VIRGINIA DEPARTMENT OF HEALTH
STATE EMS ADVISORY BOARD MEETING

FRIDAY, AUGUST 02, 2019
1:04 P.M.

EMBASSY SUITES BY HILTON RICHMOND
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RICHMOND, VIRGINIA 23294

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ON BEHALF OF THE VIRGINIA DEPARTMENT OF HEALTH:

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CHRIS PARKER, CHAIR
EDDIE FERGUSON
PARHAM JABERI, M.D.
GARY R. BROWN, DIRECTOR
SCOTT WINSTON, ASSISTANT DIRECTOR
GEORGE LINDBECK, M.D.
AMANDA LAVIN
GARY CRITZER
KEVIN DILLARD
JON HENSCHEL
GARY SAMUELS
DREAMA CHANDLER
JOHN KORMAN
TOM SCHWALENBERG

BOARD:

JASON FERGUSON

VALERIE QUICK

LORI KNOWLES

ALLEN YEE, M.D.

SAMUEL BARTLE, M.D.

MICHEL ABOUTANOS, M.D.

SHAWN SAFFORD

KAREN SHIPMAN

MIKE WATKINS

FEFF YOUNG, M.D.

MARGARET GRITTEN, M.D.

MARK DAY

GREY WOODS

William Ferguson

SPEAKERS:

CHRISTOPHER L. PARKER - CHAIR - VIRGINIA EMERGENCY NURSES

DILLARD E. FERGUSON JR. - VIRGINIA STATE FIREFIGHTERS ASSOCIATION

PARHAM JABERI, MD, MPT - CHIEF DEPUTY COMMISSIONER

GARY R. BROWN - DIRECTOR

CAM CRITTENDEN

ADAM HARRELL

SPEAKERS:

VINCENT VALERIANO

KAREN OWENS

GEORGE LINDBECK MD - STATE EMS MEDICAL DIRECTOR AND OEMS STAFF

AMANDA LAVIN - ASSISTANT ATTORNEY GENERAL

KEVIN DILLARD

JONATHAN HENSCHEL

GARY SAMUELS - VIRGINIA FIREFIGHTERS/IAFF

DREAMA CHANDLER - VIRGINIA ASSOCIATION OF VOLUNTEER RESCUE SQUAD

THOMAS E. SCHWALENBERG

R. JASON FERGUSON - BLUE RIDGE EMS COUNCIL

VALERIE QUICK - THOMAS JEFFERSON EMS COUNCIL

LORI KNOWLES - RAPPAHANNOCK EMS COUNCIL

ALLEN YEE - MD, FAAEM - VIRGINIA COLLEGE OF EMERGENCY PHYSICIANS

JASON D. FERGUSON - WESTERN VIRGINIA EMS COUNCIL

SAMUEL BARTLE - AMERICAN ACADEMY OF PEDATRICS

MICHEL ABOUTANOS MD - AMERICAN COLLEGE OF SURGEONS

DR. SHAWN STAFFORD

MIKE WATKINS

JEFF YOUNG

TIM ERSKINE

SPEAKERS:

KELLY PARKER

GREG WOODS

GARY W. TANNER - VIRGINIA ASSOCOCIATION OF COUNTIES

BETH ADAMS - NORTHERN VIRGINIA EMS COUNCIL

ED RHOADES

WALTER N/L/N

VALETA C. DANIELS - VIRGINIA ASSISTANT OF VOLUNTEER RESCUE SQUADS

CHAD BLOSSER

DILLARD E. FERGUSON - VIRGINIA STATE FIREFIGHTERS ASSOCIATION

HEIDI N/L/N

JOHN C. BOLLING - SW VIRGINIA EMS COUNCIL

VIRGINIA DEPARTMENT OF HEALTH

STATE EMS ADVISORY BOARD MEETING

FRIDAY, AUGUST 2, 2019

1:04 P.M.

MR. PARKER: I'd like to take a moment and welcome everyone to the August 2nd EMS Advisory Board quarterly meeting. The agenda is before, should be before most of you. I know we're running a little tight on seats. The staff is working to bring more seats in. First we'd like to stand for the Pledge of Allegiance. The flag is located in this direction.

(WHEREUPON, the Pledge of Allegiance was recited.)

MR. PARKER: Please remain standing for a moment of silence for those public safety members who have lost their lives since our last meeting. I ask that you keep Dr. Melton and his family as well as the entire healthcare community in your thoughts.

(WHEREUPON, a moment of silence was observed.)

MR. PARKER: Thank you. You may be seated. The first item up is the approval of the May 3rd meeting minutes. The minutes were distributed as well as posted on the town hall.

A motion to approve the minutes?

BOARD MEMBER: I submit.

MR. PARKER: Second?

(WHEREUPON, the motion was seconded.)

MR. PARKER: All in favor?

(WHEREUPON, the board members voted in the affirmative.)

MR. PARKER: Motion passed. You have before you the agenda. I need a motion to approve the agenda.

(WHEREUPON, the motion was approved.)

MR. PARKER: So moved. Second?

BOARD MEMBERS: Second.

MR. PARKER: All in favor?

(WHEREUPON, the board members voted in the affirmative.)

MR. PARKER: Agenda is approved. Chairman's report. And I apologize for this being a little lengthy, and I want to start off this meeting by reading a few statements from the EMS Agenda 2050. "More than 20 years ago, Emergency Medical Services pioneers and leaders described a vision of data-driven and evidence-based systems in the EMS Agenda for the Future. Since then, the profession has worked tirelessly

to fulfill the vision set out in that landmark document. When tasked with creating a vision for the future of the Emergency Medical Services in the United States, the charge was clear: to create a bold vision for EMS and the people we serve. A people-centered EMS system includes processes, protocols, technology, policies and practices designed to provide the best possible outcome for individuals and communities. The people-centered EMS system serves as the front line of a region's healthcare system and plays a core role in supporting the well-being of a community residents and visitors through data-driven, evidence-based and safe approaches to prevention, response and clinical care. EMS organizations collaborate with their community partners and have access to the resources they need, including up-to-date technology and a highly trained, heathy workforce." Many of you are aware, although some may not be, the system we have here in Virginia was founded mostly on the hills of this historical document of twenty years ago. As we move into this new era of EMS, one thing remains clear: Virginia stands on the forefront of being both innovate and

collaborative in our approach to Emergency Medical Services in this state. I would like to personally thank Gary and all of the office of EMS staff for pushing and oftentimes hurling, sometimes kicking and screaming, Virginia forward to remain ahead of most of the country. As prescribed in Code of Virginia, the purpose of the EMS Advisory Board is in advising the Board of Health by way of the Office of EMS on the following. The administration of the statewide Emergency Medical Services system, the Emergency Medical Services vehicles maintained and operated to provide transportation to persons requiring emergency medical treatment, and for reviewing and making recommendations on the statewide Emergency Medical Services plan. Furthermore, the EMS Advisory Board is charged to review reports on the status of all aspects of the statewide Emergency Medical Services system to determine what is in the best interest of the patients of which we serve within this great Commonwealth. With that in mind, it is imperative that we reflect and look forward and also inward to determine if we are where we should be for the future of the EMS system in

Virginia. I also want to note that we will be following the Board of Health procedures for public comment during this meeting. Those coming before the board are reminded that they will have three minutes to address the board. The board does not have to respond to public comment. And this concludes my report. Next up is the vice chair report, Eddie Ferguson.

MR. FERGUSON: Thank you, Mr. Chairman. I don't have a report at this time.

MR. PARKER: Thank you. Chief Deputy Commissioner Dr. Jaberi?

DR. JABERI: Thank you, Mr. Chair. It's a pleasure to be here. In your opening remarks, you mentioned Dr. Melton's name and I just wanted to, for those who aren't aware, just to share some messages and some information that we heard this morning. For those that don't know him, Dr. Sam Hughes Melton is a long-time physician leader and has assumed many, many different roles with the state. Previously he was in this role, the chief deputy commissioner for Virginia Department of Health, and most currently had been serving as the commissioner for the Department of Behavioral Health and

Developmental Services. We were informed that he was in a motor vehicle crash on Wednesday afternoon and was transported to UVA where he sustained very serious injuries. This morning it was reported at the commissioner's office that it does not seem that he will be able to surmount those injuries today. So again, we'd like to just certainly acknowledge him. I know there will be a lot more information coming from the governor's office, from the commissioner's office and certainly the secretary of health with regards to this event, and again we ask that you keep his family in your thoughts and prayers in this difficult time. He has touched the lives of many folks at VDH and I'm sure many of you here in this community, and his loss will be felt throughout Virginia. So again, I'm sorry to share that news with you, but thank you for the acknowledgement, Mr. Chair. The report I guess that I want to just simply share is a follow-up of some conversation, impromptu to some extent. We knew that we'd have a number of stakeholders here in this quarterly meeting gathered here in Richmond, and some questions and concerns and some paths for future strategic planning as it

relates to the relationship between the Office of EMS and our EMS councils across the state. So we've had certain discussions recently about offering additional assistance to the councils in providing some staff support, some FTEs where we would be able to better help and coordinate the administrative duties that falls upon many of our councils. Really, for the sake of efficiency, for the sake of where things like such as procurement where we could use the assets and resources of the state to be able to purchase equipment or items at a reduced rate, for a number of reasons, our Office of EMS had been again approached for some support, and I'll ask Mr. Brown to expand upon those. At the same time, we had also been asked by some stakeholders about the communications and the relationship had between the Office of EMS and our councils. We realize that we're a regulatory agency, we're contracting out to the councils, and some of the discussions that are sometimes had about the deliverables of what is expected and what we hope to achieve can require some revisiting, and really looking at how those questions and those demands or those asks are had of the councils and

what we could do to ensure that the communication between the office and the councils continues so that we can maintain our coordinated and collaborative system as we go forth. So we have an issue of staffing the councils and issue regarding communications. And then as many of you know, I took this position on ten months ago and in recent months had been working with the Office of EMS leadership to learn a little bit more about the impact the councils have had across the state, and I've come to realize, as many of you know, there have been multiple iterative processes, one approximately every ten years, to look at how we can improve service delivery across the state. We realize that the councils are an extension of the office, are able to help us implement and coordinate much of the work that the office is charged to do by code in the system. They're the ones that know the partners and they bring many of the critical stakeholders together, and that effort is not just unique to OEMS. That is exactly how we do our work and other offices across VDH. Our Office of Drinking Water has a central office in Richmond. The employees in the regional office

are ours but we work through a coordinated and collaborative system to ensure that local input is taken and received and that we're able to ultimately deliver a product in the service that takes into account the variability across this beautiful and very large state. So the discussions have kind of evolved around where do we need to standardize and where do we need to keep that local flexibility in a discussion I presume will continue ten years again from now and twenty years again from now, but some interest in looking at what exactly again do we need the councils to do to ensure that we have this coordinated and collaborative system, what is the ask of the Office of EMS, how can we really partner most effectively to ensure the citizens, the providers, and all other stakeholders receive the necessary services from VDH and again our local stakeholders. So I just wanted to put this out there on the table. We had this discussion with the Executive Advisory Committee on Wednesday, and it was felt that we should openly share this interest with all of our members here today. We are working on developing that stakeholder input, but we wanted to simply

let you know that this was something that VDH, the Office of EMS was looking at in terms of again the role of the EMS councils, how we can best support them, and future collaborations going forth. While that is the long-term project, I do want to allow Mr. Brown to comment on some of the more immediate steps and requests of our office in terms of the administrative support that some of the councils have asked of OEMS to take on.

MR. BROWN: Okay. Thank you, Jr. Jaberi. For those of you that were here for the February meeting of the State EMS Advisory Board, Gary Critzer, who was past chair of the advisory board but also president of the Central Shenandoah EMS Council, did report on a, kind of a new approach, a new model in the Commonwealth of a partnership with that council. They had approached us about some of their challenges, whether it be fundraising to staffing to service delivery, and we entered into just open discussions and dialogue, and it was really driven by Central Shenandoah, their Executive Committee, and their board of directors with regards to what was the best opportunity for that

region of the state through the council for support of their EMS system, their EMS providers, their EMS agencies, the hospitals, and so forth. It was, as we began that dialogue, it did become very evident, and they expressed this themselves, that the sustainability of their council was pretty bleak in some respects, and they were really looking to, at a different way of doing business. And that business, what was finally agreed upon, again it was a true dialogue and coming to an agreement that we would place state staff in that region. The council still exists, still has a board of directors, but we would assume all the staffing and operational responsibilities, and that includes everything from rent to payroll to HR, just the infrastructure of technology support, the VITA drops, the computers, the phones, and really take that burden off the council and the amount of time that they were using to try to fundraise, and then being in competition with their jurisdictions and agencies, which was becoming more and more difficult for them to continue with reasonable funding for the council. So we have entered into an agreement with the board of

directors of the Central Shenandoah EMS Council, and Mr. Critzer did present this to the board in February. Immediately following that, there was some additional interest expressed to the Office of EMS from a couple other councils. We have not moved swiftly, but we are moving forward with discussions with these couple of other councils that are exploring this same opportunity to be able to possibly mirror something very similar to Central Shenandoah, but knowing that it needs to be what's right for those council service areas. It is not the desire, it has never been the goal of the Office of EMS, Virginia Department of Health to do away with regional councils. In fact, what we're trying to do is support regionalized systems of care. That tier in the Commonwealth is really important. We have national documentation most recently from the Institute of Medicine that talks about regionalized systems of care, and we have to have that. The Office of EMS, Virginia Department of Health cannot do everything from Richmond, nor should we. It has to be a reasonable approach. There has to be the protocols. There has to be the drug box exchanges. It has to be local

involvement to reflect what the EMS system needs in their particular service area, because one size does not fit all. So it has to be, we can't go in and just with one model if you will and say here it is, take it or leave it, and that has been stated that we've had approach in some respects on some things like that. That is not our approach. This has to be customized. It has to be worked out with each of the councils and it has to be something that is doable. It has to be something that is going to make improvements and it is going to make a difference, and we're driven by several creeds if you will, but the main one, and I'm glad that the Chair read from the Code of Virginia, because this is patient-care driven. If we do what's right in the Commonwealth, no matter what region you're in, to improve and do what's right for the delivery of EMS patient care, then we're doing our jobs, and that's what has to drive this process and that's what is driving it. The second thing that I've always lived by is do the right thing, and we're going to do the right thing. And so it is a collaborative effort. I'm glad that Dr. Jaberi is here. He knows that it's a collaborative

effort that needs to be instilled and he's very well aware that we have to have good communications, and we do need to move forward. We need to, models that were put into place in the 1970s and 1980s simply are not working for today. Things have changed. So that's kind of I guess a little bit of some specificity, but that's really where we are at the moment. It's just, it's an open dialogue and it's really working together, and we'll work with any of the other regions that at any point they want to approach us, but we're not going into any area of the state and initiate discussions first. We're waiting to see if any councils that liked what they heard about Central Shenandoah and they have approached us, then we will listen. And that's exactly what we're doing right now.

MR. JABERI: Thank you and just to piggyback on that, again, this is being shared, oftentimes we come here to present a plan. It's just a simple opportunity for us to be transparent and let you all know of our intent. Certainly open to any feedback, comments, questions. Many of you have your specific contacts of the Office of EMS, but with regards

to these two issues, I would ask that you do, if you have those contacts, to cc Mr. Brown or myself where appropriate so we can be kept abreast of the necessary questions and desires that need our attention. But again, I just want to simply appreciate, send my appreciation to all of the individuals that did come forward throughout the course of this week and prior to share their concerns. We at the Virginia Department of Health take all of those comments quite seriously and we like to take action that shows our responsiveness and hopefully our ability to resolve those issues. So thank you again and thank you or allowing us to have this update.

MR. BROWN: Thank you, Dr. Jaberi. We're down to the Office of EMS reports. I guess, let me do a little bit more. Maybe I shouldn't be announcing what I'm getting ready to announce, but just to be fully vetted here, we have put in a budget amendment through the VDH process. All state agencies' offices every year are given an opportunity to submit proposed bills or budget bill language and so forth, and we have put in a request, it's a non-financial budget

request. It's only to establish FTEs, in the case we need them, and what we're doing is just trying to again be visionary to be proactive. If we need to pool from a pool of FTEs because we bring on another council and support that council through state staff, then we're able to have those FTEs. So that has been put forward. We don't know what the outcome of that's going to be at the moment, but we are working that way. And to give one other example, one of the executive directors for council said that they were spending up to seventy percent of their time fundraising and it's becoming really even more difficult to have support for the council, and it's said that the sustainability of that council is probably less than two years. So they are being proactive in working with us, but we also have to have the infrastructure and the ability, because we don't want to see a council or region fail. We want to see it succeed. And if we're going to come in and help be part of the solution, we will need a pool of FTEs. So again, just want to kind of put that out there. I hope that was okay. Oh, he didn't say yes.

MR. JABERI: Just for those that

don't work in the state government, just to understand, let me explain why Gary is sharing that. So that was an office request of the commissioner's level. That issue is actually, the discussion started on Wednesday going forth. In order to meet the needs of Central Shenandoah, we just simply took from our agency FTE pool. We all have a certain number of individuals we can hire, regardless of whether we have funding or not, and so, you know, those are positions that could be a disease surveillance specialist, a public health nurse, wherever. So we created those positions earlier this year. However, the request that had come in was roughly twenty-nine FTEs. So the reason we share hat here is it's important when VDH puts forth those requests, if it is approved in that forum, I believe we'll probably have a more sequential introduction that we would recommend to the secretary's office, which then needs to be, you know, approved by the governor's office before it's brought forth to the general assembly, is that many times, it's looked upon as expanding the size of government. So it's important for you all to understand what the process is like, is that if we do want state

FTEs to help support the councils while we have the funds for it, it's still creating new positions and expanding the size of government, so we would need to work with the messaging with our local partners in order to ensure and really help elucidate why we are doing what we're doing. So while we were able to respond to Central Shenandoah's needs using the current FTEs of VDH, we do not have additional FTEs to be able to respond to the newer requests that have come in. So again, just in the spirit of transparency, sometimes we deal with, in the state agencies, specific challenges that prevent us from necessarily being able to move forth, and I want to just make sure everybody has that understanding. So that consideration is working its way up through the commissioner's level and the secretary's level, and certainly your input as to whether you feel this is an appropriate path to take would be helpful as we make our case to the secretary and the governor's office. Thank you.

MR. BROWN: Thank you. At this time, I'd like to introduce a new member to the state EMS Advisory Board. As you know, Northern

Virginia was represented by Jose Salazar and he retired from Loudoun County, and so the Northern Virginia EMS Council did submit three nominees to the secretary of the Commonwealth's office for the governor's consideration, and the governor did make his appointment, and we were notified earlier last week that it's Beth Adams. Beth, if you'll raise your hand and say hi. And so Beth is representing the Northern Virginia EMS Council with the unexpired term of Jose and then will be eligible obviously for reappointment. At the moment, Beth is a quality manager for the EMS Division Fairfax County Fire and Rescue Department. She's also been an adjunct assistant professor in the clinical research and leadership of the health science programs at George Washington University in D.C. She's been in that role since 1995 to the present. She is really a laundry list here of professional experience, education, licensure and certification, and selected professional activities, very highly qualified. I've met Beth I think back in the nineties and it's really a pleasure to have her on board as the newest Advisory Board member, and Beth, I'll see if you would like to say anything

to the board.

(WHEREUPON, Ms. Adams indicated negatively.)

MR. BROWN: Okay.

MR. PARKER: To be transparent, she just met me about three minutes before...

MR. BROWN: Exactly.

MR. PARKER: ...the start, so...

MR. BROWN: Exactly.

MR. PARKER: ...welcome aboard.

MR. BROWN: Okay. And as we're doing some recognition, we do have, at Office of EMS, we do have an employee that I do want to recognize, and if she could at least come forward and stand in the middle so we can embarrass her, Heather Phillips. She's somewhere in the room. Okay, while Heather is walking towards the center, here's a resolution, it's the State EMS Advisory Board Certificate of Recognition. By virtue of the authority vested by the State Emergency Medical Services Advisory Board of the Commonwealth of Virginia and the Virginia Office of Emergency Medical Services, there as hereby officially recognized S. Heather Phillips Green. Whereas S. Heather Phillips, National Registry Paramedic, has dedicated more than thirty years

of service to the EMS field as a volunteer and career professional, she has represented EMS interests throughout the Commonwealth by serving at the local, regional, and state level to help improve Virginia's EMS System. And whereas Phillips has served as an EMS provider, educator, staff member of the Virginia Office of EMS, in September of 2001, Phillips became a Virginia Office of EMS program representative, and in March of 2006, she accepted the role as program representative supervisor. She has held up her retirement, to her retirement now. Whereas Phillips has managed numerous commitments effortlessly throughout her career, her extensive knowledge and expertise in the field of public safety has allowed her to actively participate on various committees and serve as a resource of information to EMS agencies and to the EMS community. Whereas consistently Phillips worked to improve the quality and service delivery of EMS Virginia as a provider, instructor, and compliance investigator. In addition, she maintains numerous certifications in emergency management and as an EMS instructor. Therefore, be it resolved that the Virginia Office of EMS

and the State EMS Advisory Board hereby commends and honors S. Heather Phillips Green for her commitment and contribute to Virginia's EMS system and for her service to protect the health and promote the well-being of all people in Virginia. Signed by myself and Chris Parker. So, Heather?

(WHEREUPON, the audience applauded.)

MR. BROWN: Okay, well, as we're honoring someone that's retiring, we're going to recognize someone that just started, so Cam Crittenden, if you will introduce the newest member of your staff. Hey Cam, can you come to the mike? I know you love that.

MR. CRITTENDEN: Thank you, everybody. Narod Misroy has been working with the Office of EMS for the last year as a contract epidemiologist. We got approval from our leadership to post that as a full-time position and we recruited and interviewed multiple candidates. Narod was one of them, and he came through with flying colors, was the best candidate and we were very fortunate to offer him a full-time position and he accepted, so he is part of our team permanently now. So welcome

him.

(WHEREUPON, the audience applauded.)

MR. BROWN: Okay and following the path of recognition, we do have a board member that needs to be recognized and was just recently appointed chief of Goochland County, and that is Eddie Ferguson. Where is Eddie? Oh, right here.

(WHEREUPON, the audience applauded.)

MR. BROWN: That was a big deal. He was even on television here in the Richmond area for the announcement and so forth, and let me tell you, if you're looking for a good county to move to, you can move to Goochland because you're going to be in great hands with Eddie and his staff.

MR. FERGUSON: Appreciate that.

MR. BROWN: Okay, along these lines, I will continue with Adam Harrell to introduce an intern that's in our office, and if Adam will come to the microphone, too, and we're going to have our intern explain the project that he's working on, which I think will be of interest to everyone here.

MR. HARRELL: See, I came up to

the mike without having to be prompted. And I'm not going to be near as long-winded as Cam. I'm going to let Vince do the talking. Vince came to the Office of EMS as a graduate intern for the summer. He comes from Liberty University, and I'm going to let him provide you a little bit more on his background and the project that he's working on.

MR. PARKER: Is that microphone on?

MR. VALERIANO: Hello?

MR. PARKER: There.

MR. VALERIANO: Okay. Thank you for having me here. It's an honor to be here. I've really enjoyed my time at the Office of Emergency Medical Services and I have a passion for the project that they have tasked me with. As many of you know, EMS provider mental health is a serious issue. In 2015, reviving responders conducted a national survey on EMS provider mental health and found that EMS providers contemplate and commit suicide at a rate ten times higher than the national, or the general population. In 2018, the Ruderman Foundation did a study and found that first responders are more

likely to die by suicide than in the line of duty. So EMS provider mental health is a serious issue, and currently we don't have any information or data about EMS provider mental health within the state of Virginia. And so my project that I've been tasked with is to build a surveillance instrument to assess EMS provider mental health. And so some of the objectives of that are to one, get a baseline understanding of what is the mental health status of our EMS providers. Two is understanding what are the barriers to EMS providers seeking help. Three is understanding what services are being utilized and what services are needed. Four is understanding the culture and attitude surrounding mental health within EMS agencies and to see if there's, EMS providers feel supported, if EMS providers feel that there are high levels of stigma within their agency, just to get an understanding of that. And then five I think is important is to provide EMS providers a safe and stigma-free place to express concerns about mental health issues that they may have seen or are experiencing. And so our goal is to really understand what are the issues surrounding EMS

provider mental health, and then two is to really have data to back up interventions that we will do in the future. And so these past two months, I have been working on building a survey with my team. We've had internally the Office of Emergency Medical Services. We have constructed a survey utilizing previously validated questions and creating some of our own. We have sent out the survey to a thousand randomly selected EMS providers to pretest the instrument. We made final changes to the instrument, and this past two Mondays ago, we sent out the instrument. And so as of today, we have out of thirty-four thousand EMS providers that we sent the instrument to, the survey to, we have about twenty-three hundred responses. So I can give you guys some stats of our baseline of what we have so far. So as of today, 62.8 percent of EMS providers reported having experienced being burnt out in their career or volunteering as an EMS provider; 54.6 report experiencing traumatic stress that has had a negative impact on their mental health as an EMS provider; 40 percent report that they have suffered from depression due to serving as an EMS provider; 38.5 percent

believe that they have experienced PTSD due to serving; and 14.7 percent reported that they have contemplated suicide since becoming an EMS provider. And so these are just some of the really crude baseline statistics that we have so far. We're going to be doing another week of data collection, and then after that, we're going to be analyzing the data and then coming up with a plan of action. But our ultimate hope is that this survey will result in further action that will help EMS provider health and safety and resiliency and hopefully also decrease stigma that may be around EMS provider mental health. Thank you.

MR. PARKER: Thanks, Vince. Appreciate that. I would also have, kind of challenge Vince and Adam and Karen that we submit a post-abstract to the National Association of State EMS Officials for next year for their competition. I think we're going to be very strong in terms of a submission and I think it will gain national recognition. Just another example of things that we're doing as an office that truly is I think ahead of the curve and ahead of other states in terms of what we're

doing. So stay tuned. Oh yeah, well, I tell you, Karen, you said you like surprises, so let me call on you. We have done, and I think we mentioned at the last board meeting, met the call presentation, and we actually rolled out the video at last year's EMS Symposium at the banquet that night and kind of talk about that and any statistics off the top of your head and also our award.

MS. OWENS: Oh, well, I didn't make note cards. So as y'all know, the Make the Call Campaign was a targeted campaign to all of public safety to take the stigma away, to get them to understand that it's okay to make the call and to, you know, step up and recognize mental health as an issue. We shared it. We did a targeted campaign that actually ended at the end of July, of posters, Twitter posts, Facebook posts that actually targeted first responders. We kept the video up. When we first shared the video on Facebook, the Richmond Ambulance also shared it and they had over twenty-four thousand views in the first two days, which was very mindboggling. So that targeted campaign is technically done. We're no longer advertising

the campaign or the video across social media, but it's all out there still. It's available, the video, the posters, all of the media that was put together by the company we worked with is available for free to anybody that wants it. It's at www.vdh.virginia.gov/makethecall. Okay, I had to make sure. I didn't want to give you the wrong website. And you know, the company that we worked with was actually very excited for the work. They were passionate about it, you know, put together a good product. Do you want me to give the rest of the, okay. I see a lot of head shakes. And they submitted it to a competition, the fortieth anniversary of the Telly Awards is this year, and they were excited to share with us that the Make the Call Campaign won a bronze Telly for the category that it was submitted. These are awards that are given to media that has developed, Conan O'Brien has won awards for media shown on his show, CNN, Fox News, a lot of, MSMBC, they've all kind of submitted some of the health videos that have gone out have been put in for this, so we were really excited to win bronze and glad that it got a little more attention just nationwide to get

that campaign out. I have no statistics, though.

MR. BROWN: Thank you, Karen. We won a bronze out of fifteen thousand submissions for awards. And now that she mentioned the fortieth anniversary of the Telly Awards, that's a good segue for me to talk with the fortieth anniversary of the Virginia EMS Symposium. And so that's coming up in November. Irene I know has reached out to every member of the EMS Advisor Board, and years ago we, even though it's really hard on the staff, it was still, we thought it was important that the last quarterly meeting of the calendar year for the state EMS Advisory Board be held in concert with the State EMS Symposium. And we have held it there I guess probably for at least the last twenty years, it seems, and we felt it was important to, because that's really the largest gathering of EMS providers at any one time in the Commonwealth of Virginia, and to be able to, number one, expose them to who the advisory board was, but also give the advisory board members an opportunity to look at the providers and say the decisions we make are impacting each of you. So it's a really win-win educational session both ways, and we have

found that it's really well-attended. Our EMS providers like that opportunity to know who the advisory board is, what they are, what you do and so forth. So anyway, we do waive the registration fee for the advisory board members to attend the entire symposium. We do cover at least one night of lodging for you, and multiple nights in terms of if you're also attending any of the committee meetings or you're a member of any of the other committee meetings that are taking place at the symposium. If you have not registered, do see Irene so she can get you registered in our system because we do have to override a couple of the fields to waive the fee and things of that nature and let her know what lodging requirements you have and so forth to attend the symposium. And speaking of that, we have over four hundred classes scheduled this year, so we're keeping with the four and the fortieth, and that's the largest number of classes of any conference in the entire United States. So again, we're really pleased about that. We have tremendous tracks, tremendous speakers both from Virginia and nationally and internationally. We're going to have, in working

with Kevin Dillard. We're going to have guests from Germany here during the symposium. We normally have, we've kind of gone a little bit international of people attending the symposium, and it's really a great even, so please make sure you get in touch with Irene so we can take care of you. I think there was something else I wanted to say about the symposium, but it's, you know, we hope that you celebrate with us on the fortieth and we look forward to seeing you down on Norfolk on November the 6th. That Wednesday is the actual board meeting, but then we also have a lot of committee meetings and then all the classes. And one thing I, Chris, I haven't even had a chance to talk to you about this, but we were able to, we were approached by Ed Brazle with Virginia Beach, and we do have a couple of sessions that he and Virginia Beach are going to offer on the shooting even that occurred in Virginia Beach, and he would like and I think it would be appropriate, some time on the advisory board schedule on November the 6th to also make a presentation to the board. So that's something that will take place, too, so again, a lot of good highlights that are going on. We're

bringing back Randy Mantooth who, if you're as old as I am, you remember Emergency on TV and that's what got a lot of people involved in EMS in the country. We have Bob Page who retired his Grim Reaper presentation years ago, but he's going to, he's promised to brush that off and do that for one more encore just for us. And we've got some other national speakers for some general sessions and we're bringing back a banquet speaker for the Saturday night EMS awards program. Okay. I will, oh, I'm supposed to mention this, too. On Friday, August the 16th in Charlottesville at the Holiday Inn Monticello is a VDH Office of Health Equity and Office of EMS is offering a mobile integrated healthcare community paramedicine summit. Dr. Jaberi will be there to speak, Dr. Allen Yee will be there to speak. We have some out-of-state guests including from Georgia and also counsel from Page Wolfberg & Wirth, Kevin McGinnis, who is a program manager for the National Association of State EMS Officials, who's also been a national leader in mobile integrated healthcare community paramedicine. And so this is free. I will look at Tim and Chris, if there's anything that they

want to add to this that I'm maybe not covering, but you can get with Tim or Chris or myself or contact the office and again, if you have an interest in that, that is being offered on August 16th at no cost. And with that, I'm going to turn to George, and George, maybe you can hit on the first thing that was in the green book, and I always mention that you got a copy of the quarterly report. It is on our website as well for those that are not on that distribution list, and maybe you can talk about HB nineteen?

DR. LINDBECK: Seventeen?

MR. BROWN: Seventeen? 1943.

DR. LINDBECK: So just a brief update on that, this is concerning provider exposures. We've been managing that for a long time fairly well. Recently we've become aware of some gaps in that system, particularly when we deal with victims, patients who have expired in the field, and how do we get testing done on both first responders as well as good Samaritans who have attended to patients who have died in the field, and it has exposed a lot of issues. How to run serology testing on cadaver blood, who can do that? It turns out that there are no labs in

Virginia that are credentialed to run serology on cadaver blood. Who's going to provide counseling for those people, who's going to provide post-exposure prophylaxis when needed, et cetera. So we had a meeting about two weeks ago with OCME and it was a very productive meeting in terms of getting everybody at the table discussing concerns and sharing their issues. It wasn't at the point where we could make any decisions yet, but we are moving that along. Right now I don't, I can't say that we've got a solution for that problem. It's probably going to require some regulatory language and some changes to make that work, but we are working on it and we realize it's an issue. I think that's about it. I don't think I have anything else to report that won't be covered by one of the committees.

MR. BROWN: Okay, thank you, George. And I think that's, we'll stop there, Mr. Chair, because anything else I would mention will probably be covered under the committee reports. Thank you.

MR. PARKER: Thank you, Gary. Amanda?

MS. LAVIN: I don't have anything.

MR. PARKER: Okay. All right, so now we're down to the State Board of Health EMS representative report. I received an email earlier in the week from Gary Critzer and then a second email this morning. Unfortunately, he could not be in attendance this week due to a family emergency. He continues to thank the EMS Advisory Board for allowing him to represent EMS on the Board of Health and apologizes immensely for not being able to attend the meetings this week. Much of his report has already been covered by the Office of EMS reports and Dr. Lindbeck. The next Board of Health meeting will be on September 5th at the Perimeter Center, and this concludes his report. So we are now down to standing committee reports and action items. First up is the Executive Committee. The Executive Committee met on Wednesday, July 31st, and there was a lengthy discussion surrounding the much-needed evaluation of both committee and advisory board structure and composition. There are currently committees with clearly-defied goals and objectives, and there are committees that do not have such. The Executive Committee strongly feels that there needs to be a retreat

workday for the entire advisory board with an outside facilitator to look at both committee and board composition. The Executive Committee has tasked the office to work with them in planning such a retreat and more to come on this. This concludes the Executive Committee report. Financial Assistance Review Committee, Kevin Dillard?

MR. DILLARD: Thank you, Mr. Chair. No action items. We will be offering another webinar for the rescue squad assistance technical assistance. That's going to be on Thursday, August the 15th from 1:00 to 3:30, and we will also be offering some classes at the EMS symposium. The Fall Branch cycle just opened yesterday, and it closes on Monday, September the 16th. Thank you.

MR. PARKER: Thank you, sir. Administrative Coordinator Jon Henschel and you can give your Rules and Regulations Committee report.

MR. HENSCHEL: Okay. Rules and Regs met on Wednesday. Most of the topics we discussed were informational. The regs are currently, we're pausing at this point to allow

time for replica language to be modified within the regs as well as the mobile-integrated healthcare. Other than that, the rest of the information can be found in your quarterly report.

MR. PARKER: Thank you. Legislative and Planning Gary Samuels?

MR. SAMUELS: Legislative and Planning met this morning. We have no action items. Again, we went over a lot of informational topics and reviewed some legislation from the past year, and we're planning to alter our meetings scheduled for November into an October meeting so that we can review the state EMS plan so it will be ready to move forward at the November meeting, working with Chris and his team.

MR. PARKER: Infrastructure coordinator, Dreama Chandler?

MS. CHANDLER: None of the committees have any action items. Transportation Committee, in speaking with Eddie, they had no grants to review so they had no meeting. Communications Committee met this morning. There was not a quorum, so there was no business

conducted, but they did have a lengthy very informational meeting and I will turn the other over to Tom.

MR. PARKER: Thank you. Emergency Management Committee, Tom?

MR. SCHWALENBERG: Good afternoon. The Emergency Management Committee met yesterday. We have no action items at this time. Three items for just general information, we did review the new triage tag, which incorporates both salt and start. We reviewed that and approved that to move forward for production. We also reviewed the emergency operation training documents, both a registration form and a roster form, with a goal of getting better data collection on those that are taking MCI classes and partly for grant but also just to move it to a less manual process to process those course requests. And then much discussion on highly infectious disease from a standpoint of working with the Office of Epidemiology to make sure that we have a consistent message between Office of EMS and the rest of VHS, VDH, excuse me, for addressing those issues. This has some crossover with the Health and Safety Committee, as well, as far as

consistent messaging for highly infectious disease. And on that topic, just a reminder, on October 28th, there will be the Virginia Ebola Summit in Richmond, so please look out for that. That concludes my report.

MR. PARKER: Thank you. Professional Development Coordinator R. Jason Ferguson, and you may give your TCC report, as well.

MR. FERGUSON: Okay. I'll defer to the individual chairpersons to report on their committees. For TCC, the TR-98 work group met on July 9th and we made great progress on revising the TR-98 competency requirements. The new version will align more with the Appendix G that the paramedic programs follow for the COA accreditation. The work group will meet again on September the 3rd at 10 o'clock at the Office of EMS. Our goal is to focus on the quality of education versus quantity of skills performed, and we hope to have a final version to this board to approve at the November meeting. Training certification met the next day on July 10th. Billy Fritz has been reappointed to fill the non-VCCS program's position. Lisa Hale was appointed

by recommendation of VAVRS to fill their position, but she is no longer with VAVRS. So I reached out to both the executive director and the president for their recommendation, and as discussed in the Executive Committee, Scott Davis has been appointed to fill that position. There were no other action items there, and the next training certification meeting is here on October the 2nd at 10:30.

MR. PARKER: Thank you. Workforce Development Committee, Valerie Quick?

MS. QUICK: We met this morning. We have no actionable items. We did welcome Chris Payne, who is representing the military portion of VMS. He actually brought up just some information and queries about how to properly bridge his military staff into our EMS, so we actually directed him to the TCC to come up with some different options for them to take back to the military group. We do have an EMS officer course that actually filled within three days at symposium, so they're going to continue to offer that and they're going to broaden out the instructor pool. They are plugging right along with the standards of excellence. No new

applicants at this time, but they are going to do some re-visits on ones that are already accredited. The last thing is Jason Ferguson actually sent out a survey that over two thousand people responded. This was workforce based looking at what providers and agencies see as barriers and incentives to recruit men in retention, why they stay in, why they leave, and he is going to be compiling those and bringing it back to our workforce. We do have an EMS provider survey that is also going to go out within the next couple of months to be able to assess the demographics of our EMS agency. And we are meeting that Friday at 10 o'clock at symposium, I think that's the eighth, is that correct? Yeah, at 10:00 a.m. And I have no further.

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

MS. KNOWLES: Thank you, Mr. Chair. Provider Health and Safety Committee met this morning. We have no action items. Most of my report has already been covered by previous reports. We do have some continuing discussion on forming a DICO group to share information. It

was reported that the responder safety website is now listing the number of fatalities that occur on roadways, and these are fatalities that are occurring to law enforcement and other public safety, firefighter, EMS, et cetera, and there are also resources on that website for training and safety. And lastly, we reviewed the CISM accreditation application. We're going to try to make that a little bit easier for those that want to become accredited teams and peer teams. That's all I have.

MR. PARKER: Thank you. Patient Care Coordinator Dr. Allen Yee and you may give the Medical Direction Committee report, as well.

DR. YEE: I have no report as coordinator. For the Medical Direction Committee, we met this past quarter. We have no action items. We have four informational items. The Medical Direction Committee feels that the scope of practice and formulary, I mean that is the practice max within the state, but it is not, we voted to say that it is not the educational minimum. The educational, in working ad hoc with the TCC Chair, we decided that the educational minimum will be the national educational

standards which are being developed and likely released in the next year or two. So we have some time before we have to make any transitions. Another informational item is we have a working group from medical control working on critical care and mobile-integrated healthcare. Both of these working groups are developing concept documents that the Office of EMS can use as a basis for regulations. That's moving on quite nicely. The Medical Control Committee has also voted to replace, place Dr. Reed Smith from Arlington County as an open member, member at large. That's all we have.

MR. PARKER: Thank you, Dr. Yee. Medevac Committee, Jason D. Ferguson.

MR. FERGUSON: The Medevac Committee met yesterday morning. We have no action items. There was just mainly general conversation and discussion around status of regulations. Some agencies were discussing potentially applying for variances on equipment and things of that nature, and everything else can be found in the report.

MR. PARKER: Thank you, sir. EMS for Children, Dr. Bartle?

MR. BARTLE: Mr. Chairman, we last met on July 31st. We have no action items. There are a couple informational items I would like to share. We reviewed the ongoing distribution of child transport restraint systems that the committee has been giving out to various agencies. We also reviewed on the level of the Pediatric Readiness Project in the state where we're emphasizing to have a pediatric coordinator at hospitals to help with pediatric care. Two new things that are coming up that I want to share. One is that EMSC Committee is sponsoring some positions for the symposium registration fees. We have, we're going to cover forty attendees who want to go. It's the registration fee that will be covered, with the stipulation that they have to take three pediatric courses at the time of the symposium. It is a first come, first serve, so if there's anybody that you know would like to go but might be somewhat restrictive, this is basically a scholarship for the registration. Another new point is that we are starting collaboration with the Trauma Committee on the development of a state pediatric disaster planning. EMSC also would like to thank

the Office of OEMS for altering when our committee meetings meet. We're now trying to meet more with a, in conjunction with the rest of the committees here so there would be a lot more, there would be more of ability for crossover members who want to attend either EMS or EMSC or one of the other committees. That's my report.

MR. PARKER: And I want to commend you for moving the committee meeting. It was the first one I was able to attend and it was very well.

MR. BARTLE: Thank you.

MR. PARKER: Trauma system coordinator and the TAG report, Dr. Aboutanos?

DR. ABOUTANOS: Thank you, Mr. Chair. For the trauma system quarterly report, I will leave the various chairs to talk about their committee report. For the TAG report, we met today. There was no action item; however, there are a couple of things quickly to report. We did have a planning session in June, 27 of June, and that was mainly to give more orientation online to various committees as the committees are starting to grow, wanted to make sure they're all aligned under the same mission and the vision for

the trauma system plan. And there was one central theme that was, if we wanted to be a data-driven system plan, we need to know our data. And so the central theme as you will see from all the various committees is to go back and find out what are the value of different data that drive the entire trauma system plan all the way from pre-injury to pre-hospital, then to acute care and then post-acute care. And that was kind of the main aspect. The other dominant theme that was discussed today at our meeting was the trauma fund, and more strategic plan and a pathway for us to be able to figure out how do we respond and how to prepare ourself more of a unanimous voice, all the trauma centers with the help of the Office of EMS and VHHA with regard to the large threat of having the trauma fund not be available and the significant, significant impact that that's going to have on the various trauma centers. So we decided that within six weeks, we can have a system so we can have an actual plan how we're going to go forward with this plan. And last, we decided that the Trauma Administrative and Governance Committee will start meeting every six weeks instead of

quarterly because of the significant amount of work that needs to be done. And that concludes my report for the TAG.

MR. PARKER: Thank you, sir. System Improvement Dr. Shawn Stafford?

DR. ABOUTANOS: So Dr. Shawn Stafford had to leave, but I'll quickly give his report. Basically we rated that every committee is going to work on data as we mentioned, and the system committee is going to be involved specifically with housing the various data from the various continuum of care, develop a regular output of a report with regard to the data. The first report will be now in December. That's the, one of the main action. That's basically an ongoing aspect, but there was no action item for them.

MR. PARKER: Okay. Injury and Violence Prevention, Karen Shipman?

DR. ABOUTANOS: Is Karen here? I don't see...

MR. PARKER: Is there someone from the office that can provide a report? Okay. No report from Injury and Violence Prevention. Pre-Hospital Care, Mike Watkins?

MR. WATKINS: Good afternoon. Pre-Hospital Care Committee met yesterday. We have no action items. We do have some informational items. We identified some of our key areas of data requests and try to outline some of that with the Trauma and Critical Care Formatic System so we can start pulling some of that information. We reviewed the trauma quarterly report and identified some areas that we wanted to try to narrow down focus specific for age ranges, pediatrics and geriatric patients in trauma, and we identified and kind of demonstrated the challenges of data collection at the pre-hospital level with kind of an illustration with the V-Fib V3 system. So, that's all I have.

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

DR. ABOUTANOS: Jeff Young just had to step out, as well, and his committee also met today and the main action they talked about, again with the same theme of collecting data for now what is the best data for the system. There will be more to come on that. There were no action items.

MR. PARKER: Okay. Post-Acute Care, Margaret Griffin?

DR. ABOUTANOS: Actually, Tim Erskine will report.

MR. PARKER: Okay, Tim?

MR. ERSKINE: Hi, I'm temporarily Maggie. We have no action items from the Post-Acute Care Committee. The committee spent its time reviewing potential data sources for rehabilitation, also just locating rehabilitation facilities. That's a fairly nebulous concept. The Brain Injury Association has actually a large robust data base which will be the starting point and there is an idea that was formulated during the meeting at looking at acquiring rehabilitation data from trauma centers that have an inpatient rehabilitation facility to allow for a longer term view of the outcomes of trauma victims. And that's about it.

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

DR. ABOUTANOS: It will be actually Morris Reese to give the report if Morris is here. Maybe Kelly, can you give the report?

MR. PARKER: Either Morris or Kelly or someone that can give a report?

DR. ABOUTANOS: Kelly will.

MR. PARKER: Hi.

MS. PARKER: Hi. Thank you. We don't have any action items, just a couple of informational...

MR. PARKER: Can you state your name for the...

MS. PARKER: Yeah, sorry. Kelly Parker, Virginia Hospital and Healthcare Association. We discussed kind of the planning effort at the local, regional, and statewide level for emergency preparedness and disaster plans and how the Emergency Preparedness Committee can inform those plans from a trauma perspective. And then like most of the other committees, we discussed what data is available to kind of look at routine referral patterns and how we can use those routine patterns to potentially anticipate surge for some of our more vulnerable compilations.

MR. PARKER: Awesome, thank you. At this point, we've been at it for an hour and five minutes. I feel like it's time to take

about a ten-minute break.

(WHEREUPON, a brief recess was taken from 2:10 p.m. to 2:22 p.m.)

MR. WOODS: Greg Woods, chairman of the Regional Directors Group. By informational items, our group did meet on July the 31st. A couple of things that we're doing, we have agreed to be a symposium sponsor this year, so we are happy to continue supporting symposium. We also put together a work group to develop a regional EMS services assessment to help us as we move forward in the collaborative spirit that we have always enjoyed as part of the state EMS system. I do want to take a moment to note that we did meet, a small group of us, myself, Tracey McLaurin, the vice chair, and Rob Logan, who is the longest-serving regional counselor director with Dr. Jaberi, Gary Brown, and Scott Winston, to discuss the relationship, communication, and collaboration between regional EMS councils and the state, and I appreciate your comments related to collaboration because we truly believe that collaboration and partnership is the only way that we move forward and advance pre-hospital care in Virginia. We believe that

collaboration and partnership and communication is also the only way that we improve efficiencies, and we are very much open to discussions that lead to the improvement in pre-hospital care all across Virginia. With that said, we do, we have provided to you a document that refers specifically to information you received in the quarterly report. We believe that collaboration and communication must be open, honest, and transparent, and we do have issues with the way material presented in Appendix A was presented to the group, and so we provided that response. In respect of your time, we're not going to read that, but we will, I am going to summarize some of those key points and how it relates here today. I would ask that if you have any questions, feel free to direct those to me, and anything contained within our report or within the statements that I make today, I can verify in writing. I believe that statements should be verifiable, that they should be fact driven, and I have those today should anyone want to see those. So I want to frame our discussion about the Appendix A to say that it provides data related to the total contract amounts and

disbursement within specific categories, and the data presented is probably accurate in its presentation of accounting, but that is an incomplete picture of how we got to that relationship and how we performed. So in abbreviated history of the provision of continuing education of our regional councils in Virginia, you all probably remember that in May of 2016, around May, it was determined that the EMS Training Fund Program and the contracting practices were no longer allowable under state procurement laws. And so that delayed the availability of EMS training funds. Because the regional EMS councils understand the impact that those losses present for EMS agencies all across our regions, I in July of that year reached out to the Office of Emergency Medical Services and asked if there was a way to utilize our existing contracts to ensure the continuity of continuing education all across Virginia. I received a reply from OEMS that that was, that they would look into it, and then in fact in August of that year, we were informed that a process had been approved and that regional EMS councils had been identified as a contractor to ensure the

continuation of CE programs in Virginia. So along the way after several months we, in May, we were told that an MOU had been approved. On May 24th, we received an electronic copy of that without any information related to finances related to it, and we also scheduled a meeting with OEMS where we could meet and discuss that MOU, what was expected from it, and at that meeting for the first time we were given an opportunity to look at the financial model that was presented by the state. That financial model, we had a couple of issues with that, based on the unique geographic and demographic variations within Virginia. In two specific areas, one related to the number of CE programs per locality and one related to the number of CE courses that, auxiliary CE courses that should be completed by providers in our regions. We expressed those concerns and we were told that that funding mechanism had been determined by OEMS, and it was not open to discussion. Now over the course of time, there were five versions of the MOU, and a stream of emails back and forth making some adjustments to the contract language within that MOU, but not changing the formula

that had been presented to us. And prior to that, we had had no input into either the MOU language or the financial structure that was proposed for us. We were told at that meeting that this represented a funding maximum, that this was the maximum amount per region that would be allocated under that MOU. However, after we signed, we had questions related to how that was going to be administered. So in follow-up communication with OEMS personally, I asked about those auxiliary numbers because for Southwest Virginia, the number was incredibly skewed. And we were told again that this was a funding maximum, that we would be compensated for what we accomplished and not penalized for what we did not do. That was affirmed again when another regional council director emailed the state and we got a reply from Charles Faison, who at that time was managing the program that we were correct, we would be compensated for what was accomplished, not penalized for what we couldn't do. We do have copies of those emails. If anyone would like to see them, I'd be happy to share those with you. From that time forward, we received no feedback or information regarding

performance or any changes to the expectations under those MOUs. It was extended and a new contract reached the following year, which is year two represented in that report. It wasn't until May of this year that we received any kind of feedback, and it was the document that now is included in Appendix A in your quarterly report, indicating that we had not performed as expected under that contract. The two, some of the issues that we have related to how that was presented and the implications of that report are that we were not a party to the creation of the funding matrix used in FY-2018 or FY-2019. The regional councils expressed their opposition to that funding matrix because we didn't feel that it realistically represented regional demands, nor did it take into account the geographic or demographic differences within regional councils. We were told at that first initial meeting that we could either take that MOU with that funding mechanism or leave it, and that if we chose not to execute the MOU, they would find an alternative means to do that. The administrative fees that are referenced in that report were not negotiated or determined by the regional EMS

councils, and in fact, we were not, we did not invoice for those fees throughout any of the terms of those two contracts. Those were added, calculated and added by the state office, and no feedback was received at any time indicating a performance deficiency or change in outcomes. We believe that collaboration is essential in creating and implementing programs that impact Virginia's EMS system, and it's necessary to ensure efficiency to produce plans that consider the geographic and demographic variations across Virginia. And Gary, I do want to thank you in your comments for noting that regional EMS has significant variations across Virginia and that we must in our processes meet those unique demands that are representative of regions. And that has been the goal and the aim of the regional EMS councils since our implementation and our founding nearly forty years ago. We believe that collaboration between OEMS and stakeholders is essential to advancing the field of Emergency Medical Services in Virginia and understanding very well those unique needs, those unique challenges that arise from our geographies and our demographics. We've always striven to be

proactive in our collaborations to build successful programs. Under the current MOU that was presented at our meeting in May, we were once again presented a document that we had not seen that defined a funding matrix that we had no input into. While we had opportunity for some discussions during that meeting, having not received the document in advance, we could not have informed discussions related to the impacts of that program or how we were going to administer those. So in that spirit of collaboration that we talked about, that following Monday I emailed the state to Mr. Chad Blosser and said, "Thank you for your presentation at our meeting on Thursday. I've spoken to numerous colleagues since our meeting about this proposal. The majority seem to agree that this is an innovative approach to ensuring the provision of EMS continuing education across Virginia. My colleagues have expressed their support of the program and desire to work collaboratively to make the program successful. With that said my colleagues have expressed challenges to implementation of this program as proposed. Not having the information in advance

precluded thorough discussion and dialogue during our brief meeting. With time to read the MOU and analyze costs, many of us have identified operational challenges to implementing this program as presented. Many of these arise out of the unique geographic, demographic, and structural characteristics of our regions. However, I believe that I can speak for our group in stating that our shared goal is to make this program succeed. I believe that we can build a better plan and better product by working together. As chair of Virginia's regional EMS councils, I am requesting a meeting to continue these discussions. I do not believe it must necessarily involve the entire regional director's group. I believe representative groups from the RDG and OEMS would be sufficient. I am willing to come to Richmond if necessary to meet or to meet between here and there. Please let me know what dates you have available and we will go from there. I did receive a reply back that Adam Harrell would be answering those questions, but we never got to a point where we had a meeting to discuss that MOU proposal. For background, I had already prior to this point

emailed all of the other regional EMS councils, asked them to refrain from directly contacting OEMS and expressing their individual views, to send those to me by email so that I could in a direct way address all of those concerns on behalf of all of us. Polling our group and having heard from all of them, only one region in the Commonwealth prior to my sending this email had had direct communication with OEMS after we left Richmond after being presented with these documents. So on Tuesday, May 7th, we received an email from Adam Harrell, noting that due to the considerable issues with deliverables, contract value, terms and conditions, and the desired level of performance and availability of continuing education, they were rescinding their offer of the CE MOUs for all regions. At this point, one region had already signed and returned the MOU in anticipation of being able to work through to implement this program. So I did follow-up with Gary Brown after receiving Adam's reply, and I noted that yesterday I requested a meeting as chair of the regional director's group, which had to talk through some questions raised after reviewing the proposed CE MOU and

having time to work with those numbers to project costs. Having not provided those documents in advance precluded informed discussion, and it's not an approach that I expect of government offices. Similarly, drafting such a plan with no input from EMS constituents or those intended to implement it cannot produce a truly well-reasoned and developed systemic solution. My email to Chad expressed my desire to work together to develop a workable and successful plan; however, it appears my offer has been summarily dismissed. This is not a positive or helpful response in this situation. And then I went on to say while I've advocated for partnership and collaboration between the regional offices and the state for years and continued to do so, responses and reactions such as this do not convey the openness nor transparency expected of government. Then I asked, I ask for your intervention as the head of OEMS to change the manner of discourse between members of the state office and OEMS to move toward greater partnership. Since those times, there have been a lot of communications related to those MOUs that were proposed in May of this year. They do not adequately describe what

happened, nor do they describe the exchanges between the regional EMS councils and OEMS, and they're not conducive to building and fostering collaborative relationships. Those who have studied leadership, we know that trust is essential and that honest and open communication engenders trust. I am very much encouraged and our regional directors are very encouraged by the efforts by Dr. Jaberi to talk with us and to foster opportunities for dialogue, but we do not appreciate the report that implies that our performance was inadequate when that measurement criteria had been affirmed multiple times by OEMS and we were in good faith executing financial schemes that we had no part in drafting to the best of our abilities; and we don't appreciate the non-transparent and sort of biased approach that has been taken in explaining those interactions over time. We look forward to continued discussions and we look forward to having open frank and honest discussions about what regional EMS councils should be doing and how we work with the state to accomplish the goal that all of us in this room should have, and that is simply improving pre-hospital care and making

sure that the patients that we touch have the best outcomes possible all across Virginia. I will not get into any of the details unless you ask of the specifics of what that MOU looked like or why I make the statements that there were challenges to it. You're welcome to ask those questions and I can speak from my region, or you can find me on a sidebar. If you have any questions, I encourage you to ask your regional EMS council, and as noted, I can share with you those email exchanges if you feel they're beneficial. With that, I conclude my report.

MR. PARKER: Thank you. We're now down to public comment period. For those wishing to make public comment, you're asked to come to the microphone, state your name, and then the Chair, myself, will recognize your three minutes as noted on the clock in the center of the room. You are asked to speak slowly so the court reporter can understand what you're saying.

MR. TANNER: Mr. Chair?

MR. PARKER: I open the floor for public comment.

MR. TANNER: Mr. Chair? I'd like to make a motion that this document that was

handed out be added to the minutes of the meeting.

MS. ADAMS: Second.

MR. PARKER: So we'll call for a vote. All in favor signal by lights on. So I have one, two, sorry about that. All right, all in favor say so by saying aye.

(WHEREUPON, board members voted in the affirmative.)

MR. PARKER: Any opposed? Any abstained? Motion passed.

(WHEREUPON, the motion was passed.)

MR. PARKER: Public comment period. Is there anyone wishing to bring any business before the board today?

MS ADAMS: Mr. Chair? I've been asked by the Northern Virginia Fire and EMS Chiefs to provide a statement, and in light of what just preceded, this seems like a good time for that.

MR. PARKER: Okay.

MS. ADAMS: Thank you again for making me feel welcome on day one. Roughly thirty years ago I joined the Minnesota EMS...

MALE: Turn the mike.

MS. ADAMS: Turn the mike towards me. Thirty years ago I was welcomed to the Minnesota EMS Advisory Committee, had been appointed by that governor, so what's old is new again. In the intervening years, as Gary noted, I have spent much of my time as an educator. My first dozen years in Virginia, I taught with George Washington University full time and at one point was responsible for continuing education for five of the seven major jurisdictions in Northern Virginia. So I had a pretty good handle on what was going on and have worked closely, and in the dozen years since, I've been in the, working for a specific agency. So on behalf of the Northern Virginia Fire Chiefs and EMS Chiefs, I've been asked to share this information with you. The Northern Virginia EMS Council has met or exceeded all parameters for performance for the MOU for disseminating training funds. The office of EMS has stated that the cost of doing business on the previous MOU was prohibitive; however, the MOU stated that the regional EMS councils would receive ten to eleven percent of their allocated amount as administrative fees. This caused many of the EMS councils to receive

the same amount or even more money than what was invoiced for their region. The proposal was brought up by the regional directors and again by the Northern Virginia Chiefs at a meeting at the Virginia Office of EMS to suggest that the MOU be amended to only provide the ten to eleven percent based on invoices provided. This incentivizes the additional training and collaboration within the region, thus making it easier for EMS providers to find CEU classes closer to their home or even workplace. When the regional directors offered to assist in making the proposed new MOU a more effective program, Office of EMS staff stated they do not negotiate with contractors. Although the terminology of contractor in quotes is correct, citing section 32.1-111.11 of the Code of Virginia, establishing the regional councils in defining their function and purpose. The purpose of the councils is to collaborate with the Office of EMS, local government officials, physicians, hospitals, and EMS agencies to plan and coordinate EMS activities at the regional level to promote quality of care. The establishment of contracted educators directly through the Office of EMS

specifically bypassing the councils is not an effective way to collaborate. Introducing a change in the MOU during a meeting in May with expected implementation by July 1 is not a very effective way to make positive change. Self-imposed deadlines on the part of the Office of EMS makes it difficult to plan for the future on a regional level. A contingent of the Northern Virginia Fire Chiefs traveled to Glen Allen on June 12th of this year for a meeting with Office of EMS staff to voice their concerns. Shortly after the conclusion of that meeting, Mr. Brown asserted that the Office of EMS would be working on a new plan to be presented to the NoVA Fire Chiefs as an alternate option, and to date there has been no plan received by the group. The Board of Directors at the Northern Virginia EMS Council is appointed by the EMS agency heads within our region. Those are the fire chiefs. They determine the representation to the board, and so when the EMS councils, Northern Virginia EMS Council Board speaks, the majority or speaking on the behest of the fire chiefs. Bypassing the Northern Virginia EMS Council with programs such as these makes it difficult for the

Board of Directors and the chiefs to work with the Office of EMS. As customers of the Office of EMS, this can't be the norm, and they have four asks. Ask number one: the best option would be to restore the MOU for training funds with the amendment that the administrative fees paid to the councils be based on their invoices provided to the Office of EMS. Two, if that cannot be done, the chiefs would like the Office of EMS to work with the Board of Directors from the Northern Virginia EMS Council to develop an MOU effective for all parties. And in addition, three, changes of significance brought forth by the Office of EMS should be discussed at this board or at the appropriate subcommittee so that there is an opportunity for its discussion prior to implementation. And lastly, what commitment or specificity is there with regard to collaboration with the EMS councils for training that will be conducted in their region by these state-funded contractors. Thank you. And I'll, Chris, I'll send you an email copy of this. Thank you.

MR. PARKER: Thank you. Is there anyone else that would like to come before the

board?

MR. RHOADES: Mr. Chairman, Ed Rhoades coming to you as chairman of the Health and Human Resources Subpanel of the Commonwealth Preparedness Panel, inviting the board to come to our next meeting on September the 10th of this year at the Glen Allen Library off Staples Mill Road. Thank you.

MR. PARKER: Is there anyone else that would like to bring any business before the board?

MR. HUMER: My name is Walter Humer. I am currently, been working in EMS for thirty years. Some people here know me. Thirteen years in Richmond, seventeen years in Dinwiddie County where I reside. I have seen a lot of people injured throughout my time as I was a medic, so I come to the conclusion, I started an organization that's a 501(c)(3) nonprofit charitable organization called Foundation Trauma. It is, with the mission of helping those that have been critically injured. To date, I have helped four families that have been sent from area hospitals to level one trauma centers and sent back home. They are in need of financial

help mainly, so I was able to help them as much as I could. So I'm looking for some recognition and you all putting the word out for me to help other people. Thank you for your time.

MR. PARKER: Thank you, sir. Is there anyone else that would like to bring any business before the board? At this point, we're at the unfinished business. Is there any unfinished business to come before the board today? Valeta?

MS. DANIELS: I just have a couple of questions about some reports that were given today. One is what about giving the regional councils more people? And I don't understand what the state is hiring people to do CEU credit classes for versus it being the regional councils. That's my first question. I have another question, but, so I'm just not understanding the difference there. Did we pull it from the regional councils and now the state is going to handle that?

MR. PARKER: Hey, Adam.

MS. DANIELS: I'm just not clear on how that happened and what those positions are, what they're going to be expected to do.

MR. HARRELL: So what the state is, what the office is doing is we're hiring contractors. We're hiring people to perform category one CE for every planning district. So these are not taking funds away from the council, you know, that were, not taking people away from that, that type of arrangement. This is a new model for providing specific category one CE throughout the Commonwealth.

MS. DANIELS: So were the councils not presenting enough category CEU one, CE category ones?

MR. HARRELL: The overall CE that was being delivered was not meeting expectations. I can't say that each council didn't meet performance measures. It was the program as a whole was not meeting the CE needs that were anticipated. So this is a different approach of providing staff instructors within the planning districts to provide that continuing education.

MS. DANIELS: And then how will they be disbursed?

MR. HARRELL: It will be, it's roughly one per planning district. Some planning districts, because of their size of geography,

receive two, but it is one full-time employee, forty hours a week, providing continuing education to every planning district.

MS. DANIELS: And what about, so do the regional councils still have their training funds?

MR. HARRELL: No, ma'am.

MS. DANIELS: Okay. So the training funds have been pulled from the regional councils?

MR. HARRELL: That is correct.

MS. DANIELS: In lieu of the state hiring people to do this.

MR. HARRELL: Correct.

MS. DANIELS: Do they have state benefits and all that?

MR. HARRELL: No, they do not. These are contract employees through the state's contingent labor contract. So they do not have full-time benefits. They receive an hourly wage per that contract.

MS. DANIELS: And where are they going to work out of?

MR. HARRELL: They will be home-based employees with state assets. They have

access to state email. They have a state telephone. They have projection and educational equipment. They will be monitored by the ACE Division and will be under Mr. Chad Blosser as direct reports.

MS. DANIELS: All right. I just have some concerns about this, but okay, thank you.

MR. HARRELL: Mm-hmm (indicating affirmatively).

MS. DANIELS: Okay, question number two, Dr. Lindbeck and Dr. Jaberi. So I just find it hard to believe that the Medical Examiner's office has never ever had an employee exposed to something. What did they do if they, I mean, I know that they suit up. I know, but things rip, things tear, so what's their internal process if one of their employees is exposed?

DR. LINDBECK: So a different issue, they have had exposures. The point is that they don't run serology in-house. It gets sent out to a reference lab. And there are only two reference labs in the country that do this. One is at the Mayo Clinic in Rochester. The other is LabCorp, and the closest LabCorp lab is

in North Carolina right now. So the OCME has looked after their own employees...

MS. DANIELS: Right.

DR. LINDBECK: ...but they've never had a mandate to look after the EMS system, first responders, and nobody really knows what to do with the good Samaritans.

MS. DANIELS: Right.

DR. LINDBECK: Because nobody really has responsibility for them and responsibility incurs costs and availability, and we just don't have that system. So OCME has always looked after their employees, but again, they don't run these serologies in-house. Even their toxicology work generally gets sent out to a reference lab. Does that make sense?

MS. DANIELS: Yes, sir. Thank you.

DR. LINDBECK: Okay.

MR. PARKER: Any unfinished, any more unfinished business? Sorry.

MR. BOLLING: Just an additional question. The...

MR. PARKER: Can you slide the microphone a little bit?

MR. BOLLING: Normally I don't have to have a little audio assistance to project my voice, but I'll be happy to. The, going further with her question, the new continuing education program is a replacement program as a result of rescinding the CE MOUs, correct? So this is just moving forward?

MR. HARRELL: That is correct.

MR. BOLLING: And secondly, how will success of this program be measured? What are the metrics to measure success of this program?

MR. HARRELL: So there will be multiple factors utilized to measure success. So we are, we will solicit input from the agencies, the operational medical directors, the individuals that are listed in our system as super users for each agency within those planning districts, as well as provide a mechanism for individual providers to provide input to the office to say these are the topics that we want to see taught within our region. We're also working with our epidemiologist in-house to take a look at patient care data to determine areas, you know, areas of specific education based upon

region to take that back to the agencies and operational medical directors to say based upon the data, these are areas of deficiency. So once education is being delivered, we're going to gauge it from customer satisfaction surveys, determining how well the EMS community is accepting that education, how well was the quality of the education delivered. We're also going to monitor this geospatial identification of availability of CE versus, you know, time of day, number of providers, and then compare that to historical data to determine performance.

MR. BOLLING: Excellent. Have you set a bar as to what is acceptable and what is not?

MR. HARRELL: In, from...

MR. BOLLING: For those results. What...

MR. HARRELL: We have historic data..

MR. BOLLING: Okay.

MR. HARRELL: ...that we are using as a baseline right now and we're also utilizing industry-specific educational customer service metrics, so similar to what you see at community

colleges and universities.

MR. BOLLING: Are these the same metrics for measurement that were part of the previous MOUs when the councils were overseeing that?

MR. HARRELL: You can't, so it's different methodologies, so we can't, it's apples to oranges, the education that's going to be delivered, because under the old method, it was the councils utilizing multiple educators and multiple individuals that may be delivering various topics through various methodologies. So this is a universal-guided approach throughout the entire Commonwealth to be able to gauge performance on a statewide level, as well as being able to drill down to specific planning districts and regions.

MR. BOLLING: Were the metrics for measurement of success, the way it was previously done, were those communicated through the MOU or was it left open?

MR. HARRELL: So when you look at it from a standpoint of performance, there was no identified performance metric specifically to each council. It was the overall utilization of

the monies to produce education within each region is what we looked at as a performance factor, because at the time, that's what that program was to do, was to put education out. We saw a, we didn't see education necessarily being delivered in each of those regions. That's the data that's in the advisory board report.

MR. BOLLING: So it was more about spending the money than it was the end result? Is that...

MR. HARRELL: No, sir.

MR. BOLLING: Okay.

MR. HARRELL: That's not what I'm saying.

MR. BOLLING: All right, then say it again for me.

MR. HARRELL: What I'm saying is...

MR. BOLLING: A little slower for me, clarify for me.

MR. HARRELL: ...there were specific things that were put into that contract to say that X number of courses could be taught in a specific FIPS code.

MR. BOLLING: Okay.

MR. HARRELL: And that's how the budgets were determined. So as was previously stated, there was a contract maximum. This is the maximum we'll pay for the number of classes being taught.

MR. BOLLING: Okay.

MR. HARRELL: Looking at that as a performance measure, if the money was not spent, classes weren't being taught. So we also had direct input from providers throughout the Commonwealth that they were not finding classes, they didn't have classes available in their regions, although they had heard through the advisory board and through other communications that money was going to the regions to support education. So what we're going to look at now is taking that into account. That's how we're going to gauge performance moving forward.

MR. BOLLING: Okay, thank you.

MR. HARRELL: Yes, sir.

MS. DANIELS: I have another question. So what about the merit badge courses, the ACLS, PALS, those?

MR. HARRELL: At this time it's not included in this CE program. This is

category one continuing education.

MS. DANIELS: Because that hurts. That hurts a lot. So how can we be able to get those, still get those classes, as a volunteer, still get those classes because I don't have $150, $250 to put out for one merit badge course.

MR. HARRELL: So one mechanism is return to locality monies. They are able to be utilized for training purposes. That money can be used by a jurisdiction to identify specific education they would like to have conducted. The move away from auxiliary programs was one we were seeing substantial utilization of that as a means of continuing ed., and through national research, it's been identified that utilizing auxiliary programs as a primary means of continuing education is not effective. Because now you can get ACLS online. You go in and you might show somebody your skills or you may perform them on a mannequin. So what we were looking at is this money being utilized to put educators out there or hands-on in-person education, not necessarily a merit badge course that helps bulk some hours together to recertify.

MS. DANIELS: Then it doesn't go

towards certification hours anymore? ACLS and PALS don't. They used to. I think it was about two years.

MR. HARRELL: They still do. National Registry does not require them anymore.

MS. DANIELS: Right.

MR. HARRELL: But they, you do get CE, CE is available for auxiliary courses.

MS. DANIELS: Okay. Something's not right and I certainly hope that the board and our director will work with the EMS councils because it just seems that there has been a lot of not taking into account the regional councils, and we certainly obviously need those as Gary alluded to at the beginning, so.

MR. PARKER: I appreciate your comments. Is there any other comments to come before the board?

MS. ADAMS: I have a question.

MR. BOLLING: For my last follow-up, one other just, I'm sorry.

MS. ADAMS: Go right ahead.

MR. BOLLING: I'd just like to follow-up with one other comment, and while they're referred to as a merit badge course, I

need you to answer for me, just pull up a seat beside me here, Adam. While they may be referred to as merit badge courses, I feel like that's an understatement of actually what the classes are, and while National Registry may not require those, there are some operational medical directors in our region, I'm going to go back to address some regional needs, that do require these classes. And where we're operating under their license, our agencies are operating under their license, I do feel like those classes, while they aren't merit badges, they do have merit and I feel like that now saying we're going to let what your operational medical director is requiring, we're going to shovel the cost of that back on to the localities, and that's how it's going to be perceived, and the little towns throughout Southwest Virginia, we've got everything on our backs we can. Can these classes not be a part of the education program, blend this to meet the needs of each region? Some places may not need this, and I thoroughly understand that, but I do know the region I come from, these are required by some of the operational medical directors. So could there be

some type of blending or some type of research to say okay, well, if this is what that region needs, then we'll include this as part of it, to have a more effective program, and then I'll digress.

MR. HARRELL: I can make the same comments that I made to VAGEMSA earlier referenced to the auxiliary programs. It's not that we haven't, that we decided, you know, we're not going to fund auxiliary programs anymore. The mechanism that we're getting out right now to provide continuing education that's required for recertification is to get these educators out. We're still looking at options for auxiliary programs. As was alluded to earlier, the old training funds program went away because of fraud. The bulk of that fraud occurred through auxiliary programs, because what we continue to see, and even recently are seeing, is people falsified the required documents to the parent organization just for the sake of getting the money. Now I'm not saying that that's the only reason it's not included in this, but there has to be a different methodology looked at to provide auxiliary programs on a statewide basis.

And in some respects, trying to look at this from what can we do as you said regionally to be able to promote these, looking at things like working through the Virginia Community College System or working through, I know VCU here in Richmond offered discounted courses. What can we do along those lines? It's not that we are completely discounting auxiliary courses. It's that through a means of procurement, we have got to identify a way that we can vet what we're paying for.

MR. BOLLING: Maybe even through the regional councils. Backing up to what you said about there was fraud, was there any investigation, any charges, any prosecution made?

MR. HARRELL: There was investigation occurred and that was forwarded on to the appropriate agencies.

MR. BOLLING: Okay, very good. Thank you.

MS. ADAMS: Are these educator positions being posted on vajobs.gov or whatever it's called so that the host of talented capable providers and educators across the Commonwealth may apply for consideration?

MR. HARRELL: No, these are not

state FTEs. These are individuals that are being brought on through a mandatory use contract for contingent labor, so they're not required to go through the normal HR processes.

MS. ADAMS: So it's not an open application?

MR. HARRELL: No.

MS. ADAMS: If I decide I want to leave my job tomorrow and say hey, I've been pretty good at this for damn near forty years, I can't apply?

MR. HARRELL: The ACE Division has been working on communicating out the openings and the availability as well as rigorous processes for ensuring the educators that we're bringing onboard.

MS. ADAMS: So the answer is no, I cannot apply.

MR. HARRELL: No, you can contact the ACE Division and they can provide you more information relative to any positions that are open.

MS. ADAMS: Okay. All right, I have another question, not about that at the moment. My other question is, I know that

NAEMSP, that Virginia, that VFIB adopts the NAEMSP standard for our data sets, and I wonder, and I know in conversations both at NAEMSP in January and at Pinnacle last week that they are continuing to evolve the data sets. My question is at what point are we going to have options for our non-binary clients, customers, patients, providers to have choices other than male, female, and question mark? That doesn't seem very twenty-first century. So I just want us to start considering that unknown or unable to determine, or as it stands now a question mark, doesn't seem to speak to the inherent worth and dignity of each patient we encounter.

MR. PARKER: Thank you.

MR. BOLLING: Mr. Chairman?

MR. PARKER: Oh, I'm sorry.

MR. BOLLING: I'd like to follow-up, general no fault and I'd just like to share with, while I may have been here asking some questions about how things work, I would like to clarify where he, Adam just advised they were contract employees, not full-time employees of the Office of Emergency Medical Services, correct?

MR. HARRELL: That is correct. They are contract employees.

MR. BOLLING: Excellent. I just want to commend the Office of Emergency Medical Services for doing that because that does provide a more cost efficient way of having these employees without having to have everything that goes with it, correct?

MR. HARRELL: Correct.

MR. BOLLING: And I admire you for that. Why was that not offered in the Memorandum of Understanding that was proposed to the councils? We were going to have to bring them on as full-time employees with benefits. I think a lot of the question about the cost associated with it could have been alleviated if it had been clarified to the employee, the regional councils those employees could be through a contract work organization.

MR. HARRELL: So those discussions have been had with the councils before about using contract employees. That was not something that was in this. That was a discussion that we had with them at that time when this was presented that they did not have to be employees

of the council, they could be contractors.

MR. BOLLING: Okay, very good. That was included in the MOU original?

MR. HARRELL: As far as I know. Chad would have to help me with that.

MR. BLOSSER: I mean, the figures, I don't think there was anything in there that specified it had to be a full-time employee. The word full time was referenced for forty hours a week, so it was understood in that regard, but...

MR. BOLLING: I think in the spirit of collaboration, there's where a big disconnect is because I read the MOU and it referenced full-time employees, and in figuring our taxes and insurance that would have to go along with a full-time employee started adding costs to it. That's where the questions came from, but we never really had an opportunity to sit down and discuss that with you, but again, hats off to OEMS for using the contract employees. That is an excellent mechanism. Appreciate you, thank you.

MR. PARKER: The Chair recognizes Dr. Jaberi.

DR. JABERI: Can I just see if Adam can make a clarification. So I'm not sure if these are mutually exclusive. A contract employee, for those who don't work with the state system, we don't wind up paying for the fringe and the benefits, but you could still work the full forty hours so you are a full-time employee as in you're working more than thirty-two hours, but you're not necessarily requiring those health benefits. So it's separate from an FTE and the concept of when we look at our maximum employment level and the state agency, going back to some of the discussions I had earlier about the council's requesting assistance with the administrative support, we have a certain number of employees that VDH can hire. I won't quote the number but it's an X amount, and that's all that we're legislatively allowed to have. So when we say an FTE, we want to be really careful what that means. FTE in the concept that it's one of the positions that's included in our employment level or are we talking about an abbreviation for full-time employee which could be a contract employee or an actual FTE of the state? So Adam, do you want to come and clarify? I think there's some

confusion over this, that a contractor can be full-time as in work forty hours in that sense.

MR. HARRELL: That is correct. Any employee that, any person that works over thirty-two hours for payment is considered full time, unless there is something defining that, which the state does have policies that define that, as well. In this instance, these are full-time employees. They are full-time contractors for the Commonwealth of Virginia, and specifically to the MOU, there was a full-time salary option in there as well as additional monies provided for fringe, so it was not something that was not accounted for in that contract. And you know, in looking at those factors, that's why it was given as an option, and there was, you know, specific discussion relative to the contractor component in that meeting. So again, there is, there are things that are in that MOU when we use the term full-time employee in a contract or MOU, it's not in the same sense as a full-time employee for the Commonwealth or an FTE for the state.

MR. BOLLING: Appreciate that and I want to say that within five minutes, we have

clarified something that we were not able to clarify from the regional councils asking for a meeting to discuss this, because the dollar amount put in for fringe benefits was way short of being able to carry the Worker's Compensation or the Worker's Comp insurance and the health benefits that would go with it. This is something that could have been made to work, but I just hate to see that from the fact that we were never able to get together, and we need to do this. And it doesn't have to be here in this meeting. We need to sit down together and learn to work together. But it seems like there's a barrier between us. We need to go to lunch more often. We need to have these discussions so that we don't lose things in the context of an email coming out or a memo being handed out and asking to turn it back in before we leave. We can clear up a lot of this, but there's a severe disconnect of communication going on. But that cleared up in just five minutes, we cleared up one of the points of contention of that MOU because the way it was presented, it was going to cost additional monies to the councils to employ, our council to employ those three people. But we were looking

for a way to do it and the way the state did it would have been perfect for us, too. I wish we could have talked beforehand. Come on to Bristol more often. I'll take you out to dinner and we'll talk. There's so much we can accomplish working together because we as regional councils are on the same thing as you, same team as you. Everybody in this room, we're all about patient care, and if we all get all the mules pulling in the same direction at one time, oh boy, the sky is the limit, and I'll go back to what Gary Brown once said. We're looked upon as a national model and I take pride in that and I'd like to see us keep going that way. I digress.

MR. BLOSSER: Mr. Chairman, so I would just like to reiterate what Ms. Daniels said about the value in the merit badge classes and merit badge classes is probably an understatement for what the value they really have. They may not bring forward the amount of CE that they once did and they may not be totally in align with the NCCR models as they once were. However, I think they do help us to address certain types of emergencies and certain types of patient populations, and that would be medical

patients, cardiac patients, trauma patients, and certainly geriatric and definitely pediatric patients. We have a lot of value in those classes. Operational medical directors are going to continue to require those programs, and fire and EMS chiefs are going to continue to require those programs because they guarantee the provider skills, hands-on skills, much like maybe one of the similar objectives to having the educators go in the field for face-to-face hands-on training. These programs do require that. And yes, the expense is going to be passed back onto the EMS provider, and those lucky ones that work for agencies who were well-funded will have to absorb the impact of that in their budget on the cost of about $60 in addition to what they had been paying. So I would say that we should take a look at that. I've also mentioned on a number of occasions, and certainly I think there are some things working to do this, as well, is some of the CE money could possibly go to support departments that have already invested into online training platforms. Only as an example, Target Solutions seems to be one of the more up and coming programs that providers and

departments use to get out CE. So I will say that in this forum. Again, we spoke about it earlier in VAGEMSA and I do believe the Office of EMS is working behind the scenes to make that possible. And I will just point out the obvious, too. We've had a communication breakdown and it seems like this is probably one of the more controversial issues that I recognize that's come forward in a long time, and I don't know exactly how we do this or how we go back and try to include all the stakeholders, but it seems like that if there's a will and there's a way, that we should have a reset on some of the decisions that might have been made recently and go back and take a look at those. Some may have already been made, and I understand fully that this is an advisory board and is not a policy board. However, I think there's an opportunity before us and I think we all have demonstrated in the past how well we work together and how we can overcome challenges and take into account everyone's consideration. And so that's what I would say and I would be happy to help any way that we could think of a way to do that.

MR. PARKER: Thank you, sir.

MR. FERGUSON: Mr. Chair?

MR. PARKER: Where was that?

MR. FERGUSON: Here.

MR. PARKER: Thank you.

MR. FERGUSON: Question for you, Adam. With the current model that you guys have put in place with these contractors, do they, will they work with the councils to determine needs for the different areas and regions?

MR. HARRELL: Absolutely.

MR. FERGUSON: So while obviously I agree with my colleagues here that maybe communication could have been a little bit better in this situation, and I do also see the merit in the merit badge courses and I have voiced that to you all, as well. Whether the councils contracted these individuals or whether the office contracts these individuals, at the end of the day, will not he same service be provided that will affect the citizens of the Commonwealth?

MR. HARRELL: Absolutely.

MR. FERGUSON: Okay, I just wanted to make sure, and these council members have been made aware, they know that they have a stake in

this?

MR. HARRELL: We have advised throughout that these individuals would be contacting the councils for input and information. We did have to provide clarification at one point that, you know, these individuals did report, you know, what the reporting structure was. But this has been advertised and discussed as a collaborative effort.

MR. FERGUSON: And hopefully after today, maybe there can be some reiteration of everything involved between you all.

FEMALE: Per my conversations with the Virginia Fire Chiefs, they were told there would be no collaboration with the councils or the agencies.

MR. HARRELL: Gary?

MR. BROWN: That would be incorrect. If that was told to you, that was not accurate.

FEMALE: Thank you.

MS. QUICK: I have a question for, I don't know if Mr. Harrell or Mr. Woods can better address this, but I'm thinking about

really audience here. If the regional council program wasn't successful, was that because there wasn't an audience for that and is that going to be the same with this kind of contract. I think that as an educator, and I've been an educator for over twenty years, too, how I have supplied education has changed dramatically in the last twenty years, and the, I guess the, many of the larger agencies now are doing that themselves, and even the smaller agencies are utilizing online options and options that are easier and more accessible to their population. So I'm wondering if there really is a bigger elephant in the room here as to who this is really serving and who is going to really have access to this educator that comes. If I am agency A and I want twenty hours of that time versus agency B that wants ten hours of that time, how is that going to be I guess looked at?

MR. BLOSSER: I think most of you know me. I'm Chad Blosser with the Office of EMS. The educators have been given autonomy to work with the individuals in their area that includes EMS agencies. They've been provided with data, contact information, and as soon as we

have one more release to the EMS portal in about a week or two, there will be additional information available to them so that they have three points of contact at agencies within their assigned service area. As far as, what was the question? I'm sorry, I just...

MS. QUICK: Yeah, I mean, was, this I guess is a council question but was there a failure of the constituents to come to the councils and ask for these classes? Or were they simply not being offered or, yeah?

MR. WOODS: So I'll be happy to attempt to address that, speaking specifically for Southwest Virginia EMS Council. In the original CE MOU, it defined both category one CE programs provided per locality and an amount for auxiliary programs. In Southwest Virginia today, I have a little over fifteen hundred EMS providers. Of those, only around 450 are ALS providers, and in the original CE MOU, I was allocated nearly thirteen hundred auxiliary course completions. If you were to say, well, in a given year, all of those providers were going to take three auxiliary courses, the numbers sort of add up, but we know that those are on a two-

year cycle. So typically you're recommended renewal is in two years. So in year one, we might have made a case for that, but in year two then, our case would have been zero should have been offered for auxiliary training, but it was not changed. That was my specific discussion with the original CE MOU, that those numbers were not valid for Southwest Virginia, and I can dig that down just a little bit further. We are also the American Heart Association training center for Southwest Virginia. We do ACLS and PALS. We serve both hospitals and EMS providers. Per year, we're averaging around four hundred cards to hospitals and providers in both ACLS and PALS. So even if we used those numbers, we'd have only gotten to, you know, maybe eight hundred. But we were told that those figures were historical data and we were not, it was not negotiated with us. So when I signed the MOU, obviously I had concerns knowing I do not have thirteen hundred providers in Southwest Virginia who will take auxiliary courses. So when you see the amount of the award for Southwest Virginia, it includes a totally inflated amount for auxiliary courses that we were never going to reach. And because I

was concerned with that, led to my reaching out to Chuck Faison, who was administering the program, to confirm that we weren't going to be penalized if we couldn't get there. I think it was an unrealistic number and I could have provided that data from my region and those actual numbers of ACLS and PALS courses that were being offered, and we are the A&J Training Center. Many of those are going to hospitals and they have in-house programs, and so they didn't need those outside training. But we didn't have that opportunity and so, you know, that report that sort of shows that total amount was never the numbers that should have been provided for Southwest Virginia, but rather than reject the MOU as was offered to us, we didn't have to produce it but we could accept it or reject it, knowing that that would mean that education in Southwest Virginia would continue to be halted until another process was defined, we signed it and then we sought clarification and we had multiple emails from Chuck Faison indicating that, you know, it wasn't a performance issue, that that was a maximum and there was no penalty. They would adjust those numbers in the future

based on who was actually taking those courses. Does that answer your question...

MS. QUICK: What about the category one? I mean, do you have a flux of people that are coming to you that are asking for these courses, taking these courses for category one?

MR. WOODS: I can only say for Southwest Virginia, we've been doing category one CE training for, well, I've been there fifteen years, at least fifteen, I would estimate probably thirty years, so we were doing programs already. We successfully offered, you know, two CE programs in every locality in Southwest Virginia both years of that contract, both of those MOUs. So we were able to fill up the classes. In the first year, we had occasions where the numbers were lower, but we were seeing that grow, and I would anticipate that other regional councils would probably say the same.

HEIDI: Heidi from the Old Dominion EMS Alliance.

MR. PARKER: The chair recognizes Heidi for three minutes.

HEIDI: Thank you. I'm sorry,

Greg, I was just adding to what he was saying. ODEMSA was successful in our program. Look at the numbers. First quarter we're here, second quarter we're here, third quarter we're here. Fourth quarter, which is not in your report, by the way, I guess what happens again in the first quarter of the next year, we drop right back down to the bottom. That's why our first quarter number is so low. The contract, which we can't do anything about or talk to anybody about, is only good for one year. So if you're an educator or you're at an agency trying to plan your funding with us, the regional councils, we can't tell you what you can do in the first quarter because we don't know. Thank you.

MR. PARKER: Thank you. Is there any other questions? Okay. So we are continuing down the agenda. Any other unfinished business?

MS. DANIELS: Just one thing I would like to let my last point to point out. It just seems weird that it's not posted, the availability of that position is not posted and that you have to call the Department of Education to find out how to apply for it. It just seems like it's being handpicked rather than everyone

having a fair shot at that job. So I just, so it seems like there's still, it's not very transparent being, giving everyone the same opportunity to apply for that position if they wanted or not.

MR. PARKER: Thank you. Any other unfinished business? Okay, we're down to new business. Any new business to come before the board? Any new business to come before the board? Hearing no new business, is there a motion for adjournment?

(WHEREUPON, the motion was moved and seconded.)

MR. PARKER: Motion, I don't even think we need to carry that or pass it. Thank you.

(WHEREUPON, the VIRGINIA DEPARTMENT OF HEALTH ADVISORY BOARD MEETING was concluded at 3:24 p.m.)

CAPTION

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

It was requested that the matter be taken by the reporter and that the same be reduced to typewritten form.

CERTIFICATE OF REPORTER AND SECURE ENCRYPTED SIGNATURE AND DELIVERY OF CERTIFIED TRANSCRIPT

I, **KOREY ROGERS**, Notary Public, do hereby certify that the forgoing matter was reported by stenographic and/or mechanical means, that same was reduced to written form, that the transcript prepared by me or under my direction, is a true and accurate record of same to the best of my knowledge and ability; that there is no relation nor employment by any attorney or counsel employed by the parties hereto, nor financial or otherwise interest in the action filed or its outcome.

This transcript and certificate have been digitally signed and securely delivered through our encryption server.

IN WITNESS HEREOF, I have here unto set my hand this 9th day of August, 2019.

/s/ KOREY ROGERS
COURT REPORTER

Q

Regional Council Document
Requested by Motion and Approval
to be added as an Addendum to the
Minutes

Regional EMS Council Response to CE Education Provision in Virginia

August 2019

FOREWARD

In their quarterly report to the State Emergency Medical Services (EMS) Advisory Board dated August 2, 2019, the Virginia Office of Emergency Medical Services (OEMS) included an appendix which included a document titled "Performance Review of Regional Council Continuing Education (CE) and Auxiliary Program MOU". The document provides data related to total contract amounts and disbursement within specific categories. While the data presented is accurate in its presentation of accounting, the report is incomplete. Virginia's Regional EMS Councils have drafted this document to provided context and to ensure that EMS stakeholders have a complete understanding related to this report as well as proposed and implemented changes in the delivery of education in Virginia.

HISTORY OF CE AND AUXILIARY CONTRACTS

In 2016, changes in state procurement requirements necessitated changes in contracting practices related to the Emergency Medical Services Training Fund (EMSTF), including a prohibition against contracting with individual instructors. The change created a delay in EMS Training Fund availability across Virginia.

To minimize the potential negative impact on EMS education arising from this change, Southwest Virginia EMS Council Executive Director Greg Woods sent an email request to OEMS asking that consideration be given to utilizing existing regional EMS council contracts to ensure the continuation of EMS education until a final plan was developed. OEMS acknowledged the request and indicated that it would be forwarded to and discussed with OEMS senior leadership.

In August 2016, OEMS announced that an alternative solution for EMS education delivery had been approved. OEMS would enter into a memorandum of understanding (MOU) with each of the eleven regional EMS councils to provide EMS education in the Commonwealth. Contracts would be developed to facilitate this process.

In May 2017, OEMS indicated that the draft MOU for course instruction for auxiliary and CE training had been approved. OEMS scheduled a meeting with regional council directors in late May 2017 to discuss specifics related to the proposed contracts. On May 24, 2017, regional council directors received an electronic version of the draft MOU which excluded projected funding information. In the follow up meeting with OEMS in late May, OEMS provided projected funding amounts to each regional council. Discussion was held concerning some of the proposed language and resulted in mutually agreed-upon changes. The funding matrix was also discussed, with regions expressing concerns in two general areas that did not consider geographic/demographic variations between and within regions:

- the number and distribution of proposed CE programs within localities
- the proposed numbers of students for auxiliary courses

schedules, and position salaries that could not be modified by the regional councils. The MOU had a stipulated implementation date of July 1, 2019, and the Regional EMS Councils were asked to sign and return the agreements as soon as possible to begin the hiring processes.

Virginia's Regional EMS Councils were not included in any prior discussions or meetings related to this program and had no input into the projected funding matrix used in the drafted MOU. Some dialogue occurred regarding program administration; however, not having the documents prior to the meeting precluded informed discussion. Directors were positive in their comments and support of the program. Woods commented that the presentation of these documents at this meeting did not allow for adequate planning and budgeting, especially since the proposed MOU did not account for many mandatory costs associated with such positions. There was discussion about flexibility within projected funding categories for expenses not anticipated by OEMS; however, Adam Harrell stated that OEMS is not required to negotiate with "vendors." Regarding the proposed MOU, Harrell stated that regional councils could "take it or leave it." OEMS staff members noted that if the councils did not sign the agreements, OEMS would pursue other options.

Following their meeting, some directors and board members had informal sidebar discussions with OEMS staff members to determine the extent of flexibility after reviewing the proposals in greater detail. Responses were inconsistent and led to confusion. To ensure clarification, Greg Woods, acting as Chair of the Regional Director' Group, emailed Chad Blosser on Monday, May 6, and requested a meeting with Blosser to further discuss the MOU on behalf of the group. The email affirmed the regions' desire to make the program successful.

On the evening of Tuesday, May 7, OEMS Business Manager Adam Harrell sent an email to all regional councils rescinding the proposed MOU offering continuing education funding due to the "numerous issues" identified. Despite the formal request, no additional meetings between OEMS or the Regional EMS Councils had been held. Harrell noted that OEMS would contract directly with full-time educators to provide continuing education throughout the state instead of through partnership with the Regional EMS Councils.

Woods emailed OEMS Director Gary Brown to express disappointment in the actions taken by OEMS and to request Brown's intervention. In particular, Woods expressed disappointment in OEMS' refusal to meet to discuss the matter and the approach taken by OEMS staff members in handling of the situation. OEMS Director Gary Brown replied to the email expressing regret that "regional councils were unable to accept the terms of the contracts as presented."

At the time of Brown's reply, only one regional EMS council had contacted OEMS directly concerning the proposed contract. No regional EMS council had rejected the terms of the proposed MOU, and one council had returned the signed memoranda before Harrell sent his email rescinding this opportunity.

DISCUSSION

Virginia's Regional EMS Councils believe that our EMS system benefits from open and transparent dialogue between EMS stakeholders to build impactful and efficient programs that benefit the entire system. For more than forty years, Regional EMS Councils have served to identify and represent the unique needs of EMS agencies and providers in our defined service areas.

Understanding the unique needs of our regions, the Regional EMS Councils have always striven to be proactive in collaborating to build successful programs. We acted in good faith in accepting the prior-year memoranda although we believed the funding matrix was not ideal. We also sought clarification to ensure that we understood and met expectations.

Regional EMS Councils continue their practice of active collaboration and remain committed to full collaboration and partnership with OEMS. Despite concerns, the Regional EMS Councils have made every effort to work with OEMS to build an exemplary educational program. Prior history has demonstrated an opportunity to discuss concerns and to seek clarity to ensure the successful execution of collaborative projects, and such a collaborative process was anticipated and expected in rolling out the proposed CE program. We deeply regret that our request for a dialogue to collaborate and build a successful program related to delivery of CE programs was disregarded. We also regret that we will not be a part of the new program.

This document is submitted to provide additional context related to referenced quarterly report. Supporting documentation, including copies of the emails referenced in this document, will be made available upon request. If you have any questions, please do not hesitate to contact one of Virginia's Regional EMS councils.