Legislative and Planning (L&P) Committee Meeting
Richmond Embassy Suites Hotel
Friday, May 3, 2019
09:00 A.M.

Members Present:	Members Absent:	OEMS Staff:	Others:
Gary Samuels, Chair	**Rich Orndorff, Jr. (excused)**	Scott Winston	Craig Evans
Rob Logan, Vice Chair		Chad Blosser	R. Jason Ferguson
Byron Andrews		George Lindbeck, MD	Chad Vaughn
Jeff Meyer		Chris Vernovai	Frank Kinnier
Michael Player			Tom Intorcio
Steve Higgins			Gary Critzer
Ed Rhodes			Sarah Beth Dinwiddie
Gary Dalton			
Jake O'Shea, MD			

Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
WELCOME AND INTRODUCTIONS	Chair Gary Samuels called the meeting to order at 09:00 AM. The minutes from Friday, February 8, 2019 meeting were unanimously approved after review by the committee.	**Motion made by Ed Rhodes and seconded by Rob Logan to approve the February 8, 2019 meeting minutes. The Committee voted unanimously to approve the minutes.**
OEMS UPDATE	**OEMS Quarterly Report.** Mr. Scott Winston informed the committee members the OEMS quarterly report to the state EMS Advisory Board is posted on the OEMS website. The report may be viewed at http://www.vdh.virginia.gov/content/uploads/sites/23/2019/04/Quarterly-Report-to-the-State-EMS-Advisory-Board-for-May-3-2019-with-Cover-Page-1.pdf **OEMS Personnel Update.** Mr. Scott Winston provided the committee members an update on Office of EMS personnel. Ms. Jessica Rosner began work on April 25 as the new Epidemiology Program Manager in the Trauma and Critical Care Division. Prior to coming to OEMS, Jessica worked for the Office of Epidemiology in the Virginia Department of Health. Recruitment for	

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	the Accreditation, Certification and Education (ACE) Division Manager closed on April 12, 2019. Recruitment for the Central Shenandoah EMS Regional Program Manager closed on April 16, 2019. **OEMS Office Build-out.** Mr. Winston briefed the committee on a three-phase office remodel of 1041 Technology Park Drive and relocation of 1001 Technology Park suite of OEMS offices that will be completed in June/July 2019 timeframe. OEMS staff is currently working from temporary assigned office space at 1041 Technology Park and from home. Please be patient while this effort is underway. Follow the progress of construction on the OEMS Blog which is available on the OEMS Web site.	
STATE EMS PLAN	State EMS Advisory Board approved the state EMS Plan at their November 9, 2016 Board meeting. The Board of Health (BoH) unanimously approved the state EMS Plan at their March 16, 2017 meeting. Mr. Winston reported the Plan will be presented to the BoH in March or June 2020 (see State Strategic EMS Plan Timeline Update). Each committee of the state EMS Advisory Board is requested to provide input and suggested revisions to the state plan using the state Committee Planning Template (see State EMS Advisory Board Committee Planning Template). The Bylaws of the state EMS Advisory Board state, *The committee will review and assess state and federal legislation and inform the Advisory Board of any potential impact on the EMS system in Virginia. The committee is responsible for revising and updating the state EMS plan on a triennial basis. The Plan will be submitted to the state EMS Advisory Board for review and approval prior to requesting approval of the Plan from the BoH.* **<u>Community Paramedic – Mobile Integrated Healthcare (CP-MIH)</u>** The MIH/CP workgroup of Medical Direction Committee created in 2015. Reconvened on September 19, 2018. Dr. Allen Yee again serving as chair. The workgroup met on September 19, 2018, November 7, 2019, January 29, March 1 and April 24, 2019. Previous meeting minutes can be found via the link below:	 2017-2019 State EMS Plan Final.docx  State EMS Advisory Board Committee Plar  State Strategic EMS Plan Timeline Update

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	http://www.vdh.virginia.gov/emergency-medical-services/community-paramedicine-mobileintegrated-healthcare/ Senate Bill 1226 introduced into the 2019 Virginia General Assembly session regarding Community Paramedicine. A summary of the bill as introduced: "requires the State Board of Health to adopt regulations governing the practice of community paramedics. The bill requires an applicant for licensure as a community paramedic to submit evidence that the applicant (i) is currently certified as an emergency medical services provider and has been certified for at least three years, (ii) has successfully completed a community paramedic training program that is approved by the Board or accredited by a Board-approved national accreditation organization and that includes clinical experience provided under the supervision of a physician or EMS agency, and (iii) has obtained Community Paramedic Certification from the International Board of Specialty Certification. The bill requires a community paramedic to practice in accordance with protocols and supervisory standards established by an operational medical director and to provide services only as directed by a patient care plan developed by the patient's physician, nurse practitioner, or physician assistant and approved by the community paramedic's supervising operational medical director. The bill exempts a community paramedic providing services in accordance with the provisions of the bill from licensure as a home health organization. The bill requires the State Board of Medical Assistance Services to include in the state plan for medical assistance services a provision for the payment of medical assistance for home health services provided by a certified community paramedic exempt from licensure as a home health organization." CP-MIH workgroup focus: Regulations/Legislation (create framework for programs to be recognized) Home Health Interface MIH-CP Program Goals Educational Standards	

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	Funding Barriers to Implementation: (Resources, Financial, Educational, Regulatory)	
REGULATORY UPDATE	**<u>Chapter 31: Virginia Emergency Medical Services Regulations to be repealed</u>** OEMS is required to conduct a periodic review of the EMS Regulations (12VAC5-31) every four (4) years. The Rules and Regulations committee has initiated a periodic review of the Virginia EMS Regulations (12VAC5-31). A Notice of Intended Regulatory Action (NOIRA) was approved by the Commissioner on behalf of the Board of Health. The public comment period for the NOIRA was held May 15 – June 14, 2017. OEMS did not receive any public comments related to the NOIRA. On Wednesday, May 1, 2019, the Rules and Regulations Committee voted to delay moving to phase 2 of the regulatory process. Time is needed to receive additional input for revisions to the EMS Regulations related to education and training. The committee is also waiting on recommendations from the Critical Care Workgroup of the Medical Direction Committee (MDC) on the provision of critical care services in Virginia, the provision of Community Paramedicine (CP) currently under review by the CP-Mobile Integrated Healthcare Workgroup of the MDC and changes in the use of definitions and terms in the *Code of Virginia* related to licensure vs. certification. **<u>Outsourcing the collection of fingerprints for background checks</u>** to the state contract vendor, <u>FieldPrint</u>. The target date of this change is within the second quarter of 2019. Details of how fingerprints will be submitted to the OEMS after this date are being determined now and will be announced as soon as possible. This new process for fingerprint submissions will be more efficient, cost effective, and provides increased access for both regulants and EMS agencies. **<u>Recognition of EMS Personnel Licensure Interstate Compact (REPLICA)</u>** The EMS Compact facilitates the day-to-day movement of EMS personnel across state boundaries in the performance of their EMS duties (as assigned by an appropriate authority),	

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	and authorizes state EMS offices to afford immediate legal recognition to EMS personnel licensed in any other member state. **THE INTERSTATE COMMISSION FOR EMS PERSONNEL PRACTICE (Commission)** Recognition of Emergency Medical Services Personnel Licensure Interstate Compact "REPLICA" legislation creates a joint public agency known as the Interstate Commission for EMS Personnel Practice. The Commission is responsible for the oversight, management, and operations of the EMS Compact. The Commission membership comprised of one delegate from each member state. • Create by-laws and promulgate rules related only to cross-border practice; • Establish policy and procedures for cross-border practice; • Maintain the national coordinated database and information-sharing systems; Seventeen (17) states are members of the Compact: AL, CO, DE, GA, ID, KS, MS, MO, NE, ND, NH, SC, TN, TX, UT, VA, WY VA third state to adopt REPLICA legislation. TN only border state to adopt at this time. **Rules for the Interstate Commission for EMS Personnel Practice (Draft Published 15 MAR 2019)** The reason for this proposed rule- These rules are to implement the operations of the national EMS Compact by the member states represented on the Interstate Commission for EMS Personnel Practice. Specifically, these rules will enable the interstate practice of EMS personnel as authorized in each state's EMS Compact legislation and establish the uniform data elements and procedures for operation of the coordinated database as called for in the EMS Compact legislation.	

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	Public Hearing Date: May 17, 2019 (0900 MDT) Public Written Comment Closure Date: **May 16, 2019** **Regional EMS Councils** Regional EMS Councils have applied for re-designation in October 2018. Site review teams conducted visits in April and May of 2019 and final reports are being prepared for submission to the Board of Health for their June 6, 2019 meeting. **Health Practitioners Monitoring Program (HPMP)** The Office, in conjunction with VDH is in the process of finalizing an internal policy to provide a pathway for the re-instatement of impaired EMS providers who have been sanctioned because of a substance abuse issue. Collaborative efforts have begun with several committees of the state EMS Advisory Board to ensure consistency with project development regarding treatment and monitoring programs, such as the Health Practitioners Monitoring Program (HPMP) utilized by the Virginia Board of Nursing and the Board of Medicine. The Virginia Health Practitioners' Monitoring Program (HPMP) is here to help healthcare professionals with a substance use disorder or mental health or physical condition that may be impairing. HPMP refers healthcare practitioners for appropriate treatment and provide ongoing monitoring of treatment progress. Our goal for each of our participants is to facilitate and support the recovery process, including achieving and maintaining optimal physical, mental, and emotional health. Our team has the expertise to help practitioners skillfully navigate their return to safe and productive clinical practice. The Department of Health Professions (DHP) contracts with Virginia Commonwealth University (VCU) Health System, Department of Psychiatry to provide services including: Intake to determine program eligibility	

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	Referrals to providers for clinical assessment and treatment Monitoring of treatment progress and clinical practice Alcohol and drug toxicology screens when indicated Participation in the program is voluntary. Disciplinary action may be avoided and, in the absence of criminal behavioral or Board action, public records may not be generated. For those participants with Board involvement, our team provides support including participant preparation for hearings and providing the Board with documentation or testimony of monitoring compliance. HPMP services are available to anyone who holds a current, active license, certification or registration by a health regulatory board in Virginia or a multi-state licensure privilege OR is an applicant for initial or reinstatement of licensure, certification, or registration for up to one year from the date of receipt of their application.	
2019 VIRGINIA GENERAL ASSEMBLY	**Senate Bill 663** introduced during the 2018 session of the Virginia General Assembly by Senator McPike was amended in the nature of a substitute bill and passed by the Health, Welfare and Institutions (HWI) committee. The bill was further amended and approved by the legislature and subsequently signed by the Governor on March 30, 2018 in the following form: "That § 32.1-127 of the Code of Virginia is amended and reenacted as follows: § 32.1-127. Regulations. (pertaining to Hospital Licensure) *21. Shall require that each hospital establish a protocol requiring that, before a health care provider arranges for air medical transportation services* ***for a patient who does not have an emergency medical condition*** *as defined in 42 U.S.C. § 1395dd(e)(1), the hospital shall provide the patient or his authorized representative with written or electronic notice that the patient (i) may have a choice of transportation by an air medical transportation provider or medically appropriate ground transportation by an emergency medical services provider and (ii) will be responsible for charges incurred for such transportation in the event that the*	

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	provider is not a contracted network provider of the patient's health insurance carrier or such charges are not otherwise covered in full or in part by the patient's health insurance plan." 2. That the provisions of the first enactment of this act shall become effective on March 1, 2019. (deadline met) 3. That the Office of Emergency Medical Services shall, as soon as possible and no later than January 1, 2019, develop a mechanism by which to disclose to the patient, prior to services provided by an out of network air transport provider, a good faith estimate of the range of typical charges for out of network air transport services provided in that geographic area. Task is complete and disclosure form is posted on OEMS Web site. **House Bill 778** introduced during the 2018 session of the Virginia General Assembly by Delegate Margaret Ransone was amended to conform to the language in SB 663. **Senate Bill 1226** requiring the State Board of Health to adopt regulations governing the practice of Community Paramedics was passed by indefinitely (PBI) in the Senate Education and Health Committee on January 24, 2019 on a vote of 15-Y 0-N. Senator Amanda Chase who introduced the bill was informed that a MIH-CP workgroup of the Medical Direction Committee of the state EMS Advisory Board has been meeting regularly for some time. The efforts of the workgroup should be supported and allowed to continue before any legislation is initiated to take regulatory and/or statutory action. At the April 4, 2019 meeting of the Medical Direction Committee of the state EMS Advisory Board several items came up that, the committee requested the Legislative and Planning Committee to review and consider for legislation. 1) **Termination of Resuscitation**. Resuscitative efforts can only be terminated with the permission of a pronouncer. EMS personnel are not pronouncers. What is the feasibility of granting authority to EMS personnel to pronounce death under certain circumstances?	

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	§ 54.1-2972. When person deemed medically and legally dead; determination of death; nurses' or physician assistants' authority to pronounce death under certain circumstances. A. A person shall be medically and legally dead if: 1. In the opinion of a physician duly authorized to practice medicine in the Commonwealth, based on the ordinary standards of medical practice, there is the absence of spontaneous respiratory and spontaneous cardiac functions and, because of the disease or condition that directly or indirectly caused these functions to cease, or because of the passage of time since these functions ceased, attempts at resuscitation would not, in the opinion of such physician, be successful in restoring spontaneous life-sustaining functions, and, in such event, death shall be deemed to have occurred at the time these functions ceased; or 2. In the opinion of a physician, who shall be duly licensed to practice medicine in the Commonwealth and board-eligible or board-certified in the field of neurology, neurosurgery, or critical care medicine, when based on the ordinary standards of medical practice, there is irreversible cessation of all functions of the entire brain, including the brain stem, and, in the opinion of such physician, based on the ordinary standards of medical practice and considering the irreversible cessation of all functions of the entire brain, including the brain stem, and the patient's medical record, further attempts at resuscitation or continued supportive maintenance would not be successful in restoring such functions, and, in such event, death shall be deemed to have occurred at the time when all such functions have ceased. B. A registered nurse or a physician assistant who practices under the supervision of a physician may pronounce death if the following criteria are satisfied: (i) the nurse is employed by or the physician assistant works at (a) a home health organization as defined in § 32.1-162.7, (b) a hospice as defined in § 32.1-162.1, (c) a hospital or nursing home as defined in § 32.1-123, including state-operated hospitals for the purposes of this section, (d) the Department of Corrections, or (e) a continuing care retirement community registered with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2; (ii) the nurse or physician assistant is directly involved in the care of the patient; (iii) the patient's death has occurred; (iv) the patient is under the care of a physician when his death occurs; (v) the patient's death has been anticipated; (vi) the physician is unable to be present within a	

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	reasonable period of time to determine death; and (vii) there is a valid Do Not Resuscitate Order pursuant to § 54.1-2987.1 for the patient who has died. The nurse or physician assistant shall inform the patient's attending and consulting physicians of his death as soon as practicable. The nurse or physician assistant shall have the authority to pronounce death in accordance with such procedural regulations, if any, as may be promulgated by the Board of Medicine; however, if the circumstances of the death are not anticipated or the death requires an investigation by the Office of the Chief Medical Examiner, the nurse or physician assistant shall notify the Office of the Chief Medical Examiner of the death and the body shall not be released to the funeral director. This subsection shall not authorize a nurse or physician assistant to determine the cause of death. Determination of cause of death shall continue to be the responsibility of the attending physician, except as provided in § 32.1-263. Further, this subsection shall not be construed to impose any obligation to carry out the functions of this subsection. This subsection shall not relieve any registered nurse or physician assistant from any civil or criminal liability that might otherwise be incurred for failure to follow statutes or Board of Nursing or Board of Medicine regulations. C. The alternative definitions of death provided in subdivisions A 1 and A 2 may be utilized for all purposes in the Commonwealth, including the trial of civil and criminal cases. Code 1950, § 32-364.3:1; 1973, c. 252; 1979, c. 720, § 54-325.7; 1986, c. 237; 1988, c. 765; 1996, c. 1028; 1997, cc. 107, 453; 2002, c. 92; 2004, c. 92; 2010, c. 46; 2011, c. 613; 2012, c. 136; 2014, cc. 73, 583; 2016, c. 97. The committee in general felt it would be difficult to expand the list of authorized pronouncers to include EMS providers certified by the Virginia Board of Health. **2) <u>EMS providers exposed to the blood of a deceased patient</u>**. Do hospitals have a responsibility for patients that die in the pre-hospital setting? In many cases, clinical	

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	laboratories within the hospital are not certified to run blood samples from a patient that dies in the pre-hospital setting. Questions have been raised about who has access to cadaver patients, etc. Review current EMS provider exposure laws. This multifaceted problem affects both hospitals and EMS providers. Most labs are not verified to run cadaver blood. There are only a couple of labs in the US that are verified for cadaveric blood. This became known last year when a local EMS Designated Infection Control Officer (DICO) had blood drawn on a cadaver by the medical examiner's office that was sent to Richmond. It was found that there is no expectation that lab results would be provided in accordance with the law (Ryan White Act, Part G)." The law is written that a medical facility treating the victim and/or determining cause of death must respond to the request to test source blood within 48 hours. If the medical facility cannot determine, they must engage the "Public Health Officer" for help in collecting and determining the facts. Some of the issues that have been identified: 1. If a death is pronounced in the field, either the Medical Examiner or Hospital Medical Command is involved in that declaration. In either case, would this be the "medical facility treating the victim and/or determining cause of death" responsible to respond to the request for blood? 2. Who is legally able to draw blood on the cadaver? In Virginia, we have different ways of doing this; duty officers, EMS providers and Medical Examiners have all been a part of this process. Does this violate any legal issues for decedents? 3. Results are to be given within 48 hours. This is partly due to the need of prophylactic treatment but is also referred to in the Ryan White Act. How do we ensure timely blood draw and results? 4. Many hospitals have resulted cadaveric blood. Many did not know that they actually had cadaveric blood. In some cases, positive results caused a review of manufacturer	

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	recommendations that lead to the conclusion that it was not a valid test. Issues exist across the state with process and validation. 5. Only a few labs can test cadaveric blood. If they are not local (the closest is in NC), there may be a delay in processing. This would mean the 48-hour rule could not be met and the provider would need to be treated with anti-virals until the results came back. 6. Some hospitals have committed to getting this process validated but it will take some time. Will other hospitals do this? 7. This is not just an emergency responder issue. What about pathology, funeral homes or other entities that may handle a cadaver? If they get a needle stick or exposure to organs or potential infectious material, they need to be tested. 8. There is not a uniform process for field deaths. UVA is currently working on two algorithms. One would be if the body is at UVA and the other one would be if someone could draw the blood and bring it to UVA. UVA has agreed to test it. 9. Hospitals are not been validated to test cadaver blood. Some hospitals have arranged for Mayo Lab to run the blood. UVA, VCU, Sentara Martha Jefferson Hospital and Augusta Medical Center have the same issues. 10. This is a complicated process that varies greatly and needs some standard work and education going forward. VA OEMS requires certain training for DICOs but many times an EMS agency only has one DICO with limited training for complicated situations. The DICO is technically responsible for submitting in writing these requests to the medical facility. This is problematic for the state. Some suggested recommendations to address these issues are:	

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	A. Localities should form a group of Designated Infection Control Officers for full 24/hour coverage and consultation in complex cases. This would require agreements for confidentiality and affiliation for each of the DICOs. B. Local hospitals, employee health & worker's compensation organizations should work with DICO Committee to provide medical advice, counseling, lab services and treatment. C. Labs throughout the state must have the ability to test cadaver blood for HIV/Hep B/Hep C. D. Standard work for DOA exposures – algorithms. As indicated in the Ryan White Act, Appendix G, if the victim dies at or before reaching the medical facility, the medical facility or public health officer are responsible for responding to the request for exposure determination. This entity must be clearly identified and mandated to test based on evidence presented. There are a lot of supporting documents and Katherine West is incredibly knowledgeable about these laws and infection control processes. Katherine feels this is all clearly defined in the laws, however; because there is not a clearly defined process, some ambiguity exists. https://www.cdc.gov/niosh/topics/ryanwhite/ https://www.cdc.gov/niosh/topics/ryanwhite/pdfs/Figure-3_9-20-10.pdf At the February 8 meeting of the state EMS Advisory Board, Ms. Valerie Quick raised a concern to Dr. Parham Jaberi, Chief Deputy Commissioner, regarding the testing of a deceased individual who may have exposed a first-responder to a blood borne pathogen. This prompted some follow-up correspondence between Ms. Quick and the state's Office of Chief Medical Examiner (OCME).	

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	Dr. Gormley and Dr. Jaberi share concerns about the lack of testing capability across Virginia in such situations and the challenges faced (i.e. time lag) when such samples must be sent out of state. During the 2019 session of the Virginia General Assembly, Delegate Robert Bell introduced **HB 1943** in an attempt to address this need. The provisions of the bill would require the Office of the Chief Medical Examiner (OCME) to develop a process to collect and test specimens when first responders are directly exposed to blood pursuant to § 32.1-45.1. This section of the Code pertains to living people and would require the OCME to collect specimens and conduct hepatitis B and C, and HIV testing accordingly. The bill underwent significant modification and was tabled in Health, Welfare and Institutions by voice vote. The fiscal impact on current OCME operations must consider the cost to purchase collection materials and submit samples to an appropriate laboratory for testing. Because the OCME does not have data on the average number of cases that occur in the Commonwealth in which first responders are directly exposed to blood requiring hepatitis B or C, and HIV testing, the fiscal impact of this bill could not be determined. The opportunity exists to take this proposed effort and conduct a study to determine its feasibility and a plan for implementation. As with other such efforts, VDH welcomes expertise from the first responder and healthcare community to help inform next steps. Once we are provided direction on how Delegate Bell may wish to proceed, we can follow-up with the EMS Provider Health and Safety Committee and the Legislative and Planning Committee on some next steps. Mr. Gary Critzer expressed concern that the current process of testing an individual that may have exposed a first-responder to a blood borne pathogen is too complicated and needs to be simplified. The current practice requires the deemed source of exposure to appear before the General District Court Judge/Magistrate before testing can occur. It would be less time consuming if the local health district director or Emergency Department physician could direct an individual that may have exposed a first-responder to have their blood drawn and tested.	

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	HB 1998 introduced by Delegate "Cia" Price during the 2019 session of the Virginia General Assembly amends and reenacts §§ 16.1-241 and 32.1-45.1 of the *Code of Virginia*, relating to exposure to bodily fluids; infection with human immunodeficiency virus or hepatitis B or C viruses; expedited testing. **Exposure to bodily fluids; infection with human immunodeficiency virus or hepatitis B or C viruses; expedited testing.** Requires a general district court to hold a hearing within 48 hours of a petition being filed seeking to compel collection of a blood specimen for testing for human immunodeficiency virus or the hepatitis B or C viruses when exposure to bodily fluids occurs between a person and any health care provider, person employed by or under the direction and control of a health care provider, law-enforcement officer, firefighter, emergency medical services personnel, person employed by a public safety agency, or school board employee and the person whose blood specimen is sought refuses to consent to providing such specimen. The bill directs the Office of the Executive Secretary of the Supreme Court of Virginia to publish a petition form for such filing. If the court is closed during the 48-hour time period, the petition shall be heard on the next day that the court is in session. The bill allows a testing order to be issued based on a finding that there is probable cause to believe that exposure has occurred. Any person who is the subject of such order may appeal to the circuit court of the same jurisdiction within 10 days of receiving notice of the order. The bill specifies that no specimen obtained as a result of a testing order shall be tested for any purpose other than for the purpose provided for in the bill, nor shall the specimen or the results of such testing be used for any purpose in any criminal matter or investigation. Any violation shall constitute reversible error in any criminal case in which the specimen or results were used. Ed Rhodes reported on bills related to: 1) increasing the penalty for failure to follow the move over law, move over law license plates; 2) a restriction on the use of cell phones in work zones, 3) request by VDOT to equip safety trucks with lights and sirens, and 4) the elimination of reinstatement fees for suspended drivers licenses creating an $11M deficit in the Trauma Center Fund. For a complete list of legislation OEMS followed during the 2019 Virginia General Assembly session, visit the OEMS Web site at http://www.vdh.virginia.gov/emergency-medical-services/oems-legislative-grid-and-report/	

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	Mr. Rhodes inquired about what happens to an individual's term on the state EMS Advisory Board if they are appointed for a partial term (less than 3 years) and then is reappointed for an additional three (3) year term. Mr. Rhodes reminded the committee that the 2019 Fallen Firefighters and EMS Memorial Service will be held on Saturday, June 1, 2019 at 12 noon at the Richmond International Raceway Complex, Main Exhibit Hall. The Secure Virginia Health and Human Resources subpanel will meet on June 12, 2019.	**OEMS to seek guidance from Ms. Amanda Lavin, Asst. Attorney General about terms of service on the state EMS Advisory Board.**
UNFINISHED BUSINESS	No business remains unfinished.	
NEW BUSINESS	No new business.	
PUBLIC COMMENT	There is no public comment.	
NEXT MEETING DATE	Dates and location of remaining meetings for 2019 are Friday, August 2 and Wednesday, November 6. The August meeting begins at 9 AM and will be at the Richmond Embassy Suites Hotel. The November meeting is scheduled for Wednesday, November 6 at 10 AM, but is subject to change.	
ADJOURNMENT	The meeting adjourned at 10:23 AM.	**Motion made to adjourn the meeting by Michael Player, second by Rob Logan.**