. ABOUTANOS: Yes, and it actually just gives more freedom, it's not coming from a, yeah that could be possible if they truly believe this, this person serves them well, that would work. To give an example, we currently

have a physician who was trained at the American University of Beirut, Lebanon, who had the exact residency as our residency, and he had entered the State because all the, that's what his, his U. S. there and who just finished an acute care fellowship with us. And she's going to be employed as a general surgeon with us at the hospital, but cannot do the trauma care, even though she's far more qualified than anybody else that we would have for that, so if you think of the average physician much, an average patient in Virginia comes to our center at least, I as a primary co-director would much rather have her take care of this patient than someone else. And so the College recognized that across the country and they closed that loophole, but the both have significant emphasis on the local hospital to demonstrate that this person has met all these criteria.

MR. KENT: Terry Kent, so Michael, this would be clear, you're omitting the emergency physician column there?

DR. ABOUTANOS: Yes, because the column would check with ASAP they're not, they didn't want to look at this. They currently,

there is no, they don't approve any, any non-Boarded or non-eligible emergency physicians from, but I (XXX 1:43:57.7 17091) after that.

UNKNOWN MALE SPEAKER: Yeah, speaking with the ASAP leadership there was some concern when the document was written, we're happy to take a look at it, but as of right now we oppose the document. We don't believe that this is an actual problem in the Level 1 and likely Level 2 trauma centers. We are unclear whether how many non-U.S. trained docs are working at Level 3 trauma centers. So this, yes, so we will be happy to discuss further, about the trauma columns.

DR. LINDBECK: Yeah, that was my question is, what need does this reflect? Because I mean I'm in most of the trauma centers the last few years, and I can't remember this situation coming up. Certainly from an emergency medicine point of view, we would not be able to credential somebody that was not Board-eligible in the ADM. I can't speak to the other specialties so much, but you know, we look at licensure and Board certification as filters that reflect a lot of these issues, and you pass

through those filters, licensure, Board certification, and it is an assurance, if you will, of at least a minimum amount of training and qualifications to require this.

DR. ABOUTANOS: Yeah I mean this, this, that's why I took it off the table here but across the country, all trauma centers that are ACS verified have this statement in there for ED. And so this is a restriction that you, that if the Virginia it said does not want to have, it's your own decision. But it does not, it gives a lot of the, the other trauma centers, and it just gives them more freedom to say this person is excellent, and do you want to hire them? But they have to prove, that's what I, those steps are not easy steps, you got to go through all the steps before you prove that this person, I mean that are compared to everybody else, you're the, you would, the entire network and there in that person's record, it's a lot of work. So this is only used rarely, it just will close a loop in the system and we wanted to close it. That's the main, it's not something that, we don't go around recommending that we should have this, and so this is just, it's an ultimate pathway whenever a

situation like this arise, because most of them it doesn't arise, only arose recently the trauma center in Virginia, they have three times the amount of that, for them at the emergency columns.

CHAIRPERSON: Other questions or comments?

UNKNOWN FEMALE SPEAKER: So just to clarify, it's just in the first three that you're asking about?

DR. ABOUTANOS: Yes.

CHAIRPERSON: All right, hearing no other comments, we have a motion before you from the Acute Care Committee. All in favor of the motion, signify by saying aye.

ATTENDEES: Aye.

CHAIRPERSON: Any opposed, say nay.

ATTENDEES: (No audible response.)

CHAIRPERSON: Okay, the motion carries.

DR. ABOUTANOS: Okay, thank you. That to the report of the Acute Care Committee, now that the Board for the TAG Committee, we also met yesterday. There were a lot of discussion

mainly concentrated on completing a specific item. One with regard to, and this is in general, and I'm sure discussed with other committees, the ability to fully address the virtual, I know this is something that's everybody's looking at. At least for the work of the committee, while if not for the quarterly meeting, and everybody can understand the need for, and of the importance of being face to face, but the flexibility of working in virtual in between has, we believe, strongly benefit the health of the trauma system, we have to go forward with this, I mean, this is what was while we were having discussion, and appreciate Gary noting that this is something that we should be take, a different (XXX 1:47:56.8 17091) for us to address that, and that citizens need to push for that legislative (XXX 1:48:01.3 17091).

The other focus was with regard to the Trauma Fund, and there was a lot of discussion that we have not in the past two years tried significantly to impact the dwindling fund that's in the Trauma Fund really, and change the other station at the General Assembly. We had a significant effort doing this, the past General

Assembly, as you know both for trauma center sending hundreds of, of letters stating the, why the General, why the Trauma Fund should be supported, but we were not successful. So this is now three in a row and we see this as a, just a downward trend that's going to have a significant impact. So we have asked the Office of EMS for their, for their help put together a specific work group to, with the various stakeholders to look specifically at the, at our ability to readdress how we going to negotiate this, and what's the best way to find a solution for the trauma fund and how to approach the legislators, approach so that we could have a different outcome. So we truly appreciate the Office of EMS's help with regard to this.

The third thing that was discussed, it has been now more than five years, almost six years since the American College of Surgeons did their State visits, and made the report for the (XXX 1:49:33.8 17091) of the trauma systems in Virginia that resulted in 2018 for trauma system plan. The Committee felt that it is time for us to stop now and see what have we done since that happened, should that be

thorough review and that would be the charge for every committee now in the trauma system to look at the trauma system then and find out why, what have we, what have we done and what has changed, and to prioritize what we need to do to move forward. The last discussion was an important discussion that Gary also alluded to, is the fact that we still have currently a significant discrepancy between two bylaws that oppose each other and this Committee at the, at the Advisory Board, that this needs to be reconciled.

So as you just saw Morris Sweet is the Committee Chair, yet he is not a member of this Board, and so it is, it's an issue, we currently have six positions, six Committee Chairs who cannot sit on this Board, cannot vote, cannot influence on the trauma systems that should advise the Governor and that the work of, and from that part except through one vote, which is mine to push forward. And so we have, I know you have addressed this before. The trauma system plan had been approved by this Committee to move forward, and, and there was a, obviously that structure whether you add the six additional positions or whether you change the structure of

the Board, the trauma system may have not jumped into that part because it was the work of this Committee to look at. We simply said we have this, these six position that should be part of the Advisory Council. Those positions were specifically made, as you all know, to address a system level, someone addresses the P&J, someone addresses the injury prevention, someone addresses lead hospitals in acute and post-acute, but they're not based on a, on a professional level where this is as physician plan at least be on a functional level that the system would be, and that's why we believe will serve significantly this Committee.

So that was a report. I, I was, when I was thinking about giving this report to the Committee, whether I could actually have a motion, it's not coming out of me, its coming out me personally right now, but this is not put as a motion in the Committee, and a motion that we will readdress the Board restructure in order to address and discuss, between the two separate bylaws.

CHAIRPERSON: Okay, we can move forward with a motion, or between now and the

next meeting I can get together with the Executive Committee and staff and address it and come back with a report.

DR. ABOUTANOS: Thank you.

CHAIRPERSON: Okay. All right, anything else?

DR. ABOUTANOS: No, thank you.

CHAIRPERSON: All right, thank you very much. Next, we have Regional EMS Council Executive Director's report, Greg Woods?

MR. WOODS: Thank you, Mr. Chairman. The Regional Director's group has been meeting with the Office of EMS, both the Executive Directors and volunteer leadership of our organizations. Since Covid on a weekly basis we transitioned into biweekly meetings and in July we transitioned to now monthly meetings with OEMS. Our last meeting was on July the 16th and we will meet again on August the 20th. We have even working collaboratively with OEMS on a number of state-wide projects, including the ESO rollout, and there are other partnerships in development between individual EMS councils and the Office of EMS in various stages.

We do have some upcoming

activities, one of which will be a re-designation of EMS councils whose applications will be submitted this year, and along with that we are looking at our contract with OEMS to insure that it is efficient and that it meets the needs of our EMS system. Later this year, our regional group will also elect new officers. And I do want to take just a moment as the Director of the Southwest EMS Council and to echo J. C.'s words over the last couple for years, we've been looking very closely at our organization structure, with a focus on how do we improve efficiency and best meet the needs of our constituents in Southwest Virginia. So, our Board has voted with the intent of becoming a hybrid office with the Office of EMS, and so we looked very forward to the new opportunities that that will create for our providers and our regional council as a whole. I will be happy to answer any questions that you might have at this time.

ATTENDEES: (No audible response.)

MR. WOODS: Hearing none, thank you very much for your time.

CHAIRPERSON: All right, thank you

very much. At this time I will open up the public comment period. Does anybody from the public have anything they would like to address to the Board?

ATTENDEES: (No audible response.)

CHAIRPERSON: Okay, hearing none, we will close the public comment period. I will now move to tender this to the Board.

DR. O'SHEA: Mr. Chair, Jake O'Shea with the VHHA. At the prior board meeting of the EMS Advisory Board passed a motion endorsing vaccination of EMS providers. As we have watched the Delta variant rising across the country, seeing, we began to see a spike in cases in hospitalizations here in Virginia, and recognizing that we're now back under guidance from the CDC to be masked in public in areas of high substantial transmission, which would include much of, much of Virginia at this point. I was just wondering if the Office of EMS could update us on some talk about different communication that is to encourage vaccination of EMS providers, and I just wondered if they could give us an update on what has been done and what could still be done to, you know, to really make

a second push as we see this, and we have heard the term a few times, truly becoming a pandemic of the unvaccinated, but also recognizing that we are starting to see a few more breakthrough infections that, in people who have been fully vaccinated, as well as in some cases for people who are immunocompromised, that those breakthrough infections can become severe. But fortunately for the vast majority of the public, we're not seeing those severe infections for those who are vaccinated at this time.

CHAIRPERSON: All right, thank you Dr. O'Shea. So Gary if you want to direct that to Michael's staff?

MR. BROWN: Well, I will say that, I can't say that we've had a really concerted marketing campaign or anything like that, but we have used opportunities like EMS Week and other avenues to encourage vaccination of EMS providers, with statements from myself and I actually think possibly from the Commissioner that was included in that, those meetings of ours. But with that I will turn to Scott or Adam, or Dr. Lindbeck if there's anything that I'm missing.

UNKNOWN MALE SPEAKER: Yeah, Gary too echoed that and I was just confirming that they are still there. We have numerous resources on our website from Gary, but the message that Gary speaks of that includes comments from the Commissioner to specific education, I see one on here that was presented by Dr. Brooke Rosenheim, a public health physician specialist with VDH's testing team that provided specific guidance to EMS providers as well as obviously any opportunity we have to encourage EMS providers to get vaccinated.

MR. BROWN: Thank you very much, I appreciate it. I just, I think, you know, now more than ever we should make a second push on this and really put this pandemic to bed hopefully.

CHAIRPERSON: Do we have unfinished business?

ATTENDEES: (No audible response.)

CHAIRPERSON: All right, new business? Anybody have any?

ATTENDEES: (No audible response.)

CHAIRPERSON: All right, there are none. Our next meeting we are going to be

shooting for November the 12th and at this time we will adjourn the meeting. Thank you for attending.

(WHEREUPON, the Meeting was concluded at 11:58 a.m.)

CAPTION

The foregoing matter was taken on the date, and at the time and place set out on the title page hereof.

It was requested that the matter be transcribed from an audio recording and that the same be reduced to typewritten form.

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I, **JANET ENGLE**, do hereby certify that the forgoing matter was transcribed verbatim from an audio recording provided to me, that the transcript prepared by me or under my direction, is a true and accurate record of same to the best of my knowledge and ability; that there is no relation nor employment by any attorney or counsel employed by the parties hereto, nor financial or otherwise interest in the action filed or its outcome.

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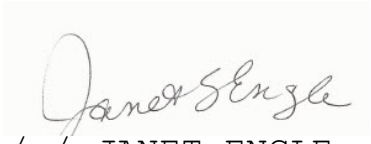
IN WITNESS HEREOF, I have here unto set my hand this 22ND day of OCTOBER, 2021.



/s/ JANET ENGLE

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