

VIRGINIA DEPARTMENT OF HEALTH ADVISORY BOARD

MEETING

AUDIO TRANSCRIPTION

FRIDAY, AUGUST 6, 2021

DRAFT

APPEARANCES

1
2 COMMITTEE CHAIRPERSON
3 VICE CHAIR VALERIE QUICK
4 GARY BROWN, OFFICE OF EMS, DIRECTOR
5 DEPUTY COMMISSIONER BOB HICKS
6 KEVIN DILLARD, RAPPAHANNOCK EMS COUNCIL
7 J.C. BOLLING, SOUTHWEST VIRGINIA EMS COUNCIL
8 MARY KATHRYN ALLEN, BLUE RIDGE EMS COUNCIL
9 AMANDA LORETI, CENTRAL SHENANDOAH EMS COUNCIL
10 LARRY BIRD, CENTRAL SHENANDOAH EMS COUNCIL
11 DR. GEORGE LINDBECK, OFFICE OF EMS, STATE EMS
12 MEDICAL DIRECTOR
13 ADAM HARRELL, OFFICE OF EMS ASSOCIATE DIRECTOR
14 GARY SAMUELS, VIRGINIA PROFESSIONAL FIREFIGHTERS
15 DR. MICHAEL ABOUTANOS, AMERICAN COLLEGE OF
16 SURGEONS, TRAUMA SYSTEM COORINATOR FOR STATE
17 EMS ADVISORY BOARD EXECUTIVE COMMITTEE
18 DR. ALLEN YEE, VIRGINIA COLLEGE OF EMERGENCY
19 PHYSICIANS, PATIENT CARE COODINATOR FOR STATE
20 EMS ADVISORY BOARD EXECUTIVE COMMITTEE
21 DR. JEREMIAH O'SHEA, VHHA REPRESENTATIVE
22 KRYSTAL SANDERS, ASSISTANT ATTORNEY GENERAL
23 JON HENSCHER, ADMINISTRATIVE COORDINATOR, OFFICE
24 OF EMS RULES AND REGULATIONS COMMITTEE
25 JIMMY BURCH, OFFICE OF EMS

1 JOHN KORMAN, ASSOCIATION OF PUBLIC SAFETY
2 COMMUNICATIONS OFFICIALS (APCO), VIRGINIA
3 CHAPTER, OFFICE OF EMS COMMUNICATIONS
4 COMMITTEE
5 THOMAS SCHWALENBERG, EMS ADVISORY BOARD,
6 EMERGENCY MANAGEMENT COMMITTEE
7 DR. JASON FERGUSON, EMS ADVISORY BOARD, TRAINING
8 AND CERTIFICATION COMMITTEE
9 VICTORIA "TORI" SMITH, VIRGINIA EMERGENCY NURSES
10 ASSOCIATION/VIRGINIA NURSES ASSOCIATION,
11 OFFICE OF EMS MEDEVAC COMMITTEE
12 DR. PATRICK M. MCLAUGHLIN, AMERICAN ACADEMY OF
13 PEDIATRICS, OFFICE OF EMS EMS FOR CHILDREN
14 COMMITTEE
15 GREG WOODS, REGIONAL EMS COUNCIL
16
17

18 **PRESENTERS**

19 MIKE COURT
20 ALEX DEE
21 CHRIS FRENCH
22 DR. BRENT MYERS
23
24
25

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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

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

7 **(WHEREUPON, applause.)**

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

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

4 **MR. BROWN:** Ten.

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

12 **MR. BROWN:** Thank you.

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

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

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

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

1 (XXX 3:02.5 17091), you know, I've been around a
2 long time, I'm in my fiftieth year, so. But the
3 good thing was that most of it was in the local
4 health departments for about thirteen years,
5 which I think has taught me a lot about how the
6 Central Office should operate. But the local
7 government and you all, I mean you know things
8 get done, and you know, the teams, we've got to
9 get together to get things done. Over the last
10 year and a half obviously you all have played a
11 great role in helping us fight this pandemic, and
12 yeah, I want to really thank you all for that. I
13 think it has opened our eyes to things that have
14 worked well, but more importantly those things
15 that didn't work well, and how can we do better
16 to reduce those things. And so already worked
17 with Gary's and trying to increase the (XXX
18 3:51.0 17091) from across the agency to where we
19 (XXX 3:51.8 17091), so thank you for allowing me
20 to be with you guys.

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

25 **MR. BROWN:** Thanks. Thank you,

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

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

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

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

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

13 **(WHEREUPON, technical matters were handled.)**

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

16 **UNKNOWN FEMALE SPEAKER:** That's
17 okay.

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

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

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

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

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

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

14 **MR. BROWN:** Okay.

15 **MS. ALLEN:** It's just me.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 **MR. BROWN:** Okay, all right.
17 George?

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

21 **(WHEREUPON, simultaneous speaking.)**

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

25 **MR. BROWN:** Okay, with that,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 **MR. COURT:** I just want to add to

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

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

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

25 **MR. COURT:** Because change is hard

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

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

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

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

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

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

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

24 **MR. COURT:** Thank you, Adam.

25 Additionally in our communications plan we do

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

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

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

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

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

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

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

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

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

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

20 **MR. COURT:** Absolutely, certainly.

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

24 **ATTENDEES:** (No audible response.)

25 **CHAIRPERSON:** If not, I will

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

3 **MR. COURT:** Thank you all.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 So again, because the Commonwealth

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

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

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

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

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

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

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

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

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

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

6 One other report I will show, just
7 really quickly before we want to show you what it
8 looks like from an EMS provider perspective.

9 These are some of our clinical reports. So these
10 are reports again, as working with hospitals that
11 we have heard are important as we are looking at
12 core measures and different timings of EMS care
13 coming into your facility, but one of the ones we
14 will show is our time to STEMI alert. So again,
15 we're taking the data coming out of the EMS
16 records, we're providing that up into this
17 report, so now you can really go see how is the
18 performance, you know, going in the field with
19 those providers. And it will take a minute here
20 because we got quite a bit of data in our demo
21 environment, but as it comes up all of these
22 reports will give you kind of an idea of what it
23 is pulling in, so there is an information button
24 in the upper right hand corner to clearly show
25 you what that is.

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

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

1 back in.

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

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

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

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

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

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

11 **MR. FRENCH:** Yes.

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

18 **UNKNOWN FEMALE SPEAKER:** I have a
19 question.

20 **DR. MYERS:** Yes, please.

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

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

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

18 **UNKNOWN FEMALE SPEAKER:** Thank
19 you.

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

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

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

3 **MR. FRENCH:** I don't have anything
4 else.

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

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

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

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

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

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

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

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

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

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

5 **DR. YEE:** Second.

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

17 **DR. ABOUTANOS:** Can I ask a
18 question, can I ask a question before that?
19 Which hospital in Virginia has automated (XXX
20 1:09:10.5 17091) the ESO?

21 **VICE CHAIR QUICK:** Very few.

22 **UNKNOWN MALE SPEAKER:** Yeah.

23 **UNKNOWN MALE SPEAKER:** Yeah. So
24 that answers your question quickly, so (XXX
25 1:09:21.1 17091) just using, using an example.

1 So yes or they, has it...

2 **(WHEREUPON, simultaneous speaking.)**

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

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

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

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

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

16 **CHAIRPERSON:** Yes.

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

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

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

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

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

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

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

1 approach it from a State level, we (XXX 1:13:49.0
2 17091). So that was, that was one effort. We,
3 we received a lot of interest and input from
4 hospitals and, not all of them, but quite a few,
5 and to this point it has been solely based on the
6 hospitals reaching out. From the support aspect
7 of this project, it would be at that point that
8 we would go out and actively start pursuing
9 hospitals to say this is, this is something that
10 is now offered, these are, you know, what is
11 covered, this is what's not, this is a benefit,
12 you know, are you interested, what can we do to
13 help you? And then of course we would approach
14 this as we have done in current projects with the
15 phased approach, not trying to, you know, again
16 eat the elephant all at one time, we're going to
17 take it in phases. ESO already has relationships
18 and agreements and input from, I believe you
19 mentioned HCA and Mercy Bon Secours.

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

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

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

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

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

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

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

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

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

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

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

18 **ATTENDEES:** (No audible response.)

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

23 **ATTENDEES:** Aye.

24 **CHAIRPERSON:** All opposed, say
25 nay.

1 **ATTENDEES:** (No audible response.)

2 **CHAIRPERSON:** The motion carries.

3 Thank you gentlemen for your presentation...

4 **DR. HARRELL:** Thank you.

5 **CHAIRPERSON:** ... and your

6 presence here today.

7 **DR. HARRELL:** Thank you.

8 **MR. FRENCH:** Thank you.

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

11 **CHAIRPERSON:** Adam, do we have
12 anything else?

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

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

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

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

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

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

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

18 **UNKNOWN MALE SPEAKER:** So moved.

19 **CHAIRPERSON:** All right.

20 **UNKNOWN MALE SPEAKER:** Second.

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

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

1 **CHAIRPERSON:** Okay.

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

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

13 **(WHEREUPON, Simultaneous speaking.)**

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

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

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

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

9 **CHAIRPERSON:** All right, anything
10 else?

11 **ATTENDEES:** (No audible response.)

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

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

25 **CHAIRPERSON:** All right, thank

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

12 **MR. HENSCHEL:** There's no report
13 from the Administrative Coordinator's Office on
14 Committee Chairs. Rules and Regs met on July
15 7th, we did meet, we had a good dialogue, a lot
16 of discussion about some things received from the
17 Committee as we looked at Chapter 32. We do
18 intend to review the material and bring that back
19 to us so we can have an action item for the Board
20 at the following meeting will be in
21 January/February for now.

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

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

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

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

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

1 dispatchers are individuals who have the most
2 responsibility, the very earliest in each and
3 every case. Also EMS and the Committee reviewed
4 and finalized telecommunicator CPR training
5 standards, where PSAP's must provide training,
6 in-telephone CPR to each dispatcher by January 1
7 of 2022. The spring cycle, as mentioned for RASF
8 grants is open now, the EMV program for
9 localities in Virginia is a priority funded item.
10 Agencies who apply for electrical, I'm sorry,
11 electronic radio equipment must provide an FCC
12 license and this, or a memorandum of
13 understanding, and this is verified by the Office
14 of EMS on the FCC's website. VDEM, or Virginia
15 Department of Emergency Management, their 911
16 Branch is transitioning PSAP's onto a next
17 generation 911 platform. That means that more
18 data will be received at the 911 Center when the
19 911 system is activated. That is dependent upon
20 the agency and their equipment that is installed.
21 The Virginia Office of EMS State Strategic Plan
22 2020 through 2022 supports accreditation for
23 PSAP's, or Public Safety Answering Points
24 operating with EMV standards, so the EMV
25 accreditation is established by the Office of

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

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

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

25 **CHAIRPERSON:** All right, thank

1 you. Professional Development Coordinator, Jason
2 Ferguson.

3 **MR. FERGUSON:** Thank you, Mr.
4 Chair. As far as coordinator goes, that's our
5 report there. I will do a report from TCC and
6 TCC Trans-certification Committee met here on
7 July 7th. We had a group update of the (XXX
8 1:28:26.4 17091) policy that's related to the
9 remote learning for continuing education that
10 will provide more flexibility for using that
11 delivery methodology. Anticipating changes to
12 the NEMSIS guidelines, we're also discussing
13 specifically regarding EMT requirements for
14 competencies, clinical, and field. So we will
15 gather some data, there will be a survey from the
16 Committee and some educators to solicit some
17 feedback, and they will report on that by the
18 next meeting. There was no other business, and
19 no actionable items. The next meeting will be
20 here on October the 6th, and Provider Health and
21 Safety did not meet, and I will ask Valerie Quick
22 to give her report for working groups.

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

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

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

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

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

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

3 **CHAIRPERSON:** Medevac minutes,
4 Tori Smith.

5 **MS. SMITH:** Good morning. The
6 Medevac Committee met on June 29th and August
7 5th. On the 29th, we reviewed and revised some
8 regulations. On the 5th, we discussed committee
9 membership, with three vacant positions, Tim met
10 with the Communications Committee this morning
11 and we will have a representative by our next
12 meeting. And we have no action items.

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

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

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

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

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

14 **UNKNOWN MALE SPEAKER:** Is that
15 okay?

16 **CHAIRPERSON:** Yes sir.

17 **UNKNOWN MALE SPEAKER:** Thank you.

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

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

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

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

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

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

15 **UNKNOWN MALE SPEAKER:** Thank you.

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

18 **UNKNOWN MALE SPEAKER:** Thank you.

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

21 **CHAIRPERSON:** Yes sir.

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

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

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

25 The action item is with result to

1 a specific discussion with regard to the ultimate
2 pathway for a physician who was not, who are not
3 Board eligible or Board certified. So that is a,
4 it was a heavy discussion, but ongoing actually
5 for, for a while with regard to this. Currently
6 the American College of Surgeons have allowed
7 physicians who are properly vetted in specific,
8 pretty detailed criteria, that if they, for them
9 to be able to serve on the Trauma panel, and
10 respond to the trauma patient, and if they were
11 approved they must go to the ultimate pathway.
12 But we've had a discrepancy that came up both
13 neurosurgery, orthopedic, and Trauma with (XXX
14 1:38:46.8 17091) the same.

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

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

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

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

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

25 **CHAIRPERSON:** All right, thank

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 **CHAIRPERSON:** Other questions or
7 comments?

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

11 **DR. ABOUTANOS:** Yes.

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

16 **ATTENDEES:** Aye.

17 **CHAIRPERSON:** Any opposed, say
18 nay.

19 **ATTENDEES:** (No audible response.)

20 **CHAIRPERSON:** Okay, the motion
21 carries.

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

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

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

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

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

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

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

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

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

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

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

4 **DR. ABOUTANOS:** Thank you.

5 **CHAIRPERSON:** Okay. All right,
6 anything else?

7 **DR. ABOUTANOS:** No, thank you.

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

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

25 We do have some upcoming

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

22 **ATTENDEES:** (No audible response.)

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

25 **CHAIRPERSON:** All right, thank you

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

5 **ATTENDEES:** (No audible response.)

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

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

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

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

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

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

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

18 **CHAIRPERSON:** Do we have
19 unfinished business?

20 **ATTENDEES:** (No audible response.)

21 **CHAIRPERSON:** All right, new
22 business? Anybody have any?

23 **ATTENDEES:** (No audible response.)

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

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

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

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DRAFT

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

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6 It was requested that the matter be transcribed from
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15 IN WITNESS HEREOF, I have here unto set my hand
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20 
21 /s/ JANET ENGLE

22 TRANSCRIBER
23
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