COMMONWEALTH OF VIRGINIA

DEPARTMENT OF HEALTH

OFFICE OF EMERGENCY MEDICAL SERVICES

IN RE: RETREAT, DAY TWO

HEARD BEFORE: RYAN S. STARK, ESQ.

RETREAT FACILITATOR

SEPTEMBER 17, 2019

DOMINION ROOM

COURTYARD BY MARRIOTT

10077 BROOK ROAD

GLEN ALLEN, VIRGINIA

9:00 A.M.

VOLUME II

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A G E N D A

(The EMS Advisory Board Retreat discussions commenced at 9:00 a.m.)

MR. STARK: Good morning. We're going to go around the room, just a quick roll call so we can get on the record here. And then we'll -- we're going to get down to work right away. Let's start with you.

DR. YEE: Allen Yee, VACEP.

DR. BARTLE: Sam Bartle, American Academy of Pediatrics.

MS. CHANDLER: Dreama Chandler, VAVRS.

MR. DILLARD: Kevin Dillard, Virginia Ambulance Association.

MR. BOLLING: John Bolling, Southwest Virginia EMS Council.

MR. TANNER: Gary Tanner, VACO.

DR. O'SHEA: Jake O'Shea, VHHA.

MR. SCHWALENBERG: Tom Schwalenberg, Tidewater EMS.

MS. MARSDEN: Julia Marsden, consumer.

MS. ADAMS: Beth Adams, Northern Virginia EMS Council.

MR. HENSCHEL: Jon Henschel, Lord Fairfax.

MR. PARKER: Chris Parker, Virginia ENA, Virginia ANA, Chair.

MR. R. J. FERGUSON: Jason Ferguson, BREMS.

MS. QUICK: Valerie Quick, TJEMS.

MR. LAWLER: Matt Lawler, Central Shenandoah EMS Council.

MR. D. E. FERGUSON: Eddie Ferguson, Virginia State Fire Fighters Association.

MR. SAMUELS: Gary Samuels, VPFF.

MS. DANIELS: Valeta Daniels, Virginia Association of Volunteer Rescue Squads.

MR. STARK: All right. Last night, was looking through some of the minutes. And you know, the -- particularly looking for where -- what initiated this retreat, you know, what we wanted to talk about.

I looked back and I saw minutes from the Executive Committee for May. Some of the main issues are composition of the Board -- current composition of the Board, 28 members.

And whether or not that is unwieldy. Number two, the committees, whether or not there's duplication. And number three, there were issues with the bylaws. And we can discuss bylaw stuff in

general if we need to. And Chris and I talked a little bit this morning about -- talked about high level issues with the bylaws.

So we can tackle that, but we're not going to sit through and, you know, go through bylaw revisions this morning. But let's just get down to work right away.

And to be quite frank, you know, we're going to get into some issues that probably, you know, are going to be a little bit contentious when we talk about composition of the Board.

You know, who's on, who's not. You know, and what purpose they serve. But that's the job of this Advisory Board is to get into those issues. So I urge you to be as candid as possible.

Think what you want to get out of this. This is your day. Actually, I ran into Valerie this morning and we talked about this in particular. And I just said, hey, do you have any ideas on any of these issues? And she said, yeah, I might have

some ideas. And I said, perfect, Valerie. I am going to put you on the spot. Valerie, I'm going to open the floor to you. And let's kick off.

MS. QUICK: Yeah, I mean, I -- I think that when -- when we started discussing as a whole -- I mean, I think that the bylaws definitely need to be looked at.

But the bylaws can certainly be done committee-based. I think that the two big issues that we're there to take over, certainly, the -- the committees and maybe restructuring them so that we could not be duplicating work.

And looking at the composition of the Board. And really trying to decide whether that Board -- I think our Board is pretty large.

And sometimes a large board doesn't yield to having meaningful conversations and work that's the resulted that. I think that that's where our committee structure is -- is really going to

be very powerful. So I think looking into those two things needs to be addressed here.

MR. STARK: Any thoughts, Valerie?

MS. QUICK: Enough.

MR. STARK: Let's -- let's go with it.

MS. QUICK: You know, the -- the thing -- if I was just to look first at the -- the committee structures, I -- I definitely think that there's a little bit of duplication.

If we were going to be honest about how we see ourselves in the future -- if we were to go back to sort of that paradigm of public safety, public health and patient care, what would be best to accomplish those goals?

What would be like in our future for that? I think that for the trauma group, the way that that was structured in -- in some ways is quite

brilliant because it does incorporate quite a few aspects of -- of patient care for our system. However, it's limited at this point to trauma. And I think that it's important for us to look at some of those other areas.

If I'm going to look at acute care, I should look at acute care as it relates to trauma, stroke, STEMI, pediatrics, you know, sort of the whole gamut fits in there, as well as post -- post-rehab and -- and certainly, the pre-hospital aspects of it.

So I think that those things need to be incorporated into that kind of schedule, rather than having two completely separate committee structures that -- that are there.

And then if you look at, you know, some of the other things like the -- we have sort of already mentioned this, the -- the Health and Safety and the Workforce.

I can think of all of that as being Workforce Support and Services. And in some ways, training, too. I mean, that all kind of encompasses the -- the larger

committee structure. I'm wondering if -- and having been to all three of those meetings, we say a lot of the same things in each of those meetings.

We talk about like Workforce and what kind of training we need to go for our workforce. What -- if you know, if initiating new initiatives like the EMS officer -- which is training days.

Which, of course, would incorporate our -- our training group. So I think that we're not necessarily bringing things together as we probably should.

So those three committees, in some ways, are doing separate work and not coming together in a fruitful manner. I think they need to -- to look at sort of merging.

MR. STARK: What were those three things again?

MS. QUICK: Well, it's really everything under -- what's the heading?

MR. STARK: Professional Development.

MS. QUICK: Professional Development.

MR. STARK: Okay.

MS. QUICK: And Professional Development is making sure that we train our providers, that we keep them safe. That we provide different avenues for them to grow and to become successful within -- as a patient care provider, but also as an administrator, as a trainer.

MR. STARK: Thoughts? Chris.

MR. PARKER: I kind of -- I think Valerie kind of hit on some of the discussion with those committees, but we also need to look at, is this the time that we throw that out and re-group and look at committee versus subcommittees. Because we clearly don't have actual subcommittees.

Our bylaws allow for that, but we don't have actual subcommittees. And then there are work groups that some committees have, like the TCC has work groups where they work on a project.

That's got a sunset aspect once that project is finished. So when you look at this, maybe now is the time that we kind of look at all of these and say, hey, is this something with -- I'll give you an example, under Transportation.

Do you make that the -- the big committee? And then you put something like air and ground under it as a subcommittee.

That way, you're having different things funneled up to where they should be versus sporadically out.

MR. STARK: Other thoughts? Dr. Yee?

DR. YEE: Me. This is Doberman who gets that.

MR. STARK: Yes, sir.

MR. LAWLER: So a lot of -- Matt Lawler. A lot of the duplication that's been discussed falls under the major headings, Administrative, Infrastructure, Patient Care, Professional Development and then Trauma System.

But you could go system, so unless you have -- take those major headings and make those the committees lump everything under that -- under that work and make that the work of that committee.

And then if you hit a point where there's a -- a hot button issue going on and you need to have a smaller or a subcommittee or focus group work on that, you can throw an ad hoc committee together to do the work and report back to the -- the big committee.

BOARD MEMBER: I agree with that.

MR. STARK: So you're referring specifically to the bylaws here, where we

list, you know, under administrative, rules and regs, Legislative and Planning, Infrastructure, Transportation, Communication, Emergency Management. Other thoughts on that? Yeah.

DR. YEE: There's some overlap between what we have in the trauma coordinator and then the patient care. Right now, it's relatively clean, you know, because trauma's dealing with really everything from the emergency department door and -- to rehab.

Right? They really deal -- with exception of that Pre-Hospital Care Committee. Now that we throw in -- patient care would -- does that include the -- the acute care stuff now?

MR. LAWLER: Matt Lawler. I think if you pull that out, then you just throw that, you know, under the patient care, along with Medical Direction, Medevac and all that. And maybe the trauma system just becomes a[n] EMS systems committee and

addresses all of the other components of the EMS system. It doesn't need -- before, you know, each of the subcomponents -- rehab, prevention, all that -- doesn't need the full attention of a committee.

But collectively, you know, they can work together. Now that would -- that would be a super, super diverse group of people that you try to pull together to do that work. That might be a challenge.

MS. ADAMS: Beth Adams, Northern Virginia. I'd move Medevac into Transportation.

MS. QUICK: I would -- I would, but I -- I think that -- Medevac, although it is a transportation modality, really what we're getting at, in essence, there is also critical care.

Which I think we're going to be broadening out and defining a little bit better throughout our state. So critical care not limited to the fact that they could be at a helicopter. But critical care --

it's badly needed as a ground transportation modality. And probably needs to be looked at a little bit more.

So I -- I would -- you could put transportation -- and Transportation incorporate all aspects of transportation, including the Medevac.

But critical care itself needs to, I think, be brought in sort of separately. So more under the Acute Care Committee.

MS. ADAMS: But wouldn't patient -- critical care be part of the patient's care clump?

MS. QUICK: Yeah.

MS. ADAMS: Yeah.

DR. YEE: That's what we've done. We've incorporate -- right now, it's working -- Medical Control's working on it.

MS. ADAMS: Uh-huh.

DR. YEE: I think we're getting close to finishing up that work.

MS. ADAMS: Then that's the logical place for it.

MR. D. E. FERGUSON: Eddie Ferguson, Virginia State Fire Fighters Association. Certainly Medical Control, Medical Direction needs to -- needs to be a trauma committee.

I'm a person that believes that's a huge part of what we do. And I hope we use that on -- if we value that in any way, fine. We won't advise them. I don't know where it could go, but --

BOARD MEMBER: [inaudible].

DR. O'SHEA: So that -- Jake O'Shea. For those who are -- I mean, when we talked about the concept of rolling trauma into an acute -- trauma into a patient care committee overall and bringing in stroke and STEMI. You know, the way the

trauma team looks at trauma care is fairly prescribed. And it's really more about looking at -- does, you know, do we have the criteria in place to provide trauma care?

Is that the same concept people are thinking for stroke and STEMI? And then, how does that overlap with other certifying bodies that exist?

You know, Joint Commission, DMV, some of the other groups that -- that independently certify for -- for stroke or STEMI care.

MS. QUICK: Well -- Valerie Quick. I'd certainly like to bring out -- I -- I used to be the EMS liaison for UVa. And there is a substantial component now in all of those accrediting bodies that requires a certain amount of EMS interaction.

So if you were to look at the stroke -- stroke designations, they have to do a certain amount of interaction with protocols, education, feedback and integration. So I think that that needs them and us to work together on this type of

committee so that -- so that we can improve overall stroke care. And then meet some of those -- those checked boxes for them. I think it's not as robust as the trauma system.

And I think that have -- if Dr. Aboutanos was here, I'm sure that he would certainly advocate that that -- that that detail and that structure probably still needs to exist in some sort of fashion.

But I think that those other entities like our -- our stroke and our rehab and infection control -- there is all sorts of other areas that we need to also make sure that we're paying attention to and we're meeting their needs.

Because their needs, every year, seems to increase as far as their interaction with EMS goes. So I think we need to acknowledge that and bring them into the loop. And it may be that we can't get rid of the trauma committee altogether because I -- I think that that is -- and well, perspective is right. But certainly

having them represented on a general acute committee that would actually encompass all of those entities, I think, would be fruitful.

MR. STARK: Other thoughts?

MR. HENSCHEL: Jon Henschel, Lord Fairfax. I can speak on my little piece of the pie, which is as administrative coordinator. I'm going to -- I also chair the Rules and Regs, and sit in on the L&P.

And I can tell you, those meetings virtually mirror each other with information. I tend to feel like the Rules and Regs are -- are guidelines because that's what we either -- you know, we adhere to that.

And that's what provides us with what we can do and what we can't do in the grand scheme of EMS. And L&P should be a -- a subset of that committee for that -- that function, whether anything is on the horizon, anything that is being put through legislation is then shared if it's going

impact what we're doing from a regulatory standpoint with OEMS. But I can tell you, those -- those meetings virtually mirror each other. So that, to me, is duplicating.

MR. STARK: Okay.

MS. QUICK: I actually think of that as an overall -- sort of an administrative committee that actually does work in legislative, but also financial.

So as a subset of that, too, you know, work group being the Financial Committee because that all incorporates the administrative part of what we do.

BOARD MEMBER: Sure. And I'm fine with the suggestion Matt made from the administrative. If that were to be an administrative committee and then have those all underneath of it.

MR. STARK: Okay. Where else do we see areas of duplication? And how do we remedy -- how do we remedy the lack of

communication? I think that that was expressed yesterday. How do we remedy the fact that we're not sharing information among, you know, the different committees?

You know, proper information isn't being disseminated to the extent that there is a bit of overlap and bleed-over into other committees. How do we remedy that? Yes.

MS. MARSDEN: Julia Marsden, consumer. My question would be, how do we currently do it so that we can then find out how we should be doing it?

MR. STARK: That's a good question.

MR. DILLARD: Kevin Dillard, Virginia Ambulance Association. I think we need to do a better job educating the committee chairs on what information we want them to report and not report. Because most of us do a little bit differently. Some people, as we talked yesterday at the Board meeting, some will say no action items and

they don't report on anything else. And as you pointed out, there's a lot of work being done. So how much information does the Board want to hear?

Because I would -- I would argue that most of the committees are -- are doing a lot of work behind the scenes. And we're happy to present that at the Board meetings if the people want to hear that.

So we just need to have a little bit of a guideline on what should the committee chairs be reporting, other than action items. I think that would help a lot.

DR. YEE: So Allen Yee, VACEP. For -- for Medical Control, what we've done in the past is we've embedded a member of the other committees with us.

So we had EMS-C, we had the trauma committees inside Medical Control. And they were reporting out. It didn't work so well, quite honestly, because they never showed up. Some of these -- some of these folks never showed up. So we're --

we're -- this -- our last meeting, we actually went back to our original thing was, you know, regional medical director and medical director at large.

So then it becomes the chair's responsibility to make sure we touch base with the other chairs.

MR. STARK: Yes.

DR. BARTLE: Sam Bartle, Academy of Pediatrics. I came in -- I started with this, one of the ideas I had was sort of like Allen saying, put a pediatric representative on the various boards to, you know, help make sure pediatrics is seen and represented.

Now a lot of this stuff that's being done, it's good to have the pediatric side. From what I've learned, it's good to have a pediatric side of it.

But I think there's -- if we're going to go back and look at who's selecting who for what committees and various committee have a pediatric

representative on. That might be something that could be looked at for some downsizing. Does everyone have to be on every board and then every committee?

BOARD MEMBER: I don't know if there's -- I mean, that's a good question. It's nice to be represented. And there's a point of, you know, it's not really going to help.

So I mean, is there -- a way of combining some of these committees or should -- or just hear it when they meet maybe to pass on information. That might be part of the problem with communications between the committees.

MS. ADAMS: Beth --

MR. STARK: Yes.

MS. ADAMS: Beth Adams, Northern Virginia. It came to light yesterday afternoon that, in fact, those minutes that we were all looking for on the Office of EMS

committee web site had, in fact, been posted to the official town -- Virginia Townhall forum. Because that's what the General Assembly had directed Commonwealth agencies to do.

So either, to my mind -- first of all, I didn't know there was a Virginia Townhall thing. I thought that was just something you did at my office when people were trying to avoid making decisions.

We'll have a townhall and get everybody's opinion. And then we'll do what we all think is best. Which is lovely, but I think that if we're going to make sure that our constituents are aware of what's going on.

Because there may very well be people in Northern Virginia who are hugely interested in some topic that hasn't risen to my radar yet.

And I don't know that I should be reporting back on that. But if they know where to look, they can follow up on it. So if we could have some kind of parallel posting so that it goes up, meets the

expectations of, you know, the legislature and then, also puts it in place where EMS folks would be inclined to look, that would be, A, helpful.

B, I think with regard to reporting back, it would be helpful to say we have no action items, but the following informational items have been posted to the web site.

So that -- because to say no action, it's like geez. Nothing's going on, when that, in fact, nothing's ready for prime time is a whole different matter.

And I think we need to make sure that people get credit for the work they're doing in a way that reflects what -- how that fits together into the grand scheme of things.

MR. STARK: Yeah. I think we talked about, you know, what's the easiest mechanism. Yes, Dr. Yee.

DR. YEE: So, Allen Yee. I get -- I want to give kudos to staff. So EMS --

also EMS staff, you know, at least in Medical Control. They update us on the activities on the permanent committees. You know, because there is -- there are staff members in the audience.

And they'll give the updates. So they've done a great job. They -- another thing that we can do as chairs is, quite honestly, do a better job of posting a better report on the -- the quarterly report.

BOARD MEMBER: Staff puts the quarterly report.

DR. YEE: Yeah. I don't ever -- I don't review it before it goes -- you know.

MR. STARK: Yes.

MS. CHANDLER: Dreama Chandler, VAVRS. One thing we might need to do is have the committee chairs look at the composition of the committees. Because if you look at the list, each one says you have

to have a person from this organization, this organization, this organization. Have them look at it and see are these people the ones that are -- that we need on this committee.

As Dr. Bartle said, trying to have pediatrics on every committee, some -- absolutely, some doesn't necessarily make sense. But it's -- it's a requirement of that committee composition.

These are the people you have to have. So maybe look at the -- have the committee chairs, whatever, look at the composition of their committees. Are these people really useful or helpful, or is there someone else that --

MR. PARKER: And I'll add to that.

MS. CHANDLER: -- they could do that.

MR. PARKER: With -- with some of the committees, if there's been folks that haven't been meeting, maybe it's time to not

just they get replaced, but maybe their organization gets replaced.

MS. CHANDLER: Yeah.

MR. PARKER: Because we've had some, in the past, where we'll go for several meetings and they don't -- they're not being represented. Maybe it's time to seek out something else.

BOARD MEMBER: And there's people that's on committees just simply because the organization said we have to have someone on this committee, so hey, you're it. They're not really engaged.

MR. PARKER: Right.

BOARD MEMBER: They're not there because they want to be.

MR. STARK: Yes.

DR. YEE: Is it possible for us to

have a chair's meeting, then? A meeting of the chairs that's before or mid-cycle of the GAB? So we can do a better job of coordinating our activities?

MR. PARKER: You're talking about the -- the coordinators?

DR. YEE: No, the actual chairs of the committees.

BOARD MEMBER: A committee chair meeting.

BOARD MEMBER: It's a good idea. I mean, keep it very brief and just, you know, this is what we're doing. This is what we need from every -- like the chair or -- this is the idea that we need help with.

MR. PARKER: Yeah, that's a good idea.

MR. STARK: What about at Symposium? Seems like that's a central

meeting spot. Oh, you guys have a lot of other stuff, but --

DR. YEE: That's the closest. My -- my suggestion for the meeting of the chairs only works -- will work if the chairs are not GAB members, right? Because if they were all GAB members, then we -- we're done.

MR. PARKER: That's kind of -- that's kind of what I'm sitting here thinking. And in the bylaws it states that each committee has to be chaired by a --

DR. YEE: Exactly.

MR. PARKER: -- Board member. So we're meeting -- so we're meeting for the GAB, then we're meeting before the GAB. So that's four more meetings a year.

If your Executive Committee's meeting in tandem with the GAB, then that's four more meetings that the coordinators have to be at. So you'll get a lot of redundancy and we're trying to slim down on

the redundancy.

DR. BARTLE: But I think -- Sam Bartle. It might not be -- not -- so much more formal, but to say -- sort of like we're doing now. It's informal. Okay, we want -- this committee's doing 'x'.

And make it not as starchy. We want to have everyone's input. We working on this project, but we think -- how can you help? What can -- do we need to help you? Can't really do that at a formal GAB meeting. Does that make sense?

MR. STARK: I think Dr. O'Shea was up.

DR. O'SHEA: Jake O'Shea. And I might channel Dr. Yee's devil's advocate here. What would happen if we had not committees at all? You stream -- you streamline the GAB. And the GAB did the work, the Board did the work. And -- and again, this is the devil's advocate. But what -- just if we think of it a little

differently, what would happen then?

BOARD MEMBER: Nothing.

MS. ADAMS: Beth Adams, to second that. So the GAB would do the work by -- by developing a work group or a task force to deal with specific projects. Is that the direction you're thinking?

DR. O'SHEA: I think so. I mean, one of the things I sometimes wonder when you look at an organization as -- as large as this where there's the comprehensive structure that has been created.

It's -- are we just filling in the structure because the structure exists or does this structure serve -- still serve the purpose for which it was originally created?

What would happen if we just said, let's get rid of all the committees and then develop them as the work becomes identified. And again, I realize this is a very extreme position. But I think it's

worth asking, at least going through the thought experiment of it.

DR. BARTLE: Sam Bartle. EMS-C is a separate group already. It's a federal-funded program in the State. So we're sort of the adopted stepchild here in some ways. So we can't -- we'll -- the way you want.

We have the stuff that -- ideas and everything that you'd like to share with us. But you know, at least we're up. With my group, actually, you can't do that.

MR. STARK: Eddie.

MR. D. E. FERGUSON: Eddie Ferguson. That's a good question. And I think you brought up something in my mind that I hadn't thought of.

So I appreciate you asking. I think if the committees were not present, I think the Office of EMS lose a lot of interaction, possibly advice and maybe -- I don't want to say direction, but in come

cases, medical direction is direction. So I don't know what they think, but I believe that they rely on those committees to provide some insight into certain -- time to explore that we share at the GAB meetings.

And what's to keep us from dedicated time at the GAB meeting to have this discussion on that lower level? That meeting is so polished that it -- it doesn't get anything accomplished.

The Board's not, obviously, serving that purpose, either. So let's dedicate time and make it known that we're going to have a frank discussion. Let's share information.

And we -- Chris, you do a great job chairing the meeting and people report out. And I think it's so polished that sometimes it's like things are already decided when it's there. But that's --

MR. PARKER: A lot of time it feels like -- yeah, you're right. A lot of times it feels like how quick can we get it done.

MR. D. E. FERGUSON: Yeah, right. We need to slow down at one of these meetings and, like you said. Let's see where it goes.

MR. STARK: Jason.

MR. R. J. FERGUSON: Jason Ferguson. So I -- I mean, I agree 100% with you. And I think that that's a -- that's a kind of a different take on -- on what we're talking about.

But I can tell you from TCC, we've done a lot of work and we've had multiple work groups. And just selecting the -- the individuals to be on those work groups, that -- that becomes a daunting task for the Office I know.

And then -- and then trying to, you know, fairly distribute -- get a diverse group of folks that can have a voice. And then there's always going to be, well, this area was left out or this individual was left out, that kind of mindset. So I think we open ourselves up to

that. But again, like you were saying, I think -- you know, just kind of consolidating some of what we have, restructure it a little bit maybe to what may meet our needs in the future.

And then using our time when we need, as an advisory board, to kind of really, you know, dig in and -- and just do the things.

BOARD MEMBER: Medevac has tackled some huge projects and made great strides. And they should sit at the table as well.

MR. HARRELL: Yeah. Let me -- let me pose something from -- from your discussions yesterday. What if we were to increase the technology offerings around some of what you're asking for?

You're say -- for example, it was a note yesterday that there's some discrepancy between what's being posted on Townhall versus documents and minutes and -- and rosters and so forth, versus what's on the web site. We can help with that with

some internal adjustments and procedure. So instead of us trying to keep two full repositories besides that which GAB going up.

The General Assembly requirements, as well as trying to post it again in another place, we can link to the mandated requirements so that you have a normal table of contents.

That's one area where we can adjust this. Another would be the idea that you brought up of being able to give intermediate reports without having to have a meeting or bring people together.

What if we provide the chairs of committees a blog structure that each of you could update as you have a meeting. And it becomes a system -- where it's open to the public, it's open to all the Board members.

But now you have intermediate meetings in between Advisory Board meetings to be able to provide updates to other committees. You could -- you know, there are a bunch of things we could do

technologically to where you can tag it. If you feel it's an interest of one of the other standing committees, you could tag that committee in that blog and say, hey, somebody needs to look at this.

And you know, it may be of interest to this group or that group. Those are just things to think about. But I mean, those are areas where we could, you know, provide you additional means to get information out there to each other.

MR. STARK: Beth.

MS. ADAMS: Question about process. Am I right in thinking that anti -- any subcommittee or work group of this body is required to meet the public meeting's requirements of the Commonwealth?

MR. HARRELL: Yes.

MS. ADAMS: So whatever we come up with -- so do blogs meet that --

BOARD MEMBER: He just said he was going to close it so only --

MR. HARRELL: Well, I mean, we could -- we could make it public. It's not that -- you're not conducting a meeting.

MS. ADAMS: Right.

MR. HARRELL: You're providing an update. You're providing -- it's a live view of committees.

MS. ADAMS: Right, but there would -- but there would still be the obligatory openness to the meeting that preceded the blog, which seems --

MR. HARRELL: Correct.

MS. ADAMS: -- redundant, yet again. It's just cooler.

MR. HARRELL: Just trying to find a way to -- you're talking about

communication. Advising us to --

MS. ADAMS: Right.

MR. HARRELL: -- communicate.

MS. ADAMS: Right.

MR. HARRELL: And effectively communicate. This is just providing you an another option should it be something you all choose to view.

MR. STARK: Yes.

BOARD MEMBER: So a couple of things. Number one, I -- I don't go to web sites just to -- to go to web sites. I'm -- I'm not a cool computer person.

I have email all the time that would -- they want to make. But I feel like -- and I'm not trying to wage war with the Office of EMS. But if it's something huge going on or something that doesn't -- others providing time in the day, or there's

something y'all could push out. Like hey, you know, look at this update and link it so I can just hit my button and it goes there.

I think that people would be more informed and it doesn't add any -- I mean, I'll be the first to say, I don't go to your web site, you know, unless there's a reason for me to do that. So number one.

Number two, why don't we start with the subcommittees about doing kind of a roll call. Because like Chris was saying, there's people that are on that list that don't show up to any of the meetings or maybe one meeting out of four.

And then cut those positions and that would start the downsizing of the committee without hurting anybody's feelings or anybody's -- you know, those to start with.

MR. STARK: Yeah, Jason.

MR. R. J. FERGUSON: Jason Ferguson. So question for the group, really. I know from the work groups that

we've had at TCC recently, on of the big issues with communication has been everyone's unfamiliarity with FOIA. So it's, I'm afraid to email Valerie because am I violating anything.

But if -- you know, or if I send out a -- hey, just want to let you guys know this is where we're at with this. And then if someone hits reply all then that becomes an issue versus a one on one conversation. That confusion, I think, interfered with some of the communication as well.

MR. STARK: So just concern over any -- anybody being able to FOIA that email?

MR. R. J. FERGUSON: Not that they can FOIA, but that you're going to violate --

MR. STARK: Okay.

MR. R. J. FERGUSON: -- the rules.

MR. PARKER: And I think sometimes that inhibits a lot of work from folks because, like last night -- I mean, it's two or three of us congregating to have a conversation about something, is that truly a meeting of -- you know, that crap. Because it's hard to get work done and it impedes process.

MR. STARK: Right. Yeah, I need to look specifically at Virginia's right to know law and see what the requirements are. But it seems like we're taxing some of those requirements, you know. But I can certainly take a look at that as part of the -- of this project. Yes.

MR. TANNER: I'd just like -- you know, being a former Board member and everything and local board of supervisors, three or more is a meeting, and it's illegal if you do that. So little group discussions and stuff technically, you're breaking the law.

MR. STARK: That's why we were all in two's last night in the lobby.

MR. TANNER: But I just wanted to point that out.

MR. STARK: Okay. Yeah, I got to look, you know, specifically at the contract of that law and see what the requirements are. Yes.

BOARD MEMBER: Really because no one is -- like on our professional activities, people come talk to us about this. I get more than one of my colleagues come and ask me something about EMS and am I breaking the law with this.

MR. STARK: Okay.

BOARD MEMBER: Just keep it one on one, don't get Groupon.

MR. STARK: Yeah, there's some distinction over that. We need to take a

look at what it -- what the law actually says. Those things, you know, you got to push them down the lane. Yes.

BOARD MEMBER: So as far as communication, I totally agree. I mean, I am all for short meetings. I am not a long meeting person at all. But we are -- we did obligate ourselves to 5:00 o'clock, not that we want to go there.

But the other thing is I would -- I would like for a minute or two overview of what each committee is doing. Because of, oh hey, they're working on this. Oh, we're kind of working on that, too, the redundancy part.

But also, this -- we're knocking at -- we have our committee meetings right before the Governor's Advisory Board so we wouldn't have time to write it up, per se, and submit it to the book. And then by the time the next three months rolls around, this is old information because all -- we have met again. So I don't know if each person can, you know,

give a 30-second to two-minute synopsis of, hey, working on the PD boards or, you know, Transportation.

MR. STARK: You want to know today?

BOARD MEMBER: No.

MR. STARK: Okay. I was just -- just in -- in the --

BOARD MEMBER: No. Shortest meeting. No. No, at the actual Advisory Board. And that way, it doesn't look like to the public, oh, they're doing nothing. They're doing nothing.

MR. STARK: Yeah.

BOARD MEMBER: They're doing nothing. Plus like I said, you know, hey, they're working on this. I have information that could help them.

MR. STARK: Yeah. No, I think

that's a good idea. Instead of no business -- you know, no report on the business, I -- I agree. 30-second update about what's going on because that's the easiest way. I mean, we're all -- we're all in one place at that point.

We don't have to sift through meetings, we don't have to worry about whether things are updated. I think that's an impact on meetings.

MR. PARKER: Didn't we used to do that? And wasn't that the issue -- because I remember when I first came on the Board, Ron Passmore's dissertation that he gave of each Rules and Regs meeting, it was, you know, a minute to two minutes.

And this is what we talked about. This is -- and then we had no action items. So we kind of did that. We used to do things like that, some committees but not all the committees. And I really thought we need to get back to that so that you're getting what you need.

MR. STARK: And so far, that's driven by the chair, too, you know, based on what information they want to receive. Sounds like you're receptive to receiving information. Valerie.

MS. QUICK: Yeah. I don't think that rehashing some information does anything but provide extra communication, so that's never a bad thing.

But I do think that if we go back to limiting the amount of committees that are out there, then you're -- you are, in essence, having doubt on some of that extra stuff.

Because you're not having to repeat yourself. So really, I guess the -- the take home point, the thing that we need to get back to is can we limit those committees, can we consolidate them?

And then after we consolidate them, if we need a special work group to work on whatever project, we can do that. But at that point, then we can look at the committee structure to see who needs to be

on that committee and how do we best represent that committee. I -- I don't think that we need to look at the committees right now and their structure and reorganize it if we're going to combine everything anyway. Or combine more things.

MR. STARK: Jon.

MR. HENSCHEL: Jon Henschel. One of the things that I see during the actual Advisory Board meeting, we talk about redundancy and the information that's shared.

When OEMS staff shares some of the information, that essentially is some of the information we've discussed in our committee in particular, Rules and Regs.

And I don't see any point in duplicating that information 20 minutes later. And they -- they do a good job of covering a lot of this stuff that I would otherwise cover. Likewise, that annual report -- or I'm sorry, the quarterly reports put out. And some of the more

generic information, if you will, is embedded within that report. So if people aren't willing to get online and to look at that if they have curiosity, should we -- you know, I can see the -- the bigger ticket items, certainly we want to share that information.

But if it's more or less the generic, this is kind of stuff we're doing every time, why should they not go on to go look at that. So I have a little bit of a mix on that.

MR. STARK: Okay.

MR. PARKER: I will say having the last few meetings where we've started on Wednesday through Friday, by the time we get to Friday, how many times have we heard about this or that?

BOARD MEMBER: We -- we have.

MR. PARKER: Six or seven times.

BOARD MEMBER: But even -- even in that meeting where you've got the public sitting back there, I mean, OEMS is giving their report. And a lot of those information items are covered. And I'm sure that involves a variety of our committees.

But I know certainly it does mine. So I just can't see giving the same information out 20 minutes later. If it's already been -- if it's already been discussed, it's been discussed.

I'll hit on a few things that may be highlights of what we're doing. Other than that, I'll let them know other information can be found in the quarterly report.

MR. PARKER: Unless it's stuff that needs to be -- you know, the minutes for the actual GAB.

MR. STARK: Yeah. It's a matter of discretion sometimes. Yeah. Dr. O'Shea.

DR. O'SHEA: So -- so if we had

fewer committees and more members of the Advisory Board on each of those committees, would that then add to the discussion that can occur in the actual Governor's Advisory Board meeting?

That -- I think one -- one of the things as a new member that I haven't fully understood is what is my eligibility to be on one committee or multiple committees?

Am I eligible to be a participant in any committee that I wish to or only the one to which I've been appointed, you know.

And -- and I think there is some benefit to the other members of the group. As we've said, communicating and participating in more than one committee so that they can get that shared information and bring it together at -- at the full Board meeting.

I also think it's unreasonable for anybody to attend all of them because there's many.

MR. STARK: Yeah. Is there any restriction on that?

MR. PARKER: So in -- in the past, it's always been that you could attend any meetings that you wanted to. I don't have anything listed except for what's supposed to be chaired by someone from the Advisory Board. That's the only thing that's listed in the bylaws.

MR. SAMUELS: Gary Samuels. Yeah, and there can be more than one Advisory Board member on a committee based on their -- what they -- what they're bringing to the committee.

So for example, with the Legis[lation] and Planning, there are numerous people on -- for Rules and Regs that probably, too.

Because we're kind of looking at training and certification issues, we're looking at a lot of different things that may come up over the year. So yeah, historically, there hasn't been anything

that limited the number of Advisory Board members. It's just been the -- there was a developed matrix of who was on each committee. And those -- those were reviewed every year.

Sometimes people are on one year and the next person that takes their place on that -- for that position on the Board decides if that's not their interest, and they want to be on something else.

So that -- that can change just based on recommendations to the Executive Committee, and then a vote.

DR. O'SHEA: And just to clarify, I -- I guess I was differentiating between being a member of the committee versus a member of the public attending the committee, which we certainly all have the right to do. But there is a distinction between those two.

MR. STARK: Yeah, Dr. Yee.

DR. YEE: So -- it's Allen Yee,

VACEP. So why -- why do we have Board members as chairs? Why don't we just -- so -- so I have experience on a few national committees and organizations. It's usually Board liaisons.

BOARD MEMBER: Right.

DR. YEE: So we would create a Board liaison to a committee. The committee could elect their own chair. It could be the same person for all we know.

I mean, I -- an example is like I'm not really a Medevac guy. I'm with -- on a previous tour on the GAB, I got named the Medevac chair. I'm like -- I don't swim. I don't like heights.

BOARD MEMBER: We'll look to that direction if you've served on this before.

BOARD MEMBER: Why do we have it that way?

BOARD MEMBER: I think that was --

historically, I mean, we're -- we're probably going back to 2000 when we did the last revision on the Board.

BOARD MEMBER: 2001.

BOARD MEMBER: 2001 time frame. It goes back to then, which our historian's not here. So --

MR. STARK: So complex the other --

BOARD MEMBER: -- to help us. Yeah, historically, it -- I think it maintained some consistency for reporting up to the Board, being that it's a Board member who's going to be at the Board meeting.

They're going to report out on -- on the committees. I mean, that's what it appeared to me because -- I mean, I can go back to Rules and Regs in -- in the late 2000's and, you know, 2008-2009. And that was kind of how Jennie posed it to me when I took her spot for Rules and Regs, was you're the person that's going to report this out

to the Board at the Board meeting.

MR. STARK: Which makes sense. But as your question more directly as why do I have to serve as the chair versus --

BOARD MEMBER: Yeah.

MR. STARK: -- just a member of that committee.

BOARD MEMBER: Or as a liaison.

DR. YEE: Yeah, just as a liaison. I mean, we go to the committees. We're going to report out to the Board. It's no big deal.

BOARD MEMBER: That's right.

DR. YEE: Yeah.

MR. STARK: The -- the bylaws regarding committee service just state that the Board -- each Board member is expected

to serve on at least one committee of the Advisory Board.

BOARD MEMBER: So it's under --

MR. STARK: Okay.

MS. ADAMS: What's the difference between expected and required?

MR. STARK: Yeah. That is -- that's a word, too, that should not have -- yeah.

BOARD MEMBER: Yeah.

MR. STARK: Yeah, that word should not -- if you are requiring them --

MR. PARKER: Check the bylaws.

BOARD MEMBER: But under the committee structure as chairs don't have to be Board members.

BOARD MEMBER: I mean, I -- it's there.

MR. PARKER: It's there. You just have to look.

MR. STARK: Okay.

MS. ADAMS: Beth -- Beth Adams, Northern Virginia. If -- if we're going to look at that, which I'm not finding, but it does say that -- that we're going to elect officers and chairs of standing committees will occur at the regular meeting. You're being appointed to committees. What's the election part of it?

MR. PARKER: So it's under committee management, under Section C, ad hoc committees. So, Section E, getting management.

The chair of each committee will be elected from the membership of the Advisory Board unless otherwise specified by Code, which happens usually in November when

we elect the up -- the committee chairs. And it says the -- the members of the committees and subcommittees may be appointed from among the members -- the Board members or from other qualified citizens of the Commonwealth. So you've got a discrepancy within the first two sentences of that.

MS. ADAMS: Okay.

MR. PARKER: Yeah. So I want to ask the group a question. For those that currently chair committees, I mean, you have had a change-over in your committee or have been on committees.

When you've had a change-over in the leadership of a committee, how -- what happens to the work that was done on the previous -- does it continue? Is there a lull? Do we sometimes feel like we have to start over?

DR. YEE: So Allen from VACEP. For Medical Control, I only -- it rolls on.

MR. SAMUELS: Gary Samuels. When -- and I can -- I can go back to the history when Jennie was working on the Rules and Regs. And she was kind of -- they're working through that process.

When she came off the Board, I had been involved with the Rules and Regs and we kept it going. We didn't -- it didn't -- the process didn't stop. We kept moving forward, but we had too many faces in the room for that.

So somebody that was there could continue the work. And I think it's that transition piece that -- and I -- I see where you're going. That transition piece is very important.

Because if you had not obtained what we're working on, if I had no knowledge of it as a totally new person to the game, it might take me a couple of meetings to figure out which way we're going.

MR. STARK: Jason.

MR. R. J. FERGUSON: Jason Ferguson. The -- if you look on the web site, it's at TCC, what we decided to was, too, was just for the -- the membership was to stagger.

So out of the nine members, we have two or three -- maybe three positions this year. We've been following with the others.

That way as membership changes, as chairs change, we still have the bulk of the group that's there that's been doing the work. And to continue that work to kind of eliminate some of that.

So we've already defined those dates now so everyone knows this is when we'll come up.

MR. D. E. FERGUSON: So with regards to Transportation, I mean, the work's just not there other than the grants. It could be some work, but I don't know if -- what it is or -- we really haven't decided. Maybe we should look for, I don't know. Our report just pretty much says --

it's not my call to say this about transportation. But we could effectively help with the FARC group by working with some other form, as a work group or --

BOARD MEMBER: Just disband as a full committee, but have them as a work group when FARC is reviewing the -- since you all have been working and reviewing the --

MR. D. E. FERGUSON: I think everybody -- as small as that group appears to be, I think everybody is in groups and committee doing that work, no matter whether it's a committee or not.

MS. DANIELS: All right. One committee down. Let's move on.

MR. STARK: I would like the input from the Office on that.

MR. WINSTON: I mean, I think -- and Kevin can speak more to FARC. I think

Transportation does provide a well-rounded surface, as Eddie said, to the grant review process. And looking at it like a subcommittee for FARC or something like that -- if it works, they'll need to continue --

MR. DILLARD: It is -- it is integral to the RSAF process.

BOARD MEMBER: But not necessarily a full committee --

MR. DILLARD: Right.

BOARD MEMBER: -- with a chair and -- and all that.

MR. WINSTON: I just, you know, you hear that word disbanded, you don't let -- it's evolved.

BOARD MEMBER: Folded in.

MS. DANIELS: Well maybe I just -- maybe I used the wrong word.

BOARD MEMBER: There you go. Folded in.

MS. DANIELS: Combined in with the FARC.

MS. ADAMS: In consultation with.

MS. DANIELS: Because you all still make that work.

MR. DILLARD: Yeah, so -- Kevin Dillard. We would not want to see the -- the work disband. So whether it's a full committee or a subcommittee of us. But we have more work that's in the way.

So we would, you know, not want to limit it just to ambulances, but any mode of transportation. Because we're seeing all kinds of requests come to us.

And we deem your group as the -- the experts. So we definitely can give y'all more work to do.

BOARD MEMBER: Today we got by with

it.

BOARD MEMBER: And that might be the problem with a lot of the committees. Like I said, you're sitting there saying we don't have any work. He says there's more for you.

What do you want us to do? What -- what do you expect from us as -- as far as, like I said, the reports at the Advisory Board. What do you want to hear?

We don't know what to report on if we don't know what you want to hear. Just -- like I said, better communication will help.

MR. PARKER: So Gary, I do have a question. Is it in our purview to put a subcommittee under FARC because that's -- FARC is not a committee of the Advisory Board?

MR. BROWN: Yes. I -- you can do it, even though FARC is codified. I still think that -- that there is connection to

the Board in terms of the Board -- Advisory Board is to appoint the members of FARC. And so therefore, you add that oversight.

And as such, I think, that also would translate into how can you make FARC even more efficient or provide the assets and resources that FARC needs to make that process even better.

But we -- we really -- even though FARC is established in Code, the Code says that we will have regulations that govern FARC. So that's up to us, even with those -- that -- that governing language is. And so I think we have a lot left over.

MR. STARK: Other thoughts. Yes, Dr. Yee.

DR. YEE: Allen Yee, VACEP. Can we just get rid of the Pre-Hospital Care Committee? I mean, it's kind of redundant when we're already the EMS Advisory Board. I mean, this is -- I mean, it's all throughout the entire structure of -- of everything we do.

MR. STARK: Other thoughts on that?

MS. ADAMS: I second.

MR. STARK: Second. Motion passed.

BOARD MEMBER: Totally. That motion was moved from the floor.

MR. STARK: Yeah, right.

MR. PARKER: But truly, that is one of the -- that is actually one of the ones that I brought to -- one of the things we're looking at. Like I said, we're looking at their goals.

Four of the five are covered, either under Medical Direction, EMS-C, Rules and Reg, Legislative and Planning, Workforce Development. So a lot of their work is already done.

The only thing that I couldn't map out was establishing minimum statewide guideline standards for each step of the State Trauma Triage criteria for both adult

and pediatric populations.

DR. YEE: Well, I think we --

MR. PARKER: However, we could assign that to --

BOARD MEMBER: Trauma is a pre-hospital sort of issue.

MR. PARKER: That's -- that's what we're talking about.

BOARD MEMBER: Oh, okay.

DR. YEE: But that should go -- that should fall under Medical Control. And has fallen under Medical Control in -- in conjunction with the -- with whatever the trauma's guiding group.

BOARD MEMBER: Pack.

DR. YEE: Pack. Yeah.

MR. PARKER: We'll tackle that -- we'll tackle that in a minute.

MR. D. E. FERGUSON: Eddie Ferguson. So the pre-hospital trauma -- that's the Pre-Hospital Trauma Committee that you're referring to, right?

MR. PARKER: Yes.

MR. D. E. FERGUSON: So while it might be covered in other groups, I think the committee structure is a well thought out process that represents all aspects of EMS.

So maybe put like it over here on the side and maybe they'll be -- the utilization maybe can assume another role. But --

MR. STARK: Jason.

MR. R. J. FERGUSON: Yeah. I was thinking the same thing. If we had like a -- we talked about like -- I mean, you

brought up the other day about more of the boots on the ground representation and that kind of thing.

Maybe at that level where you have pre-hospital, ground transport, maybe air -- that's where maybe all of that can kind of come together under patient care to represent all the horses.

You know, bring all that under one and then have representation. So you do get that feedback from the ground level up.

MR. PARKER: So the Pre-Hospital Committee has two ground EMS providers, a helicopter EMS provider, a critical care transport representative, an MBC representative, trauma program manager adult, trauma program manager pediatric, fire chief, 911 communication officer, a law enforcement representative, an EMS educator, a regional EMS council director, and trauma survivor/citizen representative, and a non-trauma designated hospital. So it truly has an encompassing of what we model that, honestly, might be a model for the entire

Board.

BOARD MEMBER: That allows them to do -- I think the -- the trauma -- the work that's done by the State Trauma Plan and that whole process, it's probably more up to date than our Board is.

So anything we can take from that process or the model that we can use to apply to other areas, whether's it stroke, STEMI or whatever, I think it would be a good idea just to look at that.

DR. YEE: Are -- are we suggesting that we make this kind of like the stakeholder committee or, you know, boots on the ground kind of committee? I mean, we got to find a nice name for it. But --

MS. QUICK: What's the purpose of what it does.

MR. STARK: Yeah.

MR. PARKER: I mean, if you're

going to create a committee, you've got to have goals. I mean, we're trying to move towards having deliverables from the committees versus just having a committee to have a committee. So...

BOARD MEMBER: So what's going to move to that?

DR. YEE: Because all of these entities, they're invested in our other committees. They're really -- they are represented, right?

And one, we'd have to change it to -- if we take over the trauma focus, then we'd have to add -- STEMI, stroke, whatever, you know, acute care representative.

I just -- I just see the work that is being done just everywhere else on the GAB board.

MR. STARK: I'm sorry. Beth.

MS. ADAMS: Beth Adams, Northern

Virginia. I -- I really think that this body has an obligation to think about the system as a whole and consult our subject matter experts on trauma or stroke or STEMI or children or grandpa's or whatever to do the work of the Board.

To insure that we are providing a comprehensive, integrative, thoughtful, data-driven, etcetera, etcetera service to the citizens and visitors of the Commonwealth.

And to continue to have a silo for trauma that's separate and unique and -- and I think EMS for Children historically both on -- on my brief time with this Board, my work in -- in the Commonwealth and -- and my time on the board in Minnesota was that EMS-C was ready to be there, at the side to consult when it was appropriate and support the rest of the things that went on.

That they never expected to have their own separate world, their own separate thing. So let's integrate things and perhaps take this model of pre-hospital care and expand it to everything. And we --

we do have representatives at this table from everything except perhaps a law enforcement officer. Unless somebody is that and I didn't know. But let's not duplicate effort.

I mean, so far every committee name I -- every committee I pulled up, Allen Yee is a representative to in some capacity. How do you have time to do anything else?

MR. PARKER: I think he's just a representative from MDC and might not be a chair of.

MS. ADAMS: Well, so far I've seen his name on three.

MR. PARKER: Oh. Good enough.

DR. YEE: That's the three. That's all.

MS. ADAMS: Okay.

BOARD MEMBER: So the only thing I

can -- that I'd like to contribute is that I was on the EMS-C committee for one or two years. And it was interesting. We took a lot of surveys, we got some -- even were able to get free -- what's the word?

BOARD MEMBER: [unintelligible].

BOARD MEMBER: Thank you. Things like that of what agencies needed and we did a lot of work there. And it's not just a rubber stamp committee. It's the ongoing how do we improve our process and how do we protect the children.

And in disasters, how do we help in disasters. So I -- there was a lot of work done on that committee. And I -- I'm sure Dr. Bartle can probably echo the same. So --

MS. ADAMS: Beth Adams. I was not trying to demean the work --

BOARD MEMBER: No.

MS. ADAMS: -- of EMS-C. I did EMS-C in Minnesota. What I was trying to say is that they have a committed focus and they are -- they -- they have -- every place I've worked with EMS-C, they have integrated well and not tried -- tried to create a whole separate structure to support the work of insuring that we care for our children, sick, injured and otherwise.

And preventing them from being sick, injured and otherwise in a way that -- that demonstrates the whole pediatric thing, which is play well with others.

Create an environment of care and -- and do it that way without -- okay, we need the trauma silo. Now here's the cardiovascular silo. Here's the neurovascular silo.

BOARD MEMBER: Right.

MR. PARKER: And Gary, correct me if I'm wrong. That is actually federally -- yeah.

DR. YEE: Yeah.

MR. PARKER: Gary Brown.

MR. BROWN: I want to say when it comes to the EMS for Children Committee and program, there are, of course, their benchmarks that have to be met. One of them is, does you state have a standing EMS for Children Committee.

And also the HRSA grants for EMS-C, that's the only federal dollars that the Virginia Office of EMS gets that is separate from the State Four for Life Fund.

And there are benchmarks that that -- that on a national and federal level that must be met that can only be done through that kind of structure. In -- in the -- not only this state, but every state has to have it.

DR. BARTLE: Sam Bartle. Thank you. It really is and it's a lot of things that we bring to the table is what this committee needs. And we're happy to share

our expertise with anybody else in this group. We actually have a structure where we get -- we are surveyed. And it's information that's helping with pre-hospital, hospital and post-hospital level of care.

Working with Dr. Aboutanos and integrating how -- make sure that EMS side is covered with it, which was required on their part that they have a pediatric portion of it.

This is -- kind of held my tongue for a while. We -- we feel like we're an important part of this system. And we provide stuff that, in the lack of our presence, is often overlooked.

In previous times before we joined this group and in other places where the EMS pediatric representation is not provided, it is overlooked. So I think it's, you know, how we use -- how we utilize that.

It's one thing, but I think that we do bring something to the table. And we're put on -- we're codified into it

-- this for a purpose.

MR. PARKER: And I honestly feel like this -- and I spoke with you after the last meeting. It was good to actually have your meeting in conjunction with the Advisory Board where previous it had been on a separate cycle.

So that way, members of the Advisory Board could attend and I was actually -- very beneficial to attend that because I learned a lot.

DR. BARTLE: And I think that it would be good for other members to see it and see that it's something that we can -- we can contribute and want to.

MR. PARKER: To your discussion last night, talked about a pediatric educator or someone on different committees to kind of have a -- a different view -- mindset as well.

BOARD MEMBER: So I guess as we're

talking about the importance of this work and we're all agreeing on -- more of that can be coming before the main Advisory Board. I mean, I think that --

MR. PARKER: Yeah.

BOARD MEMBER: -- that's the crux of what we're discussing. We need to hear more about the important stuff that's going on.

DR. BARTLE: Well, that's what -- if you look at the -- the minutes from the previous meeting, you know, it was very few -- if any -- action items. We present what we've done, and information and more information items.

If you -- I'm very confident that we're following the structure that we needed. I would like to say that that could be something that we'd like to share with everyone -- other groups.

BOARD MEMBER: Just -- I guess the

global question that I want to understand is, the -- the perspective I get is people feel like the import -- there's a lot of important work done in committees. And maybe more important done in the committee structure than occurs at the Board level itself.

And that is the way people would like it. That's the way people think we should have it going forward. Is that a fair assessment? I'm not saying it's good or bad, I'm just --

MR. PARKER: Yeah.

BOARD MEMBER: -- asking a question.

MR. STARK: What do you guys think?

DR. BARTLE: Sam Bartle. I think technically, we need to develop these -- our purpose is to advise the Board of Health what's going on. In the technical sense, you need to report what each of our groups

are doing. Even though there's not action to be taken for some big deal with the -- we needed space for the list of things that we've been doing in our committees as -- whatever it may be so it goes on record as going to the Board. Otherwise, you're telling the Board you ain't doing crap.

MR. STARK: Yeah. Some of the big concepts we're taking out of this, obviously, consolidation, restructuring of the committees. Looking to, you know -- I mean, couching some committees under others.

And potentially, you know, elimination of a committee that's unnecessary. And then just kind of sharing information, especially at the Advisory Board committee meetings, you know, just an update.

Don't presume that, you know, everybody knows about because it's been mentioned somewhere else. You know, just a quick update on business, again, with a little bit of discretion. Going to Jon's point before, I don't want to repeat

something that's already on the record. That's fine, we can use a little discretion. But I think we're all sort in agreement there.

I'm going to go through, obviously, the record from this meeting and distill some of the concepts here to put forth kind of a structure and, you know, some recommendations of what's -- what's been suggested here. Other -- yeah. Absolutely, keep going.

MR. PARKER: So the next one I wanted to -- to bring up is Emergency Preparedness and Response in conjunction with Emergency Management. And I want to read the notes or missions of the two.

So Emergency Management -- Emergency Management Committee shall focus on providing recommendations and guidance to enhance and assist EMS agencies in the development and incorporation of strategies for the four phases of emergency management, as well as utilizing those phases to best prepare and respond as an EMS agency. The

committee will also assist the Virginia Office of EMS in the development and revision of emergency management training programs that focus on a pre-hospital area of EMS and emergency management.

And then, the Emergency Preparedness and Response Committee, here are the three goals. Insure trauma system is engaged in the state disaster planning process, collaborate with OEP and insure the provision of disaster preparedness, education to trauma centers, regional councils, local emergency medical service providers. And then collaborate with OEP to assist -- to assess and maximize the use of ASPR funding to enhance the medical service capacities of the state trauma system -- centers. Don't they seem to be doing the same thing?

MR. STARK: Yes, sir. Sorry.

MR. SCHWALENBERG: Tom Schwalenberg, Tidewater EMS Council. So the short answer to your question is yes.

However, I attend both of those meeting, though I chair the one, attend the other. The -- the -- what I'll call the hospital meeting, for lack of a better term, it's -- it's solely centered around VHHA and VHHA funding, and what the coalitions are doing.

That is totally what that committee is focused on. They are not focused on what's happening pre-hospital and what's happening prior to getting to the hospital.

That has not been their focus for any meeting that I have attended. So there is duplication and I'm -- I'm all for -- if we're trying to streamline things, I'm all for that.

But we really have to look at what is the focus. Because again, not -- not -- you know, not bad mouthing what they're going.

But their focus is once the disaster reaches their door, what do we do, how do we increase our surge capability for the community. It's -- it's -- even though it sounds very similar, they're -- they're

going in two different directions right now. So --

MR. PARKER: So is that not better served as a subcommittee under Emergency Management, focusing on the hospital aspect? Because I'm looking at their goals and there are some of their goals that are very -- I mean, like goal number two says collaborate with OEP, insure -- and insure the provision of disaster preparedness education to trauma centers, regional councils, local EMS providers. So there should be a pre-hospital focus to that.

MR. SCHWALENBERG: But -- and I'm agreeing with you. I think -- I think there is some -- some collaboration and some -- and some combining that could happen. Again, going to those meetings, there's --

MR. PARKER: Because I like the structure of the committees.

MR. SCHWALENBERG: There's a lot of

duplication when --

MR. PARKER: Yeah.

MR. SCHWALENBERG: -- when you go to both of those meetings.

DR. YEE: So I think this is an opportunity, right? Because let's -- let's get real. Those ASPR funds, and then they go to hospitals. And the hospitals created their own little silos.

And then there's EMS and we've always relatively been consolidated by our regions. And like, this is what our regions do. We work together. And the two don't talk very well.

This is an opportunity to force them into a committee structure where now we see the whole spectrum. You know, I think EMS -- one of the big -- great things about us is we're all together, right? You know, even the -- the biggest thing that's going to really take you -- take -- stress the community is not a trauma disaster.

They're really finite, right? If you were talking about wide scale, you know, weather events, right? You -- you're talking about what happened in the Bahamas.

I mean, that's what -- and that's an opportunity where the hospitals can partner with us and say, how can we work together? At the end of the day, we're all in it together.

MR. PARKER: Right.

DR. YEE: So this is -- this would be a great opportunity to force them together. And then we -- we'll still have our traditional lines of, you know, EMS does everything.

Hospitals do their -- because if they're -- they're -- they call themselves the -- the little coalitions.

MR. SCHWALENBERG: Health care coalitions.

DR. YEE: The coalitions are going

to work anyway. They can still report out. This is an opportunity for -- for us to see their side and their side to see our side. And work together and build these bridges.

So across different spectrums of -- of stressors. I mean, I'm very convinced that, you know, that our state will easily handle large scale trauma, right? I mean, we did that on 9/11.

We've done it for all these bus accidents. But where we have trouble is floodings in Franklin, hospital evacuations, right? That -- these are opportunities.

And -- and HAZMAT and probably -- probably HAZMAT situations would stress us. But these are opportunities for us to build these bridges.

DR. BARTLE: And from a -- Sam Bartle. To add to what Allen's saying, a lot of the attitudes of one side or the other being, you know, respectable about really putting either one. Each side says, oh well, you know, we can take care of what we need to do. This is what we want -- we

expect you to be able to do. And it's -- looking the time for, you know, and make them talk to each other.

Because this -- and if you're going to want this from me, this is what we need from you. And this -- there's signs, phrases and terms that, oh, we expect this to happen.

And this goes on from them. And there's no one to say, yes, that will or no, it's not. But this is the reality of it. So if we put them together, they'll probably turn out a better product.

BOARD MEMBER: I agree. And one of the notes I -- I mean, just as a sidebar, one of the notes I had made here is on the Emergency Management Committee, there's no pediatric representation at all.

So -- and one of my side notes was how do we get pediatrics involved in emergency management side? Because it's -- it's not. So I -- I think it's something that can be, you know, that can be brought together and we can collaborate better.

MR. PARKER: Because there is one on the Emergency Preparedness and Response.

BOARD MEMBER: Yes, there is.

MR. PARKER: So again -- I mean, in looking at it, there's a lot of folks that are on both committees that I think would benefit better from, as Dr. Yee said, that forced partnership. Dr. O'Shea.

MR. STARK: Dr. O'Shea.

DR. O'SHEA: So I'll just voice my agreement that it makes complete sense for these two committees to, if not be combined, to at the very least collaborate heavily. I mean, this is a tremendous opportunity for the EMS Advisory Board to, you know, serve the Commonwealth well.

We've already had multiple mass shootings in the state. We've had other disasters. Figuring out how we can best serve the public in this kind of need as -- as a state is a true opportunity, I

think. And this committee is one of the best suited to help advise on that. So I -- I think working together can serve in everybody's interest.

MR. STARK: Beth.

MS. ADAMS: I'm -- I support that. And I think we should call it Emergency Prepare -- Management and Preparedness Committee and create the best of both worlds. One thing that seems to be missing, though, is infectious disease.

MS. QUICK: Yeah. I -- I think that if you were looking at large scale events -- whether you're looking at a weather event, an infectious disease process, a trauma event -- many of those structures are going to be very similar.

So providing all of that and putting that underneath. And those could be potentially work groups where you --

MS. ADAMS: Right.

MS. QUICK: -- have a work group that looks at infectious disease management. Or a work group that looks specifically at weather event management.

So I think -- I think that -- like taking that out of just the trauma realm, putting it together and actually -- I sort of jotted down some -- some notes, too.

Sort of a -- a[n] emergency preparedness and response that would incorporate like public safety and communications in there, too.

Because that obviously very much correlates with how we're going to be responding to one another. The other thing that I think should potentially come out of just being subset of trauma would be the Injury and Violence Prevention.

That really should be broadened out to be -- I really like of like a public health and prevention committee where you have prevention of not just injuries, but prevention of heart attack, stroke, just whatever -- whatever we can potentially impact. And mobile integrated

health goes nicely underneath that category. So it's a broadened group of this is our -- our public health arena. And how are we responding to public health where we're going preventative care.

We're doing mobile integrated health. So that -- that being separated out. Does that make sense?

DR. YEE: Isn't there a Virginia initiative, Healthy Virginia or something like that? Didn't the governor put out something?

BOARD MEMBER: Population health.

DR. YEE: Yeah, but there's a whole acronym that they have.

BOARD MEMBER: There is a Healthy Virginia.

DR. YEE: Healthy Virginia, whatever. Maybe we could use that name as a committee.

BOARD MEMBER: Healthy Virginia is -- appears to be a movement organized by the Medical Society of Virginia Foundation.

BOARD MEMBER: All right.

DR. YEE: It -- it's something that the governor is in and -- and I think Dr. Oliver, in his position previously, put out an initiative. I remember the logo of having a tree, you know -- you know, Dorothy.

MR. STARK: Yeah, I just pulled it up. It's hard to see. It's kind of out of focus on the screen there.

BOARD MEMBER: That's not it.

MR. STARK: That's not it. This is the Medical Society of Virginia.

BOARD MEMBER: That is -- that is -- that is what comes up when you look for -- when you --

MR. PARKER: There's also the Health People 2020 and Healthy People 2030 federal initiatives that we -- we pulled into some of those as well.

BOARD MEMBER: Can we combine the injury prevention -- injury and violence prevention into trauma's educational part somewhere else?

DR. YEE: I think that's what she said.

BOARD MEMBER: Where is it? I'm trying to find it. Where else can we add it to?

MR. PARKER: So Injury and Violence Prevention -- is that what you're asking for?

BOARD MEMBER: Yeah, combine -- roll that into -- fold that into a previous education point.

MS. ADAMS: My sense was that -- that Valerie was going to spin that out and --

MR. PARKER: Public heath and violence on committee?

MS. ADAMS: -- was going to create a public health and prevention committee. It would --

BOARD MEMBER: Encompass.

MS. ADAMS: -- incorporate violence and obesity and etcetera, etcetera, etcetera.

MR. STARK: Okay.

BOARD MEMBER: I think provider health and safety could go with that to because we're also part of the public.

MS. QUICK: We are but, you know, we're talking about that then -- I mean,

that's sort of another category combination is professional development and support, where it does incorporate Workforce services.

It incorporates training, it incorporates providing -- provider safety and health. It's what we can do to make our workforce better is train them and make sure that they have adequate mental and health resources.

MR. PARKER: Any other comments on those?

DR. O'SHEA: Would that also be a -- Jake O'Shea. Would that also be a committee that could look at the workforce numbers in -- in the state and, you know, help identify potential gaps that we may see in five, 10, 15, 20 years?

MR. PARKER: I think that's what Workforce Development, you know, goal was.

MS. QUICK: Yes.

MR. PARKER: Dealing with officer classes and things like that.

MS. QUICK: Which is a training, so it falls underneath.

DR. O'SHEA: And I guess I'm thinking, you know, are enough college students enrolling in paramedic course work? Do we have enough people, you know, growing up who are saying, I -- I want to be a provider.

MS. QUICK: No.

DR. O'SHEA: And what can we do to improve that?

MS. QUICK: In fact, we have that, actually, in Workforce Committee. So I'm the brand new chair of that, so I can't tell you a whole lot.

But what I can tell you is that a few of the things that we talked about very much dealt with the fact that we

have a deficiency in the amount of people coming through the pipeline. And how do we deal with that, well, that's a training issue.

So it's not really within the purview of that, but it certainly goes together. Same thing with, you know, how do we keep our people retained?

If we retain them and that they're healthy and then they're not having back injuries, it goes to the provider's routine health. So it seems like those three committees very often kind of piggyback on each other.

And the -- I would say that the -- the bulk of the work is probably the Training Committee with sort of these offshoots and smaller potential work groups being the other -- the other two committees.

But it really is broader, it's -- it's Workforce Management. How do we -- how do we maintain and supply our workforce.

MS. DANIELS: It's Valeta. So -- and just to give you an idea. The pay that

comes from a two-year college, getting your two-year degree for paramedicine versus I can go two years of nursing school and walk out making a lot more money.

And I have opportunities out the yin-yang. That's another issue. But yeah, pay is -- pay is another one.

BOARD MEMBER: Yeah. It's an issue for the committee, yeah.

MR. STARK: Chris, I think you had --

MR. PARKER: Oh, no.

BOARD MEMBER: Well no, I was just -- I just -- I agree with Valerie in that I think putting provider health and safety, making it its own group, but putting it under Workforce Development just makes a lot of sense. But I don't think we want to lose focus on that when we're looking at our responsibility, our advocacy -- if you will -- for our people. I -- I think that's a

great place to put it.

MR. PARKER: So the last committee topic that I had was looking at the trauma committee structure. So you have TAG and then you have System Improvement -- currently, System Improvement, Injury and Violence Prevention, Pre-Hospital Care, Acute and Post-Care which are our bylaws, committees that are reporting to committees, as Dr. Yee brought up before. So questions, comments, discussion related to how those committees are listed now.

DR. YEE: So Mike's not -- doctor -- this is Allen Yee. So Mike Aboutanos is not here. So I think that TAG has to -- I think that's the name, TAG?

MR. PARKER: Mm-hmm.

DR. YEE: -- has to stay.

MR. PARKER: Right.

DR. YEE: Right? Because all -- I think the State is required to have the -- the trauma triage and all that stuff.

MR. PARKER: Mm-hmm.

DR. YEE: So they're like -- I don't -- I don't see them -- I see the importance of them. Out of that, they can have -- they could spin off a subcommittee of trauma system improvement, right? Like we had before, then create the acute care as an all acute care. Take them out of trauma, completely out.

And we can do all the acute care, including -- we just include trauma, STEMI, stroke, geriatric, pediatrics. I mean, dental -- I don't care. You know, all that. Oh, fibromyalgia, you go to throw that in there.

BOARD MEMBER: Oh geez, here we go.

DR. YEE: Yeah. And what was the other one? What was the one --

MR. PARKER: We have -- then we had -- we were talking about acute care. Then you have post-acute care, which -- have they actually met? I forgot if they --

BOARD MEMBER: They have, yes.

DR. YEE: And then that'd be a great one, post-acute care which includes our nursing homes, rehab facilities, other SNF's.

MR. SCHWALENBERG: But just -- Tom Schwalenberg. Just a point of clarification, doesn't a lot of that fall under the health care coalitions, though? When you look at their vulnerable populations and they're looking at SNF's and nursing homes and dialysis and that kind of stuff.

DR. YEE: Sort of.

MR. SCHWALENBERG: Does that need to be its own -- I guess I'm wondering does

that need to be its own, or does that fall under Emergency Management and Preparedness? Because the goal is to make sure that those facilities are prepared and able to be resilient.

DR. YEE: I think under current structure, it's how do we get trauma patients into -- what happens to them after their -- their acute phase in the hospital.

MR. SCHWALENBERG: Right. But I'm wondering do we broaden that out -- as you suggested with acute care, we broaden that outside of acute care to look at the post-acute. The post-acute --

DR. YEE: I'm thinking about acute and post-acute care.

MR. SCHWALENBERG: From -- more globally than just trauma.

DR. YEE: Yeah.

BOARD MEMBER: I mean, can trauma be --

DR. YEE: Consolidate the committees.

BOARD MEMBER: Can trauma be a subset?

MR. SCHWALENBERG: Mm-hmm.

MS. ADAMS: What if we call it environments of care? Acute, post-acute.

DR. O'SHEA: So -- Jake O'Shea. So I guess I would say for post-acute care, the quality component of post-acute care -- trauma has this very specific focus on that. And I think that is a population where it makes a lot of sense to focus on it within the scope of EMS Advisory Board, given the charge around trauma triage specifically. I think expanding beyond that for post-acute care conditions and quality gets a little bit of, to me, scope -- from

what we're -- where we are currently. And -- and it's not necessarily within what I have seen this as the charge of this Board. I -- I think it's important from the trauma perspective.

But -- but as I understand it, that committee that as envisioned by Dr. Aboutanos has been focused not just are they prepared in disaster, but what is the quality of the post-acute care provided to patients who are discharged from an acute care trauma admission.

MR. STARK: Dr. Yee.

DR. YEE: So I'm going to play devil's advocate. I think that we -- we lack communications with our post-acute care, the -- the SNF's of the world, the rehabs from the EMS side. This gives us that opportunity.

And I'm doing a lot of work with them now, so I can take that elderly fall before she gets that hip fracture, right? So she'll never get that hip

fracture and, you know, die 12 -- 12 months later, you know, from the third fall with a femur fracture.

DR. O'SHEA: And -- and would that not fall under injury and violence prevention?

DR. YEE: A little -- a little bit, but now -- that's a good point.

MR. PARKER: Because not fall under mobile integrated health care, you're doing work -- I mean, honestly, there's a lot of, I think, potential --

DR. O'SHEA: And also, I think -- I think that's a separate topic. I think it makes absolute sense for EMS to be well integrated with post-acute facilities.

I guess I -- from what I understand has been the scope of the prior post-acute care meetings, I think you're looking at a shift -- a little bit of -- of what that is.

DR. YEE: We -- we're shifting all of them. So -- but the -- you bring a great point. Why don't we just embed post-acute care into some of the committees? That would work just as well.

DR. O'SHEA: Yeah. I agree.

MS. ADAMS: Beth Adams.

MR. STARK: Yeah.

MS. ADAMS: Northern Virginia. I think it would be really helpful -- just as not specific about committee alignment, restructuring, etcetera.

But I think it would be really helpful if we could modify the Advisory Board committee web site to not only identify when they're going to meet and who serves on those committees, but to -- but to give a little thumbnail sketch of what this committee exists to do.

MR. PARKER: Like their goals and

objectives.

MS. ADAMS: Even if it's a one-liner. Because it -- I mean, I just think that as I'm scanning between them, I'm seeing who's -- who's on those committees. And I -- and which bodies are represented, but it doesn't say what they're -- that they're there to do. All right, I just think that would be, you know, in terms of educating our community, the public, etcetera.

If they have an interest, let's figure out where we need to send them to get that information.

BOARD MEMBER: Is it just me or is it cold?

MR. STARK: It's been a long two days, but --

BOARD MEMBER: Yeah, that's out of my --

MS. ADAMS: You're probably not helped by the bright lights immediately above us.

MR. PARKER: Yeah.

MS. ADAMS: And I don't know if we can turn off just those lights.

MR. STARK: All right.

MS. QUICK: Can I just say something?

MR. STARK: Yeah, go ahead, Valerie.

MS. QUICK: I'm going to -- I'm going to play the devil's advocate actually now. Well, and to -- to back up, there -- a lot of work has been done by the trauma group that I hate to undo completely and reorganize. And I think that there is a very prescribed trauma system that requires some of that to exist. It's -- and if you

look at the structures of those committees, they're -- they're just entirely trauma representatives from different -- from different angles.

What we're sort of missing is those pieces in -- in other areas. And so, I would -- I would say that you probably have an uphill completely disbanding all of what the trauma committees are.

You could still have sort of the TAG, a couple of the committees underneath and leave trauma sort of alone before they -- their heads explode.

But I think that it's important for us to have a systems quality, a data group that actually would encompass really more of the focus of what pre-hospital care is.

Which is performance improvement and data that is going to incorporate trauma and stroke and STEMI. And so it really is an all-inclusive entity that could also include our post-acute care, post -- you know, the -- the rehab groups. So I'd hate to add a committee, which is

what essentially I'm saying. But if we get rid of a bunch of other committees, I think it's an even -- even keel.

But -- so that -- my proposal would be like the system quality and data group that actually does look at performance improvement across all spectrums of EMS care.

And it nicely feeds into Medical Direction. It nicely feeds into the trauma group that -- I -- I think you could pull out injury prevention. I think you can pull out emergency management.

If you start to mess around with some of the other ones, I have a feeling that it's not going to be in line with ACS and what the trauma needs are specifically.

That we're going to end up just pushing them off into their own little group and not necessarily correlating well with us.

DR. O'SHEA: And I --

MR. STARK: Yeah.

DR. O'SHEA: I totally agree. I -- Jake O'Shea. I clearly agree with the concept of a quality and -- and continuous improvement or -- or quality and data type of committee.

I think there's a tremendous amount of benefit to that. That it -- it's to our benefit to focus on. I guess -- one question I just want to ask about trauma committees versus some of the others is the other committees are allowed to have subcommittees.

Could we not say we have a Trauma Administrative Governance Committee in the bylaws. That committee may have whatever subcommittees it deems necessary.

And then just not necessarily reference them all within the bylaws specifically. Would that be an option for us? Would that be within the purview of that committee?

BOARD MEMBER: Just put it all

under one umbrella.

DR. YEE: I mean, that's what we used to do.

MR. PARKER: That's what we had.

DR. YEE: That's what we had. So we would go back to the other structure, which is -- I mean, it's the same -- we're doing the same thing. We're just calling it different things.

We -- we call everything a committee, right? Now we would have TAG as the committee and then they would have subcommittees.

MR. PARKER: Subcommittees.

DR. YEE: And that relieves the pressure of extra chairs.

MR. PARKER: And extra seats on the Board.

DR. BARTLE: Sam Bartle. I have a question.

MR. STARK: Yes.

DR. BARTLE: Will that -- anything with the trauma accreditation requires like all these trauma subcommittees or committees be on the Board? Or is it having it under the -- under trauma?

MR. BROWN: Sam I'm missed what -- I missed your question.

DR. BARTLE: If they were to put all these trauma committees under one encompassing trauma committee, will that still meet the requirements for the accreditation? Or do they have to have a separate --

MR. BROWN: ACS one? No. They wouldn't have any impact.

DR. O'SHEA: Say that again, Gary.

MR. STARK: No -- the answer's no. They -- they do not have to be separately enumerated in subcommittees. Yeah. Okay. Other comments? Okay. Let's take 10 minutes and then we will finish up the day.

(The EMS Advisory Board Retreat discussions took a recess at 10:33 a.m., and resumed at 10:45 a.m. The Board's agenda resumed as follows:)

MR. STARK: I'll assume everybody's now. The other big issue of the day is composition of the Advisory Board. And currently, you know, obviously 28 members of the Board right now.

There's been some -- there's been comments, you know, about the size of the Board. You know, that it's -- it can be unwieldy. So we need to determine whether or not, you know, we need this size board.

If, you know, the folks that are represented on this Board are truly serving a purpose for the Advisory Board. Chris, I'll -- I'll offer it to you to, you know, any comment? Any initial comments

that you have about, you know, current structure of the Board and, you know, or just general comments about composition of the Board.

MR. PARKER: I'm going to defer to others.

MR. STARK: Okay. Let's open it up.

MR. TANNER: I'll have a little comment.

MR. STARK: Yes, sir.

MR. TANNER: General -- I'm new to the Board. I represent VACO. And just about everybody in here is representing a stakeholder's group that represents a broad spectrum of the Commonwealth.

And I don't know that anyone should be eliminated, in my opinion. If some know of some that should be eliminated, then please speak. But it's prescribed out

on every committee where you serve and why you serve there, and what your mission is.

MR. STARK: Okay. Yes.

MR. SCHWALENBERG: Tom Schwalenberg, Tidewater EMS. I'm just going to ask, I guess, maybe more of a clarifying question. Which you say the Board is unwieldy. What -- what are we basing that off of? What are --

MR. STARK: Well I guess, you know, sometimes it's hard to get, you know, 28 members in the same place at the same time, you know, at times. Sometimes it's hard to get a, you know, a consensus on items.

If we're not seeing, you know, those types of issues then the question becomes, you know, do we believe the composition of the Board is an accurate reflection of, you know, those who promote the interests of the, you know, of the Advisory Board and those who are needed on the Board. If that's the -- what the

question becomes then.

MR. SCHWALENBERG: So -- so I think those are two separate -- I think those are two separate issues. One is --

MR. STARK: Yeah.

MR. SCHWALENBERG: -- if we're saying it's unwieldy and it's not doing its -- its mission, then I would say as a relatively new Board member, I don't -- I don't see evidence of that. So -- but maybe that's just my tenure.

So I -- I don't see evidence of that. But I -- I think -- I think those are two separate -- those are two separate pathways that you're discussing.

MR. STARK: Yeah, I agree. Dr. Yee.

DR. YEE: In the history of the Board, have we ever -- have we failed to have a quorum?

MR. STARK: Have you guys ever failed to have a quorum? Okay.

MR. PARKER: So I do have a question to pose for the group. For those that have gone through Board recomposition in other arenas -- i.e, regional councils or what not -- what decisions did you take to get to that?

Would you just look at it as -- we've got too many members and we need to consolidate down. We've got duplication of members or member services.

So just thinking about those things, kind of have that discussion. And I'm going to tag some people that I know have been through that. Matt.

MR. LAWLER: Matt Lawler. We -- talking about the Central Shenandoah EMS Council. Our EMS council for decades was -- had a board officially that if -- if everybody showed up, probably numbered close to 80 members. Because every EMS agency in the region, every hospital and, you know,

all the interest groups got a -- got a seat on the board. And I worked for the -- for the EMS council for over 16 years as a -- as a staff member, you know.

Observed this as a -- as a non-board member. And of course, Gary Critzer would be able to give you the -- you know, a much better detailed history of this, but he's not here.

So I'll try to do my best in his place. But probably 20 years ago, there was an attempt at restructuring the board. And 20 years ago, there are a lot of the -- the stakeholders were more connected to the EMS council at that time.

And -- and the -- the desire to downsize the board failed because everybody showed up and said they still wanted their vote and their piece of the pie.

And then the really -- after that, there was a lot of discussion but no -- no formal action was ever taken to -- to re-size or restructure that board until very recently when after repeat years and years

of no representation from us. We decided that it needed to -- to try it again. At that point, I had become a board member, not a staffer any more, having left and taken a new job.

We -- we -- we had gotten into a -- a situation where the executive committee of that board was empowered to do all the business of the council. And that's what was happening with this executive committee that was made up of about eight, nine, 10 people were the ones who were doing all the work.

So we said, hey look, why don't we just flip this, eliminate the executive committee, restructure the board and have a -- a work-able board that's representative of the different interest groups in the region and go from there.

So what we ended up doing is our -- our council serves 10 municipalities. And we designed a board that had one representative from each municipality, the regional medical director, a representative of the hospitals in the region, two at-large

members to -- to kind of fill the void of -- of areas where the -- that were under-represented.

And including the -- we recognized that the -- the city and the county reps were probably generally represent municipal departments, which is what happened.

So we wanted to fill -- we wanted a couple groups that have representation of the volunteer interest or whatever, you know, geographical area might have been under-represented on the council.

We ended up with a board of 15. I don't remember all of the spots, but our past president that was here before. So we ended up with a board of 15 and -- and have been, you know, working now under that board structure for -- for about a year.

And it's -- it's served us well. We have fairly good representation on the board, probably pushing 75 to 80% of the reps showing up. So it's -- that's been successful for us. Some, you know, felt like that might be a little bit too big of a

board. But I think it's a -- it's a good sized board and it's been successful for us. You know, the problem with our previous board is nobody showed up to work and get -- we would have the executive committee show up and then two or three other people would show up.

So that eight people would show up. The -- the board -- on paper, the board was unwieldy. But the functionality of it, it just didn't function, number one, was the primary reason for deciding to restructure that.

BOARD MEMBER: So I'm going to -- it kind of goes back to my last question, which is so -- so I have been through a board restructure, non-EMS related, another non-profit.

And the two things that drove the restructuring of that board were basically what -- what -- what's -- what was the current board not doing that needed to be done to benefit the organization. And then as the organization was looking towards

the future, where it wanted to go, what areas did -- that needed to be covered. Predominantly looking at stakeholder involvement that were not currently represented in the board.

And those really became our two driving sort of marching orders, if you will, to say how are we going to restructure this. And -- and the restructure was successful.

But I think the basic premise was what was -- and I'll bring it back to this board. What is the board not doing now that -- that is causing an issue?

I mean, we're -- I guess really that's a fundamental question. So what are we not doing now? Maybe I'm just not seeing it, I don't know.

But I think really, when we went through the restructure, those were the two things we looked at is -- is -- because we did have some gaps in -- in the current board. So what was the board not doing for the organization that needed to be done. And then, where do we want to position the

organization.

MR. PARKER: Okay. Kevin.

MR. DILLARD: So, Kevin Dillard.

MR. STARK: Yeah.

MR. DILLARD: My observations are that the stakeholders are currently very well represented. And I think the geographic areas are very well represented. And in my years on the Board, I've seen very good participation and I think the Board functions well. So you know, is it perfect? No, probably not. But I'm not seeing any huge concerns. I think the Board's been very functional and I think the Board's been very effective. So that's just my observation.

MR. STARK: Other observations, folks that have been on the Board for a period of time while it's at the 28 members.

DR. YEE: Allen. So if we restructure -- not restructure -- reorganize the way we do business at the Board meeting to include more committee work, can we solve -- don't -- don't we solve some of the problems that -- that are perceived?

I mean, do we have to make this drastic change now? Can we just see what changes we make now, how it affects our productivity?

MR. PARKER: One of the questions that was posed during our break was, if we restructure committees, is that suffice of how our -- our intent or need to or lack of need to restructure the Board.

Because I'm, you know, looking at some of the committees. If we put more representation on those committees where it's truly doing the work, do we need to restructure the Board?

Maybe we make this move since it's an easier move with the bylaws and changes that. And then we see where that goes, with the long term thought process do

we need to slim down the Board. We don't know where that's going to be. We don't know until we figure out this with the committees. Jason.

MR. R. J. FERGUSON: Jason Ferguson. So the question I have is, do we have anyone -- any stakeholder group that's not represented on the Board, versus looking around and saying what can we eliminate.

What's not represented, not to throw it out. And then, if we do, then maybe look at with the stakeholders that are currently here to say, is that going to be added to it?

Or is that something that we can go, okay, well, well kind of swap out here because of maybe over-representation of this particular group or that particular group.

MR. PARKER: Gary.

MR. SAMUELS: Gary Samuels. Yeah, we -- we've had this -- these discussions

before. And every time it leads back -- everybody has their -- their interest or the reason they participate. When you really break it down, pre-hospital -- we're not going to go with the regions, but pre-hospital.

There are seven representatives. Hospitals, nursing, doctors, physician societies, VACEP, whatever you want to put them, I kind of -- this group like VHHA, that's all hospital-driven things.

There's six people that represent the hospital systems. There's four that kind of represent government, and that includes the consumer position. That's kind of -- consumer's kind of representing the citizens.

VACO, VML and then ASCO [sp], which is the dispatchers. And then when you look at the regional councils, there's a mix of field providers, nurses, emergency managers. Depending on who was appointed into the position by their -- their regional councils. So the mix of groups is very

diverse. Even some of the regional councils, there's people that are nurses or -- and medics and flight medics serving in one -- serving a regional council on the Board.

So I think that's -- that's a very diverse group. Looking at other -- other groups -- other groups out there, you know, I'm kind of with you.

Who's out there that we're not already tasking in this -- in this group? I mean, this group -- this Board used to be 34, I think. And they mixed it back to 28.

And trying to grow it based on adding a position, taking a position -- I mean, is there any one council or is there any one group that wants to give up a spot because they feel like -- or is that group under-valued or over-valued on the Board.

And that's -- it's hard to say because I think the diversity of the folks that are -- that come to the table, that's our key. Because we're not group thinking. We're really weighing in how it's going to impact Northern Virginia versus southwest

Virginia versus the Eastern Shore. We're looking at all of those little pieces. We're trying to figure out how to best serve the citizens.

Yeah, we -- I mean, I could probably go down a list of interest groups throughout the state that are lobbying for other things and find something that we could plug into a hole on the Board.

Whereas with the revamping the committee structure, we're going to plug a lot of people into those holes. And I -- I think that in itself will lead to huge changes on the work that we get done and how -- how we report out at the end.

How we can support the Office with their needs and support population health and everything else. So I think there's a lot of work that's being done. But I think this is a diverse group of people that are already coming to the table to do the work.

DR. O'SHEA: And Gary, I'm going to agree with most of what you said. Jake

O'Shea. I think I would distinguish between the hospitals and the physician groups. I think where the hospitals -- the physicians often work with or at hospitals.

I would not say that they are always representative of the hospitals in that setting. So I would -- I would distinguish between those.

MR. SAMUELS: Okay.

DR. O'SHEA: And would note that, you know, by that, the hospitals have a single representative on the Board.

MR. STARK: You had mentioned that there were 34. I think, at one point, there might've been 37.

MR. SAMUELS: Yeah.

MR. STARK: So what would be, at this time, a reduction of Board at that point? Gary.

MR. BROWN: I'm leaning executive. Well actually at the time, if I remember correctly, the Board was 37 members. It was either the largest or one of the largest boards in the entire state.

And in looking at the participation -- to give you some examples of the organizations that were represented at the time and some rationale as to why they would maybe conclude that -- and there was suggestions made.

At the time, there were the three teaching hospitals in the state. Each had a seat on the Board. That was Eastern Virginia Medical School, VCU and UVa.

Actually I don't believe any of you were on the Board at that time -- I know Kevin meets a couple Boards. But those three institutions had a seat on the Board as teaching institutions.

It was decided that they -- there are organizations that we should be working with through a more umbrella organization, such as VHHA representing all hospitals, not just the teaching hospitals.

At the time, actually the Department of Motor Vehicles an the Department of Emergency Services, which is now VDEM, had seats on the Board for coordination of -- with EMS and so forth.

And as we all know -- and I think Beth brought it up yesterday -- that the roots of EMS, my roots in EMS as we know it is actually in highway safety.

And so, the thought process -- these are entities, again, that as a -- as a State agency, OEMS-VDH is us. We should be working with DMV and VDEM on a daily basis, you know, which we do.

There was the Virginia Pharmaceutical Association that was on the Board. And it was determined that we should be working -- which we do -- with the Board of Pharmacy.

So they -- we don't necessarily need that association on the Board. So that gives you some ideas of -- just samples of some entities that were on the Board that came off the Board trying to, number one, streamline a large 37-member

Board -- which was like herding cats, quite honestly. Trying to organize meetings and so forth. And where there should be already established type of relationships and connections with those organizations.

So that was a lot of the rationale in terms of paring things down. Actually from the General Assembly type of messaging we were getting as well, this was -- this was not just driven by EMS's the withdrawals were driven by the General Assembly who looked at this and said, too big of a Board. Got to pare it down. So I can stop right there and --

MR. STARK: Did that kind of answer the question? Any other comments? Yeah, Valerie.

MS. QUICK: I mean, I think it's still behooves us to look at the redundancy on the Board. And even just from a fiscal responsibility, I think that -- I think we all sort of agreed earlier that, I mean, someone from each of the regional council

areas is important. But could we -- I mean, could we actually define that a little bit more? Like instead of saying the regional councils could we actually say an EMS provider with this type of -- with -- from the municipality.

It would be and EMS administrator and then vary that through the different municipalities. That way, you actually get more of the boots on the ground potential, but then you represent all the different areas.

So one person has to be a volunteer, one person has to be a career pilot. One person has to be, you know, municipality.

DR. YEE: This is Allen. So I think the regional council reps is how we take information from the Governor's Advisory Board -- take it down to the regions and from the regions into the agencies. So I think those positions are key, you know. And I think they -- it's -- it engages all parts of the -- the system.

With that said, I would probably rephrase it as regional council or their equivalent. Right? You know, because -- because of restructuring some of the other group -- council, whatever the right term is.

I don't know. Like we don't know what the future holds, right? Because -- let's say we become, you know, let's take the extreme. You know, all 11 councils become State offices.

Then each State office will elect a representative from the region. The function will still be the same.

MS. ADAMS: Will it?

DR. YEE: Hmm?

MS. ADAMS: Will it? Beth Adams. Question, will it? Will it still be the same if it's -- if it's an office of the -- and a remote office of the Office of EMS?

MS. QUICK: But we're not looking at a functioning member of that agency.

It's a person from the region to represent.

MS. ADAMS: But the statute already says that each organization and group shall submit three nominees from among which, the governor may make appointments.

Of the three nominees submitted by each regional EMS council, at least one member shall be representative of providers of pre-hospital care.

And so, it behooves the councils to -- to fulfill that. In the case of my recent nomination, it was -- two of them are active daily providers and then there's me. The governor picked me.

So they strove to met the -- they met the requirements in the -- in the nominee's part. Who the governor picks is who the governor -- I suspect the governor didn't actually go, oh, yeah.

Beth'd be great. I suspect that -- that it was somebody in a delegated role to do that. But I think there is -- given the diversity of the Commonwealth, I think we need to continue to have regional

council representation. Because who best knows their region other than the people who live there, not the people who may have relocated there to -- to work or do something else.

MR. STARK: Yeah, Dr. Yee.

DR. YEE: Historically speaking, I mean, I been through a couple of Board -- versions of the Board, a couple of tours. And what I'm about to say is just theoretical because the individuals truly have -- really have been productive on the Board.

But all -- all of the organizations have one vote, except for one. Why does that one organization have two? Why not two -- two representatives?

MR. PARKER: So that's actually one of the questions that has been posed to me is why do we have one organization that has two seats. And then we have three seats that are covered by fire fighter -- or fire

groups. And no, do not construe what I just said. I'm just throwing that out there from some of the questions that I've been asked. I don't know the history. I don't know -- I don't know that. So just repeating --

MR. SAMUELS: I think we can -- this is Gary Samuels. With -- with the fire groups, they represent different groups of people. Not necessarily what would affect the career departments affect the volunteer departments.

And the same with EMS when you think -- when you really look at it. Not what you'd be bringing to the table or it -- it could -- it could be -- it could be different for each of those groups.

If you look at the fire chiefs and Jennifer's not here. But if you think about the fire chiefs, they're worried about how it's going to impact the budget, correct? The fire fighters, we're -- we're more worried about -- I'm worried about health and safety. I'm worried about how it impacts the line fire fighter on the career

side. I would think that volunteers are going to look at -- they're looking at funding. They're looking at, you know, if -- if we put things into place that could impact our ability to recruit and retain members.

And the same with being -- I mean, with the VAA, Virginia Ambulance Association. If you put something into place that affects the ambulance association, that now impacts how Kevin does business or how that whole group does business, throughout the state.

VAVRS is looking at, you know, how -- recruit and retention again. How it's going to impact the ability for them to get boots on the ground. So there's -- and the VAGEMSA, that's a big mix of all the groups.

Because VAGEMSA could be -- it's kind of affiliated with fire chiefs and administrators from different systems. And some regional managers. So when I look at what they bring to the table, each has a different focus. And not always what's good

for the chief is good for the -- the fire fighters in the field or the medics in the field, too.

MR. STARK: Valerie.

MS. QUICK: I -- I understand what you're saying completely and I would agree with you. But I don't think that that would negate anybody else's feeling as far as an administrator goes.

And let's just say an EMS only agency or a volunteer agency or, you know, let's say a private entity that -- they'd all have those same concerns. How do we keep our people safe?

How do we keep -- how do we financially influence this. I think that some of that should kind of is also represented already in the regional councils. That's you all belong -- and separate entities, too, regional councils, right?

MR. SAMUELS: No.

MS. QUICK: Fire chief of --

MR. SAMUELS: Fire chief, yes.

MS. QUICK: -- of a specific organization, right?

MR. SAMUELS: As a -- as a professional fire fighter, no. I may not be able to go to the regional meeting because I'm not recognized at the regional meeting. I'm not the -- I'm not the member who has been assigned to that.

MS. QUICK: If you're a transport agency with an EMS license, why wouldn't you be?

MR. SAMUELS: Because -- my understanding of the regional councils, I'm -- I'm a worker bee in the field. Whereas the chief if going to be the one that goes to that -- goes to the regional council and sits in the meetings. Or his designee --

MS. QUICK: Right.

MR. SAMUELS: -- or her designee. So if it -- it leads it to believe that it's an administrative function or at the administrative level and not at the boots on the ground level.

MS. QUICK: Well, it's definitely an issue in itself and we should be --

MR. SAMUELS: And that's -- and that's what -- I think that's why a lot of -- a lot of the -- the groups came to the table and wanted a -- wanted a place of that table.

When I -- when I go back and I'm looking at the histories online here, there were -- there have been, you know, a few ads I think -- I mean, and the last ad was probably Mike Grove's position. Because no one had even looked at that.

MS. QUICK: And why would the fire chiefs be any different than the EMS chiefs?

And I know it's because many of them don't exist. Because most of us are under fire. But I think that all of these entities matter.

I don't know that they necessarily meet three separate entities that represent fire. When -- what about some of the -- if we're dividing that out, then like what put in -- if there was an EMS association, why don't we have an EMS -- some EMS rep?

And it's because we -- we mix. And I -- by no means am I -- am I saying that we should have a large influence by -- by fire at lots of different levels.

But I think that we're getting that regardless because that's who's running agencies and calls and government statuses. I think they are well represented in -- in a lot of different areas.

And you know, should continue that committee work and should continue to just general work within the councils, I'd love them to be.

MR. STARK: Allen Yee.

DR. YEE: Is this an academic discussion, or are we just really prepared to change the Board composition now? You know, I thought in our previous we talked about let's just see how -- how changes to our -- how we do business, will that make us more productive.

I mean, do we have to make this change? I mean, I don't know if we -- I thought we were leaning toward not making changes at the Board level. Or did I miss something?

BOARD MEMBER: I don't know if you want to bring that point to --

MR. STARK: Yeah, actually it's on the table. Everything's on the table at this point.

MR. PARKER: These are all -- these are all things that we discussed in different Executive Committees or in

different -- so just bringing in it all here while we're here.

MR. DILLARD: Kevin Dillard. I'm -- I'm along the lines of Dr. Yee. I think we ought to try the committee restructure and see how that works versus splitting hairs on whether, you know, one organization has, you know, more representation than -- than the other.

Like I said earlier, I think our Board has been very effective and very efficient. And I think the biggest changes can be made at the committee level right now.

MR. PARKER: Okay.

MR. DILLARD: I mean, that's where all the work happens.

MR. STARK: Yes, sir.

MR. TANNER: Gary Tanner. Listening to the discussion, I agree with

Dr. Lee [sic] and go back to what I said in the very beginning. We have stakeholders here represented. A vast group of knowledge.

I think the changes to the committees, subcommittees is where we need to focus and not scaling down this Advisory Board.

Briefly, I'd -- I'd say there's a huge difference and that's the reason that fire's represented in three different ways. Volunteers, that's me, he's paid and you have your chiefs.

And a lot of EMS runs through the veins of fire service now. It has for years. So I don't think that should be touched at all.

DR. BARTLE: Sam Bartle. I have a question I want to everyone. I'm not looking for anybody to answer this, but it's something to think about. We need all to ask ourselves what is it that we bring to this table as a group? What can be done if we're not there? And are we bringing

anything of -- of substance and of -- that actually is making a difference. Then you know, we can justify what we do.

Or we can't -- we can't sit there and go, well, I'm here to represent my little old group, my own organization or my only -- my person. Then no, you're not.

And -- and I think we need to look at it in that way. Consider and think about it, what is -- what is it that you bring? And is what you're bringing important for the group as a whole.

Yes, we can all go around and say, yes, we're important. We do this, we bring this. But I -- we need to ask -- look at it the other way. Are we bringing something that is productive?

MR. PARKER: Question.

MS. QUICK: And -- and I would say, I'm not at all arguing that these entities are not important. That -- that's not really the -- the meaning of statement. It's just that where do we draw the line of

other people that have come up and said, I really should have a seat at the Board. So that's -- that's really the impetus for looking at those sort of structures.

I do go with what Dr. Bartle said, you know, we all -- we all are important. We all have -- have issues to bring up. But how do we streamline this to make the most sense?

And if it means we look at that in a few years while the committees really get restructured, I think that that's okay, too.

But I -- I do think that it is worth a conversation to say there are lots of entities that want to be at the table. But what table should they be at?

Is it this table, is it a committee table? And -- and how do we -- how do we best serve that.

MR. STARK: Yeah. I think it's well said. Do you advance the interest -- one of you bring, you know, from the agency to EMS system. Yes, Eddie.

MR. D. E. FERGUSON: Thank you, Eddie Ferguson. So to this point, we talked a lot about patient care and doing what's best for the patient. And I think that's the core value that we all are here for.

But I think we also have to -- I'm just going to throw it out that politics side of this. This is a Governor's EMS Advisory Board. The candidates are selected by the governor.

Can't say politics don't play into this. Some of the organizations that have seats on this Board are highly involved as legislative stakeholders. They affect change through the General Assembly.

They have lobbyists, they have funding. And so we just can't forget that because I think all combined and everybody working together on the same team like the prior EMS legislative summits that worked in the past years, I feel like that there is some benefit to the overall progression of public safety throughout the Commonwealth. And so, if we don't consider that, then we may go off in a direction that may -- we --

we may be redirected. So I would just suggest that, you know, we remember that some of the organizations that have seats at the Board are very engaged in legislative action.

And we just can't forget that. Patient care is the driving force and that's what makes the most difference in, you know, who gets the right care.

But when something's coming before the General Assembly that has an -- has an impact on patient care, such as the two Medevac bills that tried to go -- one passed and one different -- years ago.

All these agencies are at the table. And meanwhile, the Office of EMS can't be directly involved in that. I'm hoping one thing that the legislative stakeholders are some benefit to the Office of EMS in these -- in these countless hours sending out reports now that the General Assembly's in session. So just a -- just a thought. I'm patient care-driven. But I'm also not totally disconnected from what really happens based into our work.

Something to think about.

BOARD MEMBER: So just three things. First of all, I kind of agree with some of the comments that have already been made. But -- but I would propose that we look at the committee structure, we look at the work of the committee.

Does that have a change? If -- if we change all these things at one time, are we going to really know what made the difference.

If -- if -- again, I'm still struggling with what's the deficiency we're trying to fix, number one. Number two, if -- if we have people who are saying they want to be at the table, then -- and I don't know who those are -- who those representatives are.

If we have people who are saying that they want to be at the table, then why don't we just come out and say, x-y-z organization thinks they need to be at the table. And then have a frank discussion of what does that organization bring to this

Board. Again, new guy. But I -- I've not been approached by Organization X saying, I need to be at the Governor's Advisory Board. So if that's the case, then let's discuss -- you know, let's open it up and have that discussion.

MR. STARK: Dr. Yee.

DR. YEE: So Dr. Aboutanos is not here, so I'm going to speak on his behalf. He's asking for six more representatives. Who the six are, I am not 100% sure. But it is -- you know, it's going to be that injury prevention I would suspect.

MS. ADAMS: Well, he specified yesterday what he wanted, who he wanted to fill that.

DR. YEE: So we -- you know, he's a member of the Board. We should probably have some discussions around that -- the six members he's asking for.

MS. ADAMS: So -- Beth Adams, Northern Virginia. What the good doctor said yesterday was that we needed an injury epidemiologist representing the prevention group.

A health care professional, not necessarily a physician for the acute care to represent acute care. That we needed somebody in the rehabilitative services, either physical therapist, occupational therapist, or speech pathologist for the post-acute care.

He didn't -- for hospital quality and burn care, he didn't -- he said specified health care professional, not necessarily an MD.

And then for the trauma nursing care, he wanted a trauma program manager. Those were the people he was looking -- the -- the kinds of credentials or expertise he was looking to seat at the table for trauma side, representing the trauma group.

DR. YEE: Chris is looking at me

for some reason. So I'll start, I guess. This is Allen. So I think we do have that representation at the committee level. I'm going just throw that out there. My name is Sam Bartle, for the record. That's all I'm going to say. He did it.

DR. BARTLE: Payback is something.

DR. YEE: Payback. So we do have that representation, but we did put it into the committee level. Which I would argue is the workhorse of the committee -- of the whole structure.

BOARD MEMBER: I agree.

BOARD MEMBER: Are EMO's not represented in any of the committees?

MS. QUICK: And that's where I think you need to be careful. That's all I'm doing is bringing up -- that is the question that you can say, are we represented in another committee --

MR. STARK: How nuanced do we have to get --

MS. QUICK: Yeah.

MR. STARK: -- in our representation?

MS. QUICK: Like are we going to shoot ourselves in the foot by saying, we represent that within another committee. But oh, wait a minute. This group represents this hospital in the committee.

So I think that's why we have to be thoughtful about how we -- we go about saying no or yes to those certain members.

DR. BARTLE: Just a question that leads up to another part. What is it of those groups is it going to bring -- bring to -- what are we looking to get from those groups? Is it something to make a decision on at this level or something to make a decision on the committee level? Is it to help with trauma, with their ongoing

programs and changes? Is it something to help with Medical Direction? Is it something to help with -- where are we -- what is it that we want from it? Do we want one of those on the bigger board or not?

MR. PARKER: Dreama.

MS. CHANDLER: Dreama Chandler. I think they already have the representation. They all fall under the TAG, which is Dr. Aboutanos chairing that.

He has a seat on the Board. He speaks for all of those committees, so they have representation. It's not that they're not represented at all.

MR. PARKER: I think before Dr. O'Shea -- I think the -- if you look at what we did with the bylaws where we created the committees. And then in the bylaws it says the committee chairs are members of the Board. So then we look at -- if you look at restructuring the committees to make into actual subcommittees, does that negate that

meaning?

MS. CHANDLER: Why can't we make a bylaw change saying that the committee chairs do not have to be a member of the Board?

MR. STARK: Dr. O'Shea.

DR. O'SHEA: And I would -- I would kind of echo what Chris said. My understanding was this request came based on those six committees that are in the bylaws. If you remove from the bylaws and make them subcommittees of TAG, does that obviate the need for the request?

Or the other option that we had not considered is -- does the Advisory Board recommend to remove the current chairs of the committee and replace with Advisory Board members to keep it consistent with the current bylaws? I'm not advocating for that, but it is an alternate solution. I -- I would also note that I think the one group that we may not have as broad a

representation from on the Advisory Board is the prevention side of the world. And that may be a place to -- to think about. I think we are all engaged in prevention in some way, shape or form, however.

MR. STARK: Dr. Yee.

DR. YEE: So I wholeheartedly agree with Dr. O'Shea that we do not have prevention and epidemiology as part of our Board. However, the Office of EMS now has a division of epidemiology that maybe that representation. So we -- that problem may have solved itself.

MR. PARKER: So we may be able to get information through the two epidemiologists within the Office to suffice the need for the Board.

DR. YEE: Correct.

BOARD MEMBER: Is that epidemiology a tool or -- I don't -- the end result.

MS. ADAMS: Great question.

MR. STARK: Would you repeat that?

BOARD MEMBER: I said is epidemiology a tool that we -- the Board uses or is it the end result of something that we made?

DR. YEE: I think it's both.

MS. ADAMS: Mm-hmm.

BOARD MEMBER: I think -- we might want to look at what we're wanting from each member of the Board to figure out how we -- you know, that's going to achieve --

MR. STARK: I didn't hear you.

BOARD MEMBER: We need to consider what we want as members of the Board, from ourselves and from the each other and all that should be done. Then after that point, is it -- we add someone else. Take someone

else on.

DR. YEE: I would argue -- this is Allen. So I would argue that we delay that discussion until after we -- we restructure the committees and see what kind of productivity we have.

Because we have a new focus on epidemiology. This is something new to EMS. So let's give the -- let's give the structure a chance to at least to --

MR. PARKER: Right.

DR. YEE: -- create some initiatives. But I do think we need to look at the committees again with these six positions in mind -- these six entities in mind.

MR. STARK: Jason.

MR. R. J. FERGUSON: Jason Ferguson. I just want to say like -- echo Dr. Bartle did. It's -- we just have to be

mindful and look at the position, what the position represents. We can't base it on the individuals sitting at these tables.

Because we change, so we can't say, well, we've got a medic here. We've got a flight medic here. We've got an educator, we got a nurse here. Because we all will rotate off.

So what does the individual position offer the Board? And maybe we're well represented already. Maybe there's no change that needs to be made.

But looking at position itself, that does kind of -- our point before was is there any position that's missing? And we can't just base it on individual characteristics now of the -- of the existing Board.

Because I think we've all done a great job with what we've been doing, right? So I'm looking at the future of where we will be.

MR. STARK: Other comments, thought?

MR. HENSCHEL: I'll take about two minutes.

MR. STARK: Go ahead, Jon.

MR. HENSCHEL: I'm going to -- I'm going to echo what the devil's advocate said yesterday. And I have a little bit of heartache with thinking that we would, you know, go in a direction that increased the Board size again.

It's tough enough with this large a group to say we're going to get things done. As I said yesterday, we know everybody's got their own opinions about the various things we discussed.

They have their own stakeholder groups with certain interests involved. You know, we have -- to some degree -- set that aside to do what's in the best interest of the whole.

I think the more people you bring to the table, the more difficult that becomes. So increasing the size, I -- I don't feel is a good move, particularly when

we've downsized for -- for good reason. Composition, I can't sit here and tell you exactly what that looks like, particularly if we're going to say look toward the future.

It's going to evolve and change as we continue to go through these processes. I do think, to an extent, we're -- we're kind of putting the cart before the horse.

It's already been mentioned several times. I think our best bet if we're missing key stakeholders and interest groups that need a seat at the table to help us devise a more robust plan moving forward.

We have to start at the committee level. If we -- if we assess where our committees are at, what they're doing and then restructure those a little bit.

See if there's a need to add some different stakeholders, we start there. Which is certainly going to be more simple as well because we don't have to go through a big process to make that change. If we

try to change this, who knows how long it's going to take? If we even get to that point while some of us are still on the Board.

As far as the level of engagement and involvement, I can't sit here and attest to what everybody independently does. But what I can attest to, I missed one Board meeting.

And I've been here roughly four years. I look around the room and I see the same people that are here routinely virtually every time. Which I think is, at least, a big piece of this in my mind.

Now to what level everybody's engaged, I can't -- I can't say. But when I go to my own board meetings in my region and I struggle to get enough people there for a quorum.

This, to me, is a testament to at least the level of involvement people want -- want to be involved and want to be here. So I also see the vast and varied backgrounds everybody brings to the table. And I think it behooves us to recognize that -- that we are doing a fairly good job. Do

we hit every mark? Absolutely not. But that's -- that's where I sit with this. I think we have to start at that committee level, as has been mentioned, and see how that develops and then go from there.

If we feel there's another change in the making, then we look at what needs to occur here. That's just my position. Appreciate it.

MR. STARK: Any remarks?

DR. YEE: Can we go back and look at the committees again? Because we -- we're saying that the work has to be done by those committees. Let's go back and make sure that you have everything there. Who we're taking out, you know.

MR. PARKER: So part of the discussion we had was after receiving Ron's comments and the actual minutes, maybe an Executive Committee meeting to kind of point that up a little bit. Because we had some ideas floating around and Ron's taking a lot

of notes and -- and bringing them back. And then we'll have that -- we'll kind of massage it and then send it out to the group.

Any thoughts on that? Because we had talked about having the Executive Committee look at the -- maybe it was a yesterday idea.

MR. STARK: Yes, Dr. O'Shea.

DR. O'SHEA: So we did talk about the Executive Committee and I think the Executive Committee reviewing it is a good thing. I guess what I would ask is that when it comes back to the EMS Advisory Board, it does not come back in a -- let's all rubber stamp this. But rather in a format in which we have an opportunity to really discuss and dig in --

MR. PARKER: Right.

BOARD MEMBER: Draft.

DR. O'SHEA: Yeah.

MR. PARKER: Yeah.

DR. O'SHEA: In -- in the context of -- of the spirit that we've done today.

MR. PARKER: Right.

BOARD MEMBER: I'll just add to that. The Executive Committee should be the ones to take all the comments that's been made additionally today, because there's been some good discussion that might help you refine even further the committee.

BOARD MEMBER: Right. Absolutely.

BOARD MEMBER: I think that's the key and then collaborating with this group --

BOARD MEMBER: Right.

BOARD MEMBER: -- to finalize that

product that everybody's in agreement.

MS. CHANDLER: All right. So let's review. Core composition of the Board we've decided to hold off on that. Correct? So we can mark that off the list.

MS. QUICK: But can it be like no additions, no subtractions? Can it be like that --

MS. CHANDLER: Well, that's what --

MS. QUICK: -- for now?

BOARD MEMBER: At this time.

DR. YEE: For now.

MR. PARKER: Subject to change in the future.

MS. QUICK: Oh, no, I know, I know. But for now, we already have somebody bring us six potential. And so I think right now

our position is, we're going to hold on additions or deletions --

BOARD MEMBER: Yes.

MS. QUICK: -- until we get through this process.

MR. STARK: Yeah. A lot of this is going to be driven by composition of the -- the committees.

BOARD MEMBER: Yeah.

MR. STARK: Same thing with goals and objectives of the committee, that's going to be driven by that. We discussed some of the core responsibilities of the Board yesterday.

And we talked, you know, about the future of EMS and trauma -- trauma care systems. So I was -- yes, Beth.

MS. ADAMS: Question. So how would we see this proposal that Dr. Aboutanos has

submitted? Did he submit in writing?

MR. PARKER: No.

MS. ADAMS: Was it a conversation, hey Chris, I want six more committees? I mean, I ask for a lot of things that if I didn't follow a structured process or -- if there's going to be a, you know, pat on the back or elsewhere, that would say thank you for sharing.

There's no action required because there's no formal process engaged. Right? So this is a -- a wish list, a suggestion? It's not.

DR. YEE: So -- so this is Allen. I'm going to speak from Mike's behalf. You know, doctors aren't the best people in the world to put things on paper. Right?

BOARD MEMBER: Really?

DR. YEE: I think his intent was what he gave the Board -- this Board was his

version of a formal request.

DR. O'SHEA: So -- Jake O'Shea. I guess if we -- if we state the problem, which to me the problem is that we have a bylaws document that has some internal conflict, so that's a problem.

How would we resolve the conflict in the existing bylaws that has six committees that are not members of the -- whose chairs are not members of the Advisory Board.

But the bylaws require chairs of committees be members of the Advisory Board. It sounds like the preferred resolution of this group is not to add members to the Advisory Board, but rather, to revise the bylaws documents to try to remove that conflict in some way. Is that a fair statement?

MR. PARKER: Which I think some of that will be removed by removing the committees, or moving the committees to subcommittees.

DR. YEE: Yes.

MR. PARKER: I think that would take care of some of that.

DR. YEE: But not all the committees will -- not all the current trauma committees will -- will go to subcommittees because --

MR. PARKER: Right.

DR. YEE: -- acute care is likely going to stay a committee, I would -- I would hope. The public health would, I would hope, would stay a committee.

MR. PARKER: And maybe we look at within the bylaws having it to where there is not necessarily the chair, but a liaison to the committee. Some kind of working -- something. But there's potential there. I think Gary's had his hand up. Gary Brown.

MR. BROWN: I do want to address a

little bit of what we just said about a thoughtful process of what Dr. Aboutanos did submit. And -- and I do think that actually, over the past several years, that was the most vetted, the most thorough, the most methodical process that has been -- that has occurred.

The evaluation of any aspect of EMS in the Commonwealth has been years. We had an outside American College of Surgeons consultative visit in looking at various, you know, guidelines and standards and benchmarking to evaluate the trauma system.

And then once those recommendations were -- were made to this Board and to the citizens and to everyone in Virginia -- hospitals and so forth -- there was a -- it was like, okay, how do we work towards addressing those recommendations of the ACS state consultative visit?

And there was a trauma systems plan task force that was developed. Many work groups that were developed. And basically, it categorized the

recommendations. And that was a real -- it was a three-year process that -- that committee and everyone involved went through.

And then it was a recommendation that did come up to the Advisory Board to address the recommendations of the ACS visit knowing, and I -- and I think this is the good part.

I mean, it's just my opinion, that it is driving some of these discussions now. Because it's like taking a budget and you adopt a deficit budget knowing you don't have enough revenue identified.

But you -- you're not cutting back your expenditures. So you adopt a deficit budget. That's what we did here. We adopted -- or when I say we, the Board adopted a deficit budget.

And it's forcing this kind of conversation. So I do think that we still have to keep these discussions on the table. There is -- there's still a lot of history that -- of how we got where we are and so forth and so on. Chris, I look at you.

You're -- you represent two organizations. That was a conscious decision that -- that the powers that be did not want it being a -- or keep being a, and being a, as two separate seats on the Board.

They said, no. You can have one seat and you somehow work it out to have representation of those two organizations. So again, I think what's -- what the trauma folks did is -- is very good.

I think it's healthy for this Board to have these types of discussions and what is not -- you know, what is not on the table. I have some personal opinions.

One of the big things in the country right now, if you've been through the national association saying it's official, is trapped in its management. You know, the road to zero. Move over.

That's huge in this country. That's kind of missing. Mental health. Look at what's going on. And we've been talking of health and safety now. Again, I think we can -- you could -- you can address this through the committees structure and so

forth. But the -- there are lots of areas that we need to really look at that are much broader than -- actually, in some respects than what we're reflecting in some -- in some regards.

So again, that's just me. I'm just trying to speak to the facts of what occurred in terms of process and -- and also what's not affecting this Board at the table, quite honestly.

Because of the stressors that was placed on the Board by the Board knowingly adopting a bylaws change with six new committees. You know when they did that.

MR. STARK: Any comments? Yes.

BOARD MEMBER: Do you know one thing? I think it was actually brought up with Beth and Dr. Yee, that maybe there needs to be a formal, in writing if you want EMS -- have a seat on the Board. What do you bring to the table, what do you hope to address? What -- what are you representing

and how can you represent -- you know, help -- help EMS with, you know, whatever. Obviously, it needs to be re-worded. But maybe there should be a formal, in process writing.

And then it would be reviewed by, say, the Executive Committee or something like that. So just for future cases.

MS. ADAMS: Could -- could you say that again?

BOARD MEMBER: A formal process to be able to submit an application for a new position on the Board. Because you brought that up. How did Dr. Aboutanos -- was it just a speak thing?

Was it writing? No, it wasn't any of those because there is no requirement, apparently, in our bylaws that says you must go through this process to be considered to have a seat on the Board. Right?

MS. ADAMS: Okay. That's not what I was --

DR. YEE: So --

MR. STARK: Dr. Yee.

DR. YEE: So one of the things about these six positions, I mean, it's kind of an academic discussion. But they're not from an organization. Right? All of us are from organizations. The positions are functional positions.

MS. ADAMS: Right.

DR. YEE: Not organizational.

MS. ADAMS: These seats are functional positions.

DR. YEE: Yeah, they're not organizational. So that's -- you know, we add some strength to the argument that those positions should be at committee level.

BOARD MEMBER: We still have the conflict with the bylaws. They want the six positions. According to our bylaws, it says that as committee chairs, they are to have a position on the Board.

So I think we, as I said, the easiest path would be to change that wording in our bylaws. Because if not, we get those six positions.

We'd have to get into legislation because it's Code who is on this Board. Do we want to go down that road of getting legislation put in and, you know, all of this.

MR. PARKER: Because at the end of the day, we may have to seven-person Board if we go through legislative --

BOARD MEMBER: Yes. And Code changes that -- to bring about things that we don't want. So either we make them subcommittees or we change the wording of the bylaws. But as --

MR. PARKER: That's why I think we ought to take a look at the committees first.

BOARD MEMBER: Yeah, but --

MS. ADAMS: The bylaws currently say that they are on -- that they are committee. So -- that they exist.

BOARD MEMBER: Yeah, so their chairs should have a seat on the Board according to --

DR. YEE: So we need to take that line out of --

BOARD MEMBER: Yeah, so we need to solve that.

MR. STARK: Yeah, that needs to be amended.

DR. O'SHEA: Jake O'Shea. I do want to say one thing about the bylaws

change. The bylaws change were voted in at the November meeting of the EMS Advisory Board. And at that meeting, I think there were nine new members of the Board?

MR. BROWN: 18 new members.

DR. O'SHEA: 18 new members of the Board. Some of us had not received the document prior to that meeting because of -- of logistical challenges.

And I would certainly say that I didn't appreciate the impact of that change on the structure of the Board and some of the other pieces.

So I think it is appropriate for -- to look, you know, at it again. I will say, not to discredit at all the amount of work and the effort and the structure and the thoroughness that went into that process.

MR. PARKER: I agree.

DR. O'SHEA: Which I think we all

paid a tremendous amount of respect to at the time.

MR. D. E. FERGUSON: Just a quick question, it's Eddie Ferguson.

MR. STARK: Go ahead, Eddie.

MR. D. E. FERGUSON: So where -- where does the Secretary of the Commonwealth's Office come this with? When we talk about how to get a new seat on the Board, that -- that office is -- is that Board applications.

That works gets recommended then, is this what's happening here? We're going to make a recommendation? Do they set -- do they set the composition of the Board? Are they --

MR. PARKER: So the composition of the Board is set in Code.

BOARD MEMBER: Yeah.

MR. PARKER: The Secretary receives the application. So if you're -- I'll say mine. This -- the Virginia ENA/Virginia Nurses Association seat goes up next year.

So working with the president of that group next year, we've already had discussions this week about nominating three people. So when the time comes, she's already started that list.

She'll submit three names to the Secretary and then that goes to the governor. It is the governor's pick for it. So when it comes to re-compositioning the Board, that's a change of legislation. We had that discussion yesterday.

MR. D. E. FERGUSON: Right.

MR. STARK: Yes.

MR. LAWLER: So -- Matt Lawler. I think there's a concern here that we're getting ready to undo, you know, the years of -- of hard work from the -- from the trauma system with these committees. But I

think -- my view on that is that we're actually validating the work that they did. Because we want to borrow the collective wisdom of that process and apply it for our entire system.

So you know, for example, injury and violence prevention. If we take that and broaden the scope of that -- that committee, the work of the trauma system component of that for injury and violence prevention is still -- still exists and continues one.

While we also, you know, stand that and apply it, you know, more wholly to the collective EMS system for public health and local area health care and all those sort of things.

So I don't view that as kind of undoing the hard work that's been done. I view it more validating it than barring, you know, the hard work that we did and using it for the rest of the system.

BOARD MEMBER: Yeah. It's a good point.

MR. PARKER: Gary, can I have a question on -- can I ask a question on procedure? Gary Brown.

MR. BROWN: Sorry.

MR. PARKER: Is this a point where we've had the retreat and now we can take it back under advisement of the Executive Committee, or do we need to have some kind of motion from this today to take it back to the Executive Committee, the discussion on the committees? Or how does that work since this is not a true meeting?

MR. BROWN: It's -- it's not a true meeting. It is a retreat. I -- you know, to be honest, I don't think I have the -- I'm not sure I have the correct answer for you.

But I think it -- I think it should be the will of the Board members here -- the Executive Committee is in the bylaws to do the work of the Board when the Board is not in session. And you've been,

not only empowered but entrusted, to take on the work of the Board. And I think with Mr. Stark's, you know, summary and -- and write-up of this -- this retreat, I think it could be placed with the -- I mean, back to the Executive Committee at first.

Let the Executive Committee decide on the process and procedure, and then work with the Board. I -- I -- it's going to -- it would all have to come to the, in my opinion, has to come to the full Board eventually.

MR. PARKER: Right.

MR. BROWN: But I think there -- there's still -- we have to cut down on the chaos data and have -- have some sort of structure to it.

MR. PARKER: Can we also ask with that that by a certain date, the committee chairs have work with their committee -- through email. And we can get a list of -- like a current list of what -- who's on the

committees. Not necessarily goals and objectives, but what they're doing. And -- and then that would help kind of drive things.

There's a lot of missing -- if you look at Workforce and Development on the document that they have, there's no mission for that. So kind of try and figure out what their work actually is. I think that would help. Any other comments?

MR. BROWN: Can I just --

MR. STARK: Yeah, Gary.

MR. BROWN: One more thing. I -- I think it was said earlier. I don't know remember said it, but I do think that the Advisory Board committee guidance document, I think part of it -- if it's not already implied, it just needs to be clear that the -- each committee take a look at their composition, their structure. Is this still applicable? Is it -- does it still represent this -- this discipline and

environment in the system that you want it to represent. But there -- there are some that came up -- I think prior to today brought it up where, you know, it's interesting maybe attending those meetings or maybe even serving on those committee meetings.

Some committees basically don't have another seat available for another Advisory Board member.

MR. PARKER: Right.

MR. BROWN: So you do want to take -- I think you really, in my opinion, every committee needs to take a look at the composition of their own committee.

BOARD MEMBER: Yeah. That's kind of what I was going to suggest that when they look at their missions, at the mission and their goals, what is the composition? And if that is not who they need, who do they feel they need? Or do they need more seats on the committees? What -- what do

they need to do to accomplish their goals and missions. And let's include that in it.

MR. PARKER: Is it -- is it something that can be -- you know, is two weeks, three weeks enough time to get that information back to -- or just send it to me and then I'll -- I'll let it go from there. Is that enough time frame?

Or do we need to have a meeting first? Trying to not belay this -- all of this work to be done until next year. We're trying to get some of it accomplished since we are in conflict.

MR. SAMUELS: Gary Samuels. I -- I think that you need to have a meeting of -- of each committee. Whether it's, you know, before we go to the full Board meeting in November.

I don't want what comes out of this today, or what we're trying to do, to have another financial impact that we discussed -- you know, because we rushed the process to a point that we're trying to

outrun something that is not chasing us. We're -- we know that we have to fix the bylaws. That's a quick fix.

And that can be -- that can be fixed with a few tweaks and voted on at the next meeting, so that we maintain a level of transparency there with that situation.

And then, we're trying to build something that's going to take us to the future. But it's not a time machine and it's -- it's not going to move us that fast.

Because we -- I don't think everybody meeting in November understood the financial impact to the Office of EMS and to our Board. Only one or two people even questioned anything at the meeting.

I just read through it. And no one -- every -- everybody at that meeting, when you read the comments from the meeting in November, everyone wanted to get this over with.

They wanted to get this in place. No one -- no one looked at the major impact in the budget and -- any of that. No one even commented on that. There was --

there was very -- everything was, hey, we need to get this going. So I don't think we should be running fast with this as -- as we did that. Because --

MR. PARKER: Right.

MR. SAMUELS: There's going to be -- I think there's going to be more push back because people haven't -- we -- we just want to make sure that we do the right thing. And it -- it levels out this budget and sort of thing that we're looking at.

DR. YEE: So we're going to have -- this is Allen. So we're going to have some of these committees meet, even though we're going to -- that our discussions today -- we're going to have the committees meet to talk about what they've -- they're going to do.

But in our discussions today, they're -- we're going to change the focus of several of these committees like acute care, injury prevention to -- to a new, more

global focus. That's not very fair to the -- those committees. I mean, we -- the intent is -- go that direction, we need to tell them up front.

MS. ADAMS: I agree. Beth Adams. I -- that's kind of the equivalent of, we gotta talk, but this is what we've already decided. So --

MS. MARSDEN: Julia Marsden. I agree, also. It's the communication that's so valuable to actually engage them before saying this is what you have to do. We need to get their thoughts. Or at least, have -- give them an opportunity to talk about it.

BOARD MEMBER: Well, when you -- when you contact the committee chairs and ask them to do this, tell them that each committee is being looked at, and the possibility exists for this to happen.

DR. O'SHEA: I think I would -- Jake O'Shea. I think I would -- you

could've had, you know, the -- there's a question of -- of do we have duplication of efforts out there and trying to reduce any administrative duplication.

Or do we have areas where we are focused on one component of care, trauma specifically, and we should be focusing that concept more broadly across multiple areas of care. And moving from injury prevention to injury and illness prevention.

MR. STARK: Other comments? I appreciate everybody's input. I feel like we made some headway today. I will provide a synopsis and the Executive Committee's going to take a look at that.

And then we'll have these discussions with a base. And if any of you have questions in the meantime, I'll make Chris sort of my point of contact, if anything needs to be passed along to him.

But looking forward to reviewing the record and my notes from today's meeting, yesterday's meeting. Appreciate everybody's input, too. Good

discussion and, you know, very candid discussion. And so, I really appreciate you guys for having me down here. And lunch is here, so with that, if no other comments on the table, we'll go ahead and eat and get the heck on the road?

BOARD MEMBER: Well, can we have your review and not just the Executive Committee? I mean, weren't we -- are we all kind of like to -- I would personally like to --

MR. STARK: Yeah, I'll pass it along to Chris. And then you guys can discuss where -- where everything should go.

(The EMS Advisory Board Retreat concluded at 11:57 a.m.)

CERTIFICATE OF THE COURT REPORTER

I, Debroah Carter, hereby certify that I was the Court Reporter at the STATE EMS ADVISORY BOARD MEETING RETREAT, DAY 2, held in Glen Allen, Virginia, on September 17th, 2019, at the time of the State EMS Advisory Board Retreat herein.

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

Given under my hand this 18th of October, 2019.

Debroah Carter, CMRS, CCR
Virginia Certified
Court Reporter

My certification expires June 30, 2020.