VIRGINIA:

VIRGINIA DEPARTMENT OF HEALTH
STATE EMS ADVISORY BOARD MEETING

WEDNESDAY, NOVEMBER 06, 2019
1:09 P.M.

THE MAIN HILTON HOTEL
100 EAST MAIN STREET
NORFOLK, VIRGINIA 23510

1 **APPEARANCES**

2 **STATE EMS ADVISORY BOARD EXECUTIVE COMMITTEE:**

3 CHRISTOPHER L PARKER, CHAIR

4 DILLARD E. FERGUSON JR, VICE CHAIR

5 JONATHAN D HENSCHEL

6 DREAMA CHANDLER

7 ALLEN YEE, MD FAAEM

8 MICHEL B ABOUTANOS, MD, MPH, FACS

9 GARY P CRITZER

10

11 **SPEAKERS:**

12 PARHAM JABERI, MD MPH

13 GARY BROWN, DIRECTOR OEMS

14 CHRIS VERNOVAI, EMS SYSTEM PLANNER OEMS

15 GARY SAMUELS, LEGISLATIVE AND PLANNING COMMITTEE

16 P SCOTT WINSTON, OEMS

17 DR. GEORGE LINDBECK, OEMS

18 AMANDA LAVIN, ASSISTANT ATTORNEY GENERAL,

19 VIRGINIA

20 VINCENT VALERIANO, OEMS

21 DR. SAMUEL T BARTLE, EMS FOR CHILDREN COMMITTEE

22 CHIEF ED BRAZLE, VIRGINIA BEACH EMS

23 KAREN, OFFICE FOR PRESENTATIONS

24 JOHN KORMAN, COMMUNICATIONS COMMITTEE

25 THOMAS SCHWALENBERG, EMERGENCY MANAGEMENT

1 MIKE WATKINS, PRE-HOSPITAL CARE COMMITTEE
2 DR. JEFFREY YOUNG, TRAUMA AND ACUTE CARE
3 COMMITTEE
4 DR. MARGARET GRIFFEN, TRAUMA POST-ACUTE CARE
5 COMMITTEE
6 TIM PERKINS, MEDEVAC COMMITTEE
7 LORI KNOWLES, PROVIDER HEALTH AND SAFETY
8 COMMITTEE
9 MORRIS REECE, EMERGENCY PREPAREDNESS AND RESPONSE
10 GREG WOODS, EXECUTIVE DIRECTOR SOUTHWEST VIRGINIA
11 EMS COUNCIL
12 VALERIE QUICK, PROVIDER HEALTH AND SAFETY
13 COMMITTEE
14
15 ALSO IN APPEARANCE
16 ETHAN CLARK, THOMAS JEFFERSON EMS COUNCIL
17 MICHAEL PLAYER, PENINSULAS EMS COUNCIL
18 ED RHODES, VAVRS/VAGEMSA
19 MARY KATHRYN ALLEN, BREMS
20 JANET BLANKENSHIP, BREMS/BCOFR
21 KIM CRAIG, SARS/VAVRS
22 TIM ERSKINE, OEMS
23 BRIAN HRISIK, ALEXANDRIA FIRE DEPARTMENT
24 AL THOMPSON, BON SECOURS
25 JUDSON SMITH, ESS

1 BLANTON MARCHESE, ESS
2 DANIEL W LINKINS, VDH OEMS
3 CONNIE G MOORE, VAVRS
4 RICH TROSHAK, OEMS
5 STEVE RASMUSSEN, EMSC
6 FRANK KINNIER, CHESTERFIELD FIRE AND EMS
7 JUSTIN ADAMS, CHESTERFIELD FIRE AND EMS
8 CHAD VAUGHN, CHESTERFIELD FIRE AND EMS
9 ROBERT TRIMMEE, CHESTERFIELD FIRE AND EMS
10 GREGORY JONES, CHESTERFIELD FIRE AND EMS
11 DON ALTICE, ROANOKE COUNTY FIRE AND RESCUE
12 JACLYN SNYDER, AUGUSTA HEALTH
13 DONNA HURST, CSEMS
14 LUKE PARKER, OEMS
15 CARON NAZARIO, OEMS
16 RON PASSMORE,OEMS
17 ROB LOGAN, WVEMS
18 STEVE POWELL, ROCKINGHAM COUNTY FIRE AND RESCUE
19 KELLEY RUMSEY, CHILDRENS HOSPITAL OF RICHMOND AND
20 VCU
21 DANIEL MUNN, RIVERSIDE REGIONAL MEDICAL CENTER
22 RODNEY NEWTON, ODEMSA
23 JESSICA ROSNER, VDH OEMS
24 HEIDI M HOOKER, ODEMSA
25 RYAN SCARBROUGH, OPEMSA/VAVRS/LAKESIDE VRS

1 CAM CRITTENDEN, OEMS
2 MATTHEW MARRY, VHHA
3 BYRON ANDREWS, ALXENANDRIA FIRE/STERLING RESCUE
4 WAYNE PERRY, REMS COUNCIL
5 JEREMY R BENNETT, VACO
6 GREGORY S NIEMAN, VCU
7 JOE HILBERT, VDH
8 DAVID CONG, TIDEWATER EMS COUNCIL
9 RANDOLPH BRENTON, VAA
10 VALETA DANIELS
11 JETRO H PILAND
12 MATTHEW LAVIER
13 ANGELA PIER FERGUSON
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1 **40TH ANNUAL VIRGINIA EMS SYMPOSIUM**
2 **WEDNESDAY, NOVEMBER 6, 2019**
3 **1:09 P.M.**
4 **MR. PARKER:** Good afternoon. I'd
5 like to go ahead and call this meeting to order.
6 We'll first start with the Pledge of Allegiance.
7 I pledge allegiance to the flag of the United
8 States of America, and to the Republic for which
9 it stands, one nation, under God, indivisible,
10 with liberty, and justice for all.
11 If you'll remain standing for a
12 moment of silence in recognition of our fallen
13 EMS providers and public safety officials.
14 You may be seated. Approval of
15 the August 2nd, 2019, meeting minutes. You
16 should have received those from Irene on the
17 25th. Are there any additions, corrections, or
18 comments related to the minutes? Do we have a
19 motion to accept the minutes? Motion made.
20 Seconded? Call for vote. All in favor say aye.
21 **(WHEREUPON, members responded aye.)**
22 **MR. PARKER:** Any opposed? Motion
23 passes. In front of you, you have a meeting
24 agenda for today. Is there any additions or
25 changes to the agenda? We have one from the

1 Office of EMS. Under presentations we'll just
2 flip the order to where the mental health survey
3 project will be first and the Virginia Beach
4 shooting will be second. Any other changes?
5 Hearing none, so a motion to accept agenda for
6 today? Okay, motion. Seconded? All in favor?
7 **(WHEREUPON, members responded aye.)**
8 **MR. PARKER:** Motion passes.
9 Chairman's report. The only report that I have
10 as of today is the moving forward I neglected to
11 appoint a nominations committee in August. I had
12 some discussion with staff today about that. It
13 was kind of oversight on all of us. So we're
14 going to go forward with a nominations committee.
15 We'll talk about that under the executive
16 committee today and then we'll have that to bring
17 a slate of officers to the February meeting.
18 Vice chair?
19 **MR. FERGUSON, JR.:** Thank you very
20 much. I don't have a report, but I just attended
21 the retreat that we had earlier last month and
22 transportation committee a little bit later.
23 Thank you.
24 **MR. PARKER:** Dr. Jaberi.
25 **DR. JABERI:** Good afternoon,

1 everybody. Parham Jaberi, chief deputy in the
2 Health Department. It's a privilege to join all
3 of you here again. I started my tenure just over
4 a little bit over a year ago and this was the
5 first opportunity last year this time for me to
6 meet many of you. It's been a great learning
7 experience for me and look forward to the
8 continued collaborations with each of you.
9 Speaking of that, we've had some
10 very frank and robust discussions with the
11 regional councils. We just had a very good
12 meeting from, scheduled before lunch with the
13 executive directors talking about how we can
14 improve our collaboration with them. Looking at
15 the deliverables, what do our citizens need today
16 in today's modern world, how can we really look
17 at the role and the authority of the EMS and what
18 the regional councils are trying to do in
19 tailoring that need to provide a balanced,
20 effective, efficient regional EMS system and look
21 forward to many more conversations.
22 I've had an opportunity to have
23 some one on one conversations with a few of the
24 executive directors to better learn and
25 understand the varying needs across this large

1 Commonwealth. We have citizens with different
2 demographics, we've got executive directors who
3 are dealing with financial constraints.
4 We've got community partners
5 asking for different deliverables. And I feel
6 that everyone's doing their best to meet those
7 demands, but there may be opportunities for
8 further standardization, streamlining, and again
9 collaboration amongst the Office of EMS with our
10 regional councils. So I'll look forward to those
11 conversations.
12 A quick update, I want to thank
13 many of the folks here in this room including EMS
14 partners who came to the Ebola and infectious
15 disease summit held at the end of October in
16 Henrico. We had, it was on October I believe
17 28th of this year. We had Secretary Carey and
18 State Health Commissioner Dr. Norman Oliver
19 provide some opening remarks. And we had
20 multiple speakers including the State
21 epidemiologist attending.
22 We had speakers from Maryland, we
23 had speakers from National Ebola Training Center,
24 and again a very robust discussion where we not
25 only talked about Ebola but touched on a number

1 of other highly infectious diseases. And of
2 course as you all know, still talking about the
3 flu still kills more Americans. And the fact
4 that it's a potentially preventable illness
5 allows us to continue to talk about this and
6 consider the prevention mechanisms, of course the
7 primary of which is vaccinations.
8 So that issue will continue, our
9 cornerstone of public health efforts in Virginia.
10 In looking at the agenda, just want to share with
11 you, in part because of the mass shooting in
12 Virginia Beach, renewed effort and interest on
13 the part of the Virginia Department of Health and
14 now extending to the Secretary of Public Safety's
15 Office for us to partner around gun violence
16 prevention.
17 And so this is really coming at
18 this issue from a public health perspective,
19 realizing that firearms is something that is
20 owned by many citizens. We talk about the
21 potential risks in the community, how they're
22 used in an unintended way. And really
23 understanding where that violence is occurring.
24 Thinking about injuries as a
25 result of firearms and the larger spectrum of

1 violence initiatives we look at, at the Health
2 Department from domestic violence, child abuse,
3 and relating that to factors we see in the
4 community. Whether that has to do with
5 communities that are already underserved, are
6 under-resourced, and factors having to deal with
7 substance abuse. And really looking at this in a
8 more collaborative way.
9 So please look for more
10 opportunities for discussion and engagement with
11 the Health Department and again public safety.
12 We had a miniature presentation about a month or
13 two ago with again some of you in the room and
14 our secure Commonwealth resilience subpanel
15 looking at this issue where we had a
16 representative from the OCME present on gun
17 violence and the death that we see as a result of
18 that.
19 And then our injury prevention
20 program presenting the data that comes as a
21 result of again gun injuries. So there's a lot
22 of individuals in different demographics that are
23 implicated. When we're talking about homicides
24 versus suicides it's slightly different age
25 groups.

1 And the prevention methods and the
2 public health strategies need to be tailored to
3 each of those sub groups. So I'm proud to share
4 this and I believe this is going to be a topic of
5 discussion at next week's panel discussion with
6 Secretary Moran and Secretary Carey in Richmond.
7 Look forward to always
8 opportunities to meet other partners. If I
9 haven't had a chance or the pleasure of meeting
10 you, I will be around a little bit after this
11 meeting to engage with you. Again, thank you for
12 all that you do and that's my report. Chairman.
13 **MR. PARKER:** Thank you Deputy.
14 Now EMS report. We'll start with Gary Brown.
15 **MR. BROWN:** Thank you, Mr. Chair.
16 I'm going to cut right to the chase on the first
17 action item for the Board today. And because
18 Christopher Vernovai is teaching here at the
19 symposium needs to get going with that. And Tim
20 Perkins, if I can ask them to come up and present
21 a State EMS plan and say a few words about it.
22 Then I think the Chair will call for a vote.
23 **MR. VERNOVAI:** Good afternoon. So
24 we had sent out to you all the proposed draft for
25 the EMS, the EMS plan for the 2020 to 2022 and we

1 went through the review process. We solicited
2 input from all the advisory board committees,
3 staff, and other stakeholders to be able to go
4 through the plan and do some updates. There was
5 a number of large updates that had gone through
6 and we think that it's a good plan to move
7 forward with for our next three years and looking
8 forward in the future, so. Thank you all for
9 participating that didn't give input and your
10 review today as you go through it.
11 It is mandated under the State
12 code to have this done. It goes through every
13 three years, like I said. And we have, sorry, I
14 just had a loss of train of thought there. Got
15 my ideas mixed up. But so it went through the
16 legislative and planning committee on October
17 23rd, it was proposed in, and we reviewed it and
18 it was approved by the legislative and planning
19 committee on October 23rd. And it was
20 distributed to you all by Scott Winston,
21 assistant director, shortly thereafter for your
22 all's review.
23 Any questions or anything on that
24 that we can address?
25 **MR. PARKER:** So the EMS state plan

1 is your Appendix A in your quarterly report.
2 There is an action item from the legislative and
3 planning. We're kind of skipping ahead a little
4 bit. So I'm going to ask Gary Samuels if he
5 would like to, since that's been made, if Gary
6 would like to give his committee report so that
7 we have the action item on the table.
8 **MR. SAMUELS:** Yeah, like Chris
9 alluded to, we met on October 23rd at the Office
10 of EMS. We went through the plan. We spent
11 about four hours getting everything reviewed and
12 Chris and Tim Steen [phonetic] went back and made
13 all the edits. And the edits are in, reviewed it
14 again yesterday to make sure that it covered
15 everything that I had written down. It looks
16 like you're very inclusive. You got it all, so
17 I'm surprised that we kept up because we were
18 moving pretty quickly through it. I didn't think
19 it would take as long. So legend planning we met
20 and we bring this forward from the committee to
21 be voted on today so that we can move forward to
22 the Board of Health.
23 **MR. PARKER:** So here is an action
24 item that came from committee for the State EMS
25 plans that comes from committee that doesn't

1 require a second vote. So we'll place this on
2 the table. Is there any discussion related to
3 the EMS plan? Hearing no discussion, we'll call
4 for a vote. All in favor signal by saying aye.
5 **(WHEREUPON, members responded aye.)**
6 **MR. PARKER:** Any opposed? Any
7 abstain? Motion passes.
8 **MR. SAMUELS:** Thank you all very
9 much.
10 **MR. BROWN:** All right, thanks
11 Chris, thanks Tim. As the, I mentioned and also
12 what Gary said, the next steps are that the plan
13 will be presented to the State Board of Health
14 who has to approve this plan. And it is in the
15 code of Virginia that we have the State EMS plan
16 that has to be reviewed and approved on a tri-
17 annual basis, so that will be the next step.
18 I want to welcome everyone here to
19 the Fortieth Annual Virginia EMS Symposium. I
20 can tell you when we planned the first one we
21 didn't know whether we'd have a second. And, but
22 here it is all those years later and we've hit
23 our fortieth anniversary. We went pretty big
24 this year. We are right at four hundred classes
25 over a four and a half day period of time.

1 In terms of the number of
2 registrants that we have here, if you add the
3 registrants, if you add the falcony members, you
4 add staff, and vendors, we're pushing probably
5 close to three thousand people associated with
6 the symposium here in Norfolk for these four and
7 a half days.
8 And if each of the attendees, if
9 they take the maximum number of CEs that they can
10 take here at the symposium, cumulative we will be
11 awarding over forty thousand hours of continuing
12 education credits. So it's pretty big, pretty
13 enormous, and is the biggest EMS conference in
14 the country in terms of classes.
15 And we're very proud of that.
16 We're spread out into three hotels this year in
17 terms of the symposium itself. We basically take
18 up all hotels in the region in terms of lodging
19 and things of that nature. But in terms of
20 classes at the Sheraton, the Marriott, and this
21 year we spilled over here into the Hilton.
22 That gave us the opportunity to
23 make some changes and the room we are in here and
24 the room where you had lunch and then the room
25 beyond that, that's going to all be opened up

1 tonight. We'll get, this will all become an
2 exhibit hall and of course we have our normal
3 exhibit hall over at the Marriott and we take up
4 the entire Norfolk ballroom on the first floor
5 there.
6 We have 154 vendors here this year
7 as well. And again, that's larger than many
8 national conferences, EMS conferences. So a lot
9 of good stuff here, a lot of good classes. Good
10 sessions. We have some general sessions back
11 tomorrow. We have NYPD making a presentation
12 Friday morning. We have J.R. Martinez.
13 Hopefully you've looked at our website.
14 He's a soldier that was wounded in
15 Iraq and was burned over most of his body. He's
16 had probably twenty to thirty different
17 surgeries. He was really a, went to, started
18 going to VA hospitals and speaking to other
19 soldiers that were wounded and they recognized
20 that he just really had this magical touch of
21 being reassuring and really helping out his
22 fellow soldiers that were wounded.
23 And one thing led to another and
24 he's not only nationally but internationally
25 known. Actually ended up on the daytime soap

1 opera, I forget what it's called.
2 **AUDIENCE MEMBER:** All My Children.
3 **MR. BROWN:** All My Children, yes,
4 okay. And then actually ended up on Dancing With
5 the Stars a couple of seasons ago and they
6 actually won it. So, but he's really an
7 incredible person. I've had a chance to talk to
8 him on the phone and he's going to be incredible
9 in terms of what he talks about and especially
10 service to community, you know, and giving back
11 to your community.
12 And also he's going to get into
13 the mental health aspect and he's going to tie it
14 to public safety. And that's the reason he
15 accepted our invitation. He was really intrigued
16 by EMS and the similarities between service in
17 EMS and service in the military to your country.
18 And he talks about the mental
19 health aspects. He said if you see his face and
20 see his body, he said everybody can look at me
21 and they can see the deformity, so to speak. He
22 said but what they couldn't see was inside me.
23 And he said they, no one knew the depression he
24 was going through and the other things that he
25 had to overcome.

1 But he's very inspirational and a
2 very motivational speaker. So that's Friday
3 morning and we'll also be taking him around and
4 to the different hotels and you'll have a chance
5 to meet and greet as well. So hopefully all of
6 you that are still here will be able to attend
7 that.
8 And then we have Bob Page Saturday
9 morning and he's going to bring back his grim
10 reaper presentation. He retired that a few years
11 back and had said that he would not present that
12 anymore. And I'm not talking out of turn on him,
13 it's just that he had a, he had a medical episode
14 and had a near death experience and after that he
15 stopped doing the grim reaper presentation. But
16 he said for us he'll bring it back because of our
17 fortieth symposium. And of course Bob is now a
18 resident in Virginia.
19 We have the awards banquet
20 Saturday night and we have Randolph Mantooth back
21 and that's Johnny Gage from the show Emergency!
22 that got a lot of us into the field of EMS. So
23 he's going to be our keynote speaker. And of
24 course we have the governor's EMS awards and a
25 lot of other good things honoring those who have

1 lost their life in the line of duty through the,
2 and that, memorializing the national EMS memorial
3 service. And Kevin comes every year and presents
4 that.
5 So, anyway, just wanted to kind of
6 give you some facts and figures on the symposium
7 and thank you for being here. And I will turn it
8 over to Scott. He's got a staff introduction and
9 I think maybe what you want to say, follow up
10 with Dr. Jaberi on the regional councils.
11 **MR. WINSTON:** Thank you, Gary. I
12 first would like to introduce to you a new staff
13 member from the Office of EMS, Mr. Daniel
14 Lincolns. Daniel, if you'll stand. Daniel began
15 work at the Central Shenandoah EMS Council Office
16 as the State regional program manager on the 10th
17 of October. And he's had less than thirty days
18 on the job, but it sounds like he's done a
19 tremendous amount of work, done a lot of
20 listening, done a lot of traveling within the
21 region.
22 Daniel is there to provide
23 leadership and management support and with the
24 assistance of existing council staff. And their
25 functions in performing the administrative and

1 operational responsibilities. Daniel was most
2 recently worked at the John Tyler Community
3 College in their EMS program as their program
4 director. And we're very pleased to have Daniel
5 on the job for us. So thank you for accepting
6 and thank you for the, we know we've talked about
7 some of the challenges that exist and I think
8 we've picked the right person for the job in that
9 respect.
10 I don't really have anything to
11 add in terms of the discussions that we've had
12 with the Regional Councils. I will say that
13 since the last meeting there's been a lot of
14 activity. There have been a number of internal
15 meetings and there have been meetings with a
16 select group of Regional Council executive
17 directors to talk about opening and improving
18 collaboration and communication as well as
19 looking at some strategic opportunities that
20 exist going forward.
21 We are going to meet again the
22 morning of December the 6th to continue our
23 discussions and then have a more focused and
24 detailed discussion in the March/April timeframe
25 where we'll come together for a day and a half or

1 two days and really roll up our sleeves and get
2 into some fine detail in terms of the Regional
3 Councils and the Office of EMS roles,
4 responsibilities, authority, et cetera.
5 And, let's see, was there anything
6 else I was supposed to say? Other than I wanted
7 to add my warm welcome and greetings to the
8 Fortieth Annual EMS Symposium. It takes a
9 village to conduct this conference and symposium.
10 We're very fortunate to have support from a
11 number of organizations, agencies, key
12 stakeholders.
13 To mention one, run the risk of
14 forgetting others, so those of you that are
15 participating and working in the symposium, we
16 appreciate that support. If you have questions
17 while you're here, look for an OEMS staff member.
18 We're wearing the shirt of the day today is
19 black, as you can see.
20 We have different colors for
21 different days, so that may make it easier for
22 you to spot an OEMS staff member if you need help
23 with anything. Please don't hesitate to ask.
24 And welcome and we're very pleased to have you
25 all here.

1 **MR. BROWN:** Thanks, Scott. Dr.
2 Lindbeck.
3 **DR. LINDBECK:** I don't think I
4 have anything further.
5 **MR. BROWN:** Okay, I think that
6 concludes our report, Mr. Chair.
7 **MR. PARKER:** All right, thank you
8 Gary and staff. Attorney General's Office Amanda
9 Lavin?
10 **MS. LAVIN:** Shocking, I have
11 nothing to report.
12 **MR. PARKER:** Moving on. State
13 Board of Health EMS representative report Gary
14 Critzer.
15 **MR. CRITZER:** Good afternoon,
16 thank you, Mr. Chairman, members of the Board.
17 The State Board of Health last met on the 5th of
18 September. The big item that we are continuing
19 to work on are the abortion clinic regulations.
20 We took public comment at that meeting and
21 carried over any action item on that meeting
22 until our December meeting, which is coming up on
23 the 12th of December at 9:00 a.m. at the
24 Perimeter Center in Henrico County.
25 So we will be considering the

1 final draft of those regulations for approval at
2 that meeting. So if you haven't had the
3 opportunity to attend the State Board of Health
4 meeting, there's lots of other things that we
5 discuss and that we're involved in from pretty
6 much every letter in the alphabet.
7 It seems that VH, I had no idea
8 the breadth of everything that they covered. So
9 we encourage you if you're interested in the work
10 of the Department of Health beyond EMS and those
11 areas that do have impacts directly on EMS, we'd
12 welcome you there in December. So thank you.
13 **MR. PARKER:** Okay, at this time
14 we'll turn it over to the Office for
15 Presentations. And I believe that's Karen.
16 **AUDIENCE MEMBER:** I'm just here
17 for technical support.
18 **MR. VALERIANO:** Good afternoon.
19 My name is Vincent Valeriano. I'm the
20 epidemiologist with the Office of Emergency
21 Medical Services. Thank you for having me here
22 today to discuss the very important topic of EMS
23 provider mental health.
24 Last time I stood before you I
25 provided an overview of the EMS provider mental

1 health survey that we conducted in late summer.
2 The goal of the survey was to assess the mental
3 health status of Virginia's EMS providers as well
4 as the perceived mental health culture and
5 services within providers' agencies.
6 Today I'm going to provide you a
7 brief high level overview of those results. And
8 at the end of the presentation I'll give you
9 additional information on how you can get even
10 more detailed information about the results.
11 Let's begin.
12 So out of the 33,000 EMS providers
13 that we emailed, 3,003 EMS providers who active
14 served in the past twelve months responded to our
15 survey. Thirty-two, or about fifty percent of
16 those were EMTs and thirty-two percent were
17 paramedics. The majority were full time
18 providers and some of them even volunteered on
19 top of being full time, and twenty-seven percent
20 were volunteers.
21 Significantly, almost sixty-five
22 percent of the participants were associated with
23 an agency that provides fire suppression. The
24 Centers for Disease Control and Prevention's
25 health related quality of life indicators gives

1 us a snapshot into a provider's perceived overall
2 sense of health and wellbeing.
3 So out of a thirty-day period,
4 providers reported an average of 2.7 days of
5 perceived poor physical health. Which is
6 actually better than the general population of
7 Virginia, which was 3.6 in 2018. However, when
8 we look at mental health we get, we see a much
9 different picture. Out of a thirty-day period,
10 providers reported an average of 6.8 days of
11 perceived poor mental health. This is two times
12 the general population of Virginia, which was 3.7
13 days in 2018.
14 Another measure known as frequent
15 mental health distress examines the percentage of
16 adults who report that their mental health was
17 not good for fourteen or more days out of a
18 thirty-day period. In Virginia in 2018 11.6
19 percent of the general population reported
20 experiencing frequent mental distress. Our
21 survey identified 21.1 percent of EMS providers
22 who experienced frequent mental distress. We
23 then dug deeper to see additional, go ahead.
24 **UNIDENTIFIED SPEAKER:** What are
25 you defining as mental distress? Are you

1 defining depression, sadness, PTSD?
2 **MR. VALERIANO:** Good question. So
3 with this, with the frequent mental distress,
4 that uses the health-related quality of life
5 indicator where they are asked about how many
6 days in the past thirty days have you felt that
7 your mental health was not good. And so they
8 take that number and the percentage that was
9 fourteen or more days over the past thirty days,
10 that's the percentage that's frequent mental
11 health distress. Good question.
12 So we begin to look a little bit
13 deeper and we wanted to see additional poor
14 mental health outcomes. And on average out of a
15 thirty-day period providers reported 9.3 days of
16 feeling sad, blue, and depressed and 19.1 percent
17 of the providers felt this way fourteen or more
18 days within the past thirty days.
19 Additionally, providers reported
20 an average of 9.3 days of feeling worried, tense,
21 or anxious and that's almost a third of a month.
22 And 31.2 percent had felt this way for fourteen
23 or more days within a thirty-day period.
24 Sleep was identified as another
25 area of concern among our providers. Research

1 demonstrates that lack of sleep has not only been
2 associated with a multitude of chronic diseases
3 and accidental death and injury, but has also
4 been associated with poor mental health and
5 burnout. Out of a thirty-day period, providers
6 reported an average of 14.9 days of perceived
7 inadequate sleep and rest. That's half of a
8 month.
9 Next we wanted to see how many
10 providers received inadequate or insufficient
11 sleep hours which is defined as the percentage of
12 providers who reported sleeping less than seven
13 hours on average in a twenty-four-hour period.
14 So in 2018 the general population of Virginia,
15 33.9 percent received insufficient sleep hours.
16 Our survey identified 62.6 percent of EMS
17 providers experienced inadequate sleep hours.
18 Again, that's double the general population.
19 Next we wanted to look at specific
20 mental health outcomes and whether or not
21 providers experience them and if they believe
22 that their service as an EMS provider caused
23 these certain outcomes. And so just taking a
24 look at the past twelve months, fifty percent of
25 providers believe that their service as an EMS

1 provider caused them to feel burned out due to
2 the stress of the job.
3 Thirty-three point nine percent
4 believe they experience traumatic stress that
5 caused them to have, to cause them, that caused
6 them poor mental health. Twenty-six percent
7 believe that they experienced PTSD as a result of
8 being an EMS provider and thirty percent believe
9 that they experience depression.
10 When we look at suicide factors,
11 8.1 percent of EMS providers within the past
12 twelve months seriously contemplated suicide,
13 which is double the general population of
14 Virginia and the United States, which was
15 approximately four percent, within, during 2018.
16 Three point one percent of our EMS
17 providers made plans to commit suicide within the
18 past twelve months. Again, this is double the
19 U.S. general population at 1.3 percent in 2018.
20 And then twenty EMS providers told this that they
21 tried to take their own lives within the past
22 twelve months. And this number does not include
23 those who attempted and succeeded and were unable
24 to take the survey.
25 Thirty-two percent of providers

1 told us they knew of another provider who
2 experienced suicidal thoughts and eighteen
3 percent of providers told us that they knew of
4 another provider who attempted or committed
5 suicide.
6 So when you boil these numbers
7 down, during the past twelve months sixty-one
8 percent of providers experienced at least one
9 negative mental health outcome. So in this room
10 three out of every five providers believe that
11 they experience burnout, PTSD, traumatic stress,
12 and depression or suicidal tendencies or a
13 combination of all of them during their service
14 as an EMS provider.
15 In other words, according to the
16 data, you're a minority if you're an EMS provider
17 who hasn't experienced a negative mental health
18 outcome while serving. And so I say all of this
19 to encourage those who have struggled or are
20 struggling, that it's okay and that you're not
21 alone. And that this is common within this line
22 of work and it's okay to reach out and get help.
23 And for those who do experience
24 good mental health and who are currently healthy,
25 rather than responding in pride and contempt for

1 those who aren't, use your strength as an
2 opportunity to help a brother or sister out.
3 Because providers' health and wellbeing and even
4 lives are on the line and we need to make sure
5 that we're doing everything that we can to ensure
6 the health and safety and wellbeing of EMS
7 providers.
8 Lastly, we examined providers'
9 perception of their agency's mental health
10 culture. We gave providers a series of
11 statements and asked them to rate how strongly
12 they agreed with each statement. So starting at
13 the top, 34.3 percent disagreed or strongly
14 disagreed that EMS provider mental health is
15 important to their agency.
16 Forty percent disagreed that their
17 agency provides sufficient mental health supports
18 and services. Thirty point eight percent
19 disagreed that they would know where to find
20 mental health services within their agency.
21 Forty point one percent disagreed that they would
22 feel safe discussing mental health issues with
23 their coworkers. And 42.1 percent disagreed they
24 would feel safe discussing mental health issues
25 with their supervisor or upper leadership.

1 Eighteen point one percent
2 disagreed that their coworkers would encourage
3 them to get help for their mental health issues.
4 And 22.1 percent disagreed that their supervisor
5 or upper leadership would encourage them to
6 utilize mental health supports and services.
7 So as you can see, there's still
8 much work to be done surrounding EMS provider
9 mental health. Over this past several months
10 I've been working on compiling this data and
11 getting it into a dashboard that can be viewed to
12 the, for the public and stakeholders to use this
13 data to really tackle the, to help tackle this
14 issue of EMS provider mental health.
15 I provided you with a QR code and
16 a link on the right-hand side of the slide to be
17 able to actually access the dashboard. So our
18 hope for this survey is to use this data to drive
19 further actions surrounding EMS provider mental
20 health and improving EMS provider mental health
21 resources.
22 We realize that this is a really
23 big task and something that we cannot do on our
24 own and it's going to take strategic
25 partnerships, collaboration, and organic

1 innovation. And I encourage you if you want to
2 be a part of that conversation, please feel free
3 to reach out to me and to continue this
4 discussion. I provided you with my email at the
5 bottom of the slide if you have any further
6 questions. Thank you. Go ahead.
7 **AUDIENCE MEMBER:** Me again. So
8 just out of curiosity because I don't know this
9 side of it, but in the medical examiner's office
10 obviously everybody has to go there, suicide or
11 not. Is there any way that they capture the job
12 that the deceased was doing so we could be able
13 to cross reference and get that, extract that
14 information from the ME's office?
15 **MR. VALERIANO:** That is something
16 I'm not sure. I'd have to look into. Maybe you
17 know, Karen?
18 **KAREN:** So the problem lies with
19 the medical examiner's information is they
20 collect what the job is. So they are not
21 collecting data if their position was a volunteer
22 fire EMS provider. So if it was a person who
23 committed suicide that had full time job as an
24 electrician, that's what goes into their
25 information and not whether or not they were a

1 volunteer as a public safety provider.
2 **AUDIENCE MEMBER:** Can we reach out
3 ...
4 **KAREN:** We are in conversation
5 with them about how we can better collect data,
6 yes.
7 **AUDIENCE MEMBER:** Okay, thank you.
8 **MR. PARKER:** So, Laurie, I don't
9 want to speak out of turn but I think that this
10 is a great segue back into the provider health
11 and safety committee with some of this. I don't
12 want to speak for your group, but I think that's
13 something that we need to look at. I think this
14 is very important for our providers across the
15 Commonwealth.
16 I would also like to see maybe
17 have we thought of reaching out into the
18 telecommunicator group to see if this is
19 something. Because I know many of their
20 providers end up having some similar, I don't
21 know if the data would speak there as well, but I
22 don't know if that would be something that we
23 could look at.
24 I know many of them don't fall
25 under EMS agencies because some are not EMTs or

1 others, but I think that's something we might
2 want to consider as well.
3 **AUDIENCE MEMBER:** They actually
4 reached out to us. We did have some 9-1-1
5 dispatchers reach out to us as we sent the
6 survey, those who were EMS providers. We are in
7 communications through Rich Troshak our
8 communications coordinator, and we're going to
9 continue that outreach as well, yes.
10 **MR. PARKER:** Excellent, thank you.
11 Any other questions, comments, discussion? Thank
12 you, sir.
13 **MR. VALERIANO:** Thank you.
14 **MR. PARKER:** Our next presenter is
15 going to be Chief Brazle?
16 **MR. BRAZLE:** Yes.
17 **MR. PARKER:** I hope I did not
18 butcher that.
19 **MR. BRAZLE:** You got it right.
20 It's pronounced and spelled many ways. I answer
21 to all of them. Thank you. Good afternoon,
22 everybody. I appreciate the opportunity to come
23 out and speak. Sorry to have my back to
24 everybody back here.
25 This has been obviously a major

1 event in Virginia Beach and in the Commonwealth
2 with big implications for the EMS fire service,
3 emergency management. We are still wrapping up
4 some of our final after actions and actually an
5 external report coming from a consultant from out
6 of the area.
7 But we've got some pretty good
8 information to be able to share on a preliminary
9 basis. I'm going to keep this as short as I can.
10 I'll talk fast, so a lot to cover. Anybody that
11 wants the full breadth of this, I'm doing a thing
12 on Sunday as well or we've got folks that would
13 be happy to come to your agency.
14 But just real quick we're going to
15 talk about how we got to May 31st, how we handled
16 May 31st, but then the recovery phase. This is
17 an unusual event because it was at a municipal
18 facility. This wasn't abstract, it wasn't at a
19 theater or a church or something. This was in
20 our home. And then we'll talk about some of the
21 after action from the EMS side.
22 But I want to take you back to
23 2013. We've all in this business, we've all been
24 watching since Columbine and Virginia Tech and
25 Parkland the evolution of how law enforcement has

1 responded and then EMS and fire coming in behind
2 and dealing with the patients and the idea of
3 delayed intervention of the shooter and then
4 people bleeding to death delayed coming in to
5 deal with the victims.
6 So we thought we had a pretty good
7 plan in Virginia Beach and worked out wit the
8 cops, get us in there, get us in there, and we
9 did a major exercise. We took over a school, had
10 literally hundreds of responders involved. And
11 went in and here's what happened.
12 They relied completely on the
13 tactical medics for patient care. EMS has some
14 tactical medics that are embedded with the police
15 department, but they were the only ones allowed
16 in the building. Fire and EMS couldn't get in
17 until the building was cleared.
18 And this is an exercise, but about
19 forty-five minutes until meaningful patient
20 contact. And this is on the heels of what we
21 already knew from live events. We did unified
22 command there. You'll see EMS and fire unified
23 at our battalion vehicle and then there's the
24 police command post behind. The door is open,
25 but that's as close as our unified command got in

1 2013.
2 I'm not putting this on report.
3 We did an after action later and this is what we
4 came to the conclusion with, that fire, EMS, and
5 police. And when I say fire I'm going to be
6 interchangeable because we're talking about the
7 patient care part. But we need to train
8 together.
9 We need to figure out what is
10 acceptable risk for us to go in and get the
11 victims. We are, we risk a lot to save a lot.
12 Command and control has to be as much of a
13 priority of going in and getting the shooter. We
14 need to be doing incident command and then we
15 need to talk about the human services needs.
16 I'm not going to really get into
17 the human services needs as much. It's a whole
18 separate conversation. But we got this, these
19 conclusions and so we got a group together, fire,
20 EMS, police. We're three separate departments.
21 Also an Office of Emergency Management was kind
22 of the glue that brought us together.
23 And it was not Shangri la on the
24 first meetings. We really had to define the
25 lanes, because you had the law enforcement lane,

1 you had firefighters that were ready to low crawl
2 up with their deer hunting rifles and go and
3 help. And that was a perception and that's not
4 what was going to go on, but.
5 And of course volunteers, of
6 course, no way, they're not going to go in the
7 building. And, you know, getting through that,
8 and then terminology. So police and fire
9 cleared, secured is two different things. In
10 mass casualty a black patient means something
11 totally different than a black patient in law
12 enforcement.
13 So we really had to work through a
14 lot, but we came to some key things. We said
15 we're going to have unified command. This is how
16 we're going to do business in Virginia Beach. We
17 adopted a warm zone concept and casualty
18 collection point and we said we're all going to
19 use the same toys and same equipment to treat
20 patients.
21 And we created a guideline, an
22 SOP, a unified response guideline to criminal
23 mass casualty incidents, signed by all the
24 chiefs, and this is how we're going to operate.
25 We also said we're going to plan for joint lead

1 all special events because we knew if we didn't
2 do this on the regular, when the big one happened
3 we wouldn't.
4 We had a lot of marathons and
5 festivals and things in Virginia Beach, concerts,
6 and so we do those, we plan them together and we
7 respond together. So if you come down there at
8 our next marathon you're going to see a unified
9 command post, police, fire, and EMS, all sitting
10 at the same table.
11 And we're using ICS and every cop,
12 the tourniquet that the cop is carrying is the
13 tourniquet that's in the jump bag on the
14 ambulance, jump bag on the fire truck. So we
15 roll this out, we tabletop it, and then bigger
16 things in 2018. We ran most of our fire and
17 rescue folks through actual rescue task force
18 training that we didn't exercise coincidentally
19 at the end of March of this year, which was a big
20 deal. We've never even done an after action
21 report on that drill because of further events.
22 The hallmarks of our response
23 plan, very similar to many of your cities, but
24 we've got a little bit of a twist. First we're
25 going to neutralize the threat. That hasn't gone

1 away. But as soon as officers are not needed for
2 neutralizing the threat, they are to start
3 controlling bleeding, start doing patient care.
4 And that includes get the patients
5 out of there. Whether we set up a casualty
6 collection point in a secure area in the
7 building, let's say we're in a mall and the
8 shooter's been pushed halfway across the mall.
9 Or whether it's in a theater and we can just get
10 them outside. But the idea is they, the police
11 that are not engaging the shooter are to start
12 doing patient care and get people out of the
13 building.
14 This was a big hurdle. You know,
15 C-spine, C-spine, people bleeding to death. But
16 this was our standard. Then we set up the hot,
17 warm, and cold zone concept where we have rescue
18 task forces that can go into the warm zone if the
19 police aren't getting them out. We can still go
20 in under escort.
21 We borrowed a lot of that from
22 some of the things going up in northern Virginia,
23 some of the fire departments up there. But we
24 will establish unified command early and we told
25 our supervisors, our fire and EMS supervisors you

1 may get closer to a scene than you would like to.
2 So on a regular Friday night
3 shooting, yes, it does happen in Virginia Beach,
4 on your regular Friday night shooting we're
5 parsing up the block. But in a criminal MCI the
6 police supervisors are going in. And so that
7 battalion vehicle getting a little bit closer
8 could become the nucleus around which the follow
9 on police supervisors will gather.
10 We will have rescue task forces,
11 but we don't go in unless the cops say we can go
12 in. And we may have multiple casualty collection
13 points.
14 All right, so that got us to May
15 31st. So just to set the stage, it's hard to see
16 from a distance there, but if you're familiar
17 with Virginia Beach and the beaches and the
18 oceanfront, we appreciate your contribution to
19 our tax revenue. But this is about five miles
20 from there near our rural part of the city.
21 So this is our City Hall, this is
22 building two. We have lots of buildings, our
23 jail, courthouse, but of note is right here, Fire
24 and EMS Station 5 where an ambulance and an
25 engine. This is our police headquarters and

1 first precinct. And over here is our EOC and 9-
2 1-1 center. So you can see off the back apron of
3 Station 5 when the leaves are down, you can see
4 right into building two.
5 So today building two is one of
6 our biggest office buildings. It's got four
7 occupied levels with nearly four hundred
8 employees of four departments. This is critical
9 infrastructure for us. If you need to get a plan
10 approved so you can put a new deck on your house
11 or you need to dispute your water bill, you go in
12 there.
13 There's big lobbies on each floor
14 with customer service counters and then it's a
15 rat's nest of offices and cubicles throughout.
16 So the day of the shooting, we had
17 a veteran engineer who came to work and early in
18 the day he put in his two weeks' notice via an
19 email. Had an exchange with his supervisors, it
20 was all cordial. He worked all day including
21 sending emails, and in the afternoon he went out
22 on a jobsite with two other employees. He came
23 back, sent a work-related email, and at some
24 point left the building.
25 Five minutes later two people have

1 been shot outside the building, one in a car, one
2 in the entrance to the building. To which point
3 he then walked in. We think he shot the one
4 walking out the door.
5 So at 16:06, and I'm rounding
6 these off by the seconds, so don't start going
7 two, three minutes, whatever. But at 16:06 we
8 received a 9-1-1 call reporting the person shot
9 in the parking lot. Obviously the dispatcher
10 taking this information, they started getting
11 more details, people hearing shots from within
12 the building. Also we started getting 9-1-1
13 calls from within the building.
14 The suspect had a large, at least
15 one large caliber handgun with a silencer. So
16 the first call was dispatched, just engine,
17 ambulance, supervisor for a gunshot wound, but
18 then the comments were fed out, the multiple
19 people shot. So at 16:08 is when it was
20 dispatched.
21 At this point in time we believe
22 ten people have been shot. So this is the speed
23 and violence that is going to occur in these
24 scenarios. So ten people have been shot and
25 we're just getting our shoes on and out the door.

1 Officers, we had two canine
2 officers nearby. We also had two detectives
3 responding from the nearby precinct, got in the
4 building very quickly. It's a big building and
5 they went looking. Within another minute, the
6 first engine, Engine 5 arrived. They staged in
7 that back parking, that parking lot. And started
8 to establish a casualty collection point or
9 treatment area. They were joined by the
10 ambulance that got there a few minutes later.
11 What also this engine, I will go
12 back, what this engine crew did very quickly was
13 they knew there were victims outside, so they
14 grabbed the stretcher off the ambulance, said the
15 ambulance crew stay here, be the treatment area.
16 We're going to, under escort we're going to go
17 try to get the victims who are outside. So that
18 became the very first rescue task force.
19 At 16:16 we had a report from
20 inside the building officers are engaging the
21 suspect. This was the beginning of an extended
22 gun battle with the suspect. He did not do the
23 traditional get cornered and commit suicide.
24 In the interim, the senior police
25 officer arrived about the same time the battalion

1 chief and EMS supervisor all got there and
2 established unified command. And as more and
3 more brass arrived from the various departments,
4 they coalesced around what was the battalion
5 vehicle and this police captain.
6 So 16:19, we're eleven minutes
7 from dispatch. We have a report of an officer
8 who's been shot. He was dragged out.
9 Fortunately the vest stopped most of the bullet,
10 or stopped the bullet. But we were still
11 engaging the suspect now at 16:23. He barricaded
12 himself in an office and there's shooting through
13 the door, through the walls, exchanging gunfire.
14 Which did, was an issue of, you
15 know, rescue task force idea is it's warm zone.
16 Well, the entire building is still hot because we
17 don't know how far these bullets are flying.
18 At 16:29 two of the tactical
19 medics enter the building. Again, those are EMS
20 medics, we have crew and volunteer that embedded
21 with the police department. They each as they
22 arrived paired up with two special ops officers
23 also arriving, entered, and started sweeping the
24 building looking for victims. A total of five
25 tactical medics made it in the building before

1 this resolved.
2 At 16:33 our first patient was
3 transported. This actually was an ambulance
4 pulling into the complex was waved down by a
5 deputy sheriff who had a man standing on the side
6 of the road shot in the face. And so they got
7 him in, said where do you want us to go, and we
8 sent them on their way. That patient never made
9 it to the collection area.
10 So it's important that while
11 they're still shooting, shooting it out with the
12 suspect, we started that plan, evacuate,
13 evacuate. And the police were getting victims
14 out every door they could, any way they could.
15 And so the first victims arrive, they were thrown
16 in the back of a pickup truck and brought over to
17 where we had this collection area, which at that
18 point was just an ambulance.
19 They came in and brought those
20 victims, and I'll talk about the patient flow,
21 but that was our first three patients. Every
22 patient we saw, well, with one exception, these
23 patients all had high caliber gunshot wounds to
24 the neck, face, or head.
25 At 16:44 the police did report to

1 us that the suspect was in custody. We were
2 sweeping the building. The SWAT medics at this
3 point split up with supervisor, police
4 supervisors, and went room to room looking for
5 victims. But at that point, other than the
6 shooter, all the victims actually had been
7 removed from the building.
8 So you see victims were coming
9 out. We had the first three, then another, then
10 another, in rapid sequences they came out. We
11 transported them out. There wasn't a lot of
12 things going on at the scene.
13 So 17:02 we get the report from
14 the police and from the SWAT medics, there are no
15 living victims in the building. Which I will
16 tell you as somebody that was there, it was just,
17 it just all stopped. Nobody else came out. It
18 was surreal.
19 We had the final victim was at
20 17:05. This was the shooter. I will say he was
21 shot at 16:44, well, in custody and they carried
22 him out of the second floor, got him to the
23 casualty collection point out, right out to the
24 ambulance. We did have one medical patient or
25 evacuee and then at 17:55 normal operations.

1 So really six transports within
2 less than an hour and less than two hours for the
3 incident. It was fast. So just medically, since
4 this is an EMS group, we did have our bleeding
5 control kits available. People had them on their
6 belts. But due to the nature of the injuries,
7 very little care was necessary to that degree.
8 One tactical medic did pack a
9 wound inside the building, but for the most part
10 they were hauled out and headed very quickly to
11 an ambulance. So our treatment area and casualty
12 collection point never really evolved. We only
13 had a couple of victims at a time. We were very
14 fortunate in having a lot of ambulances
15 available.
16 So let's talk about the rescue
17 task forces, though. And this is a hard one to
18 see, but we had four fire companies arrived and
19 they were all assigned to rescue task forces.
20 And their role, I mentioned that first engine,
21 they grabbed that stretcher and under escort, you
22 see the long gun, got to the building.
23 And this is early. The victim, or
24 survivors coming out, officers still drawing down
25 on the windows. They did get to the two outside

1 the building, assessed was deceased, and then
2 stood by to grab anybody dragged out.
3 Later another engine company, this
4 was actually a ladder crew, went in to clear
5 elevators. Again under escort. But the victims
6 were all brought out by police, just we grabbed
7 them as they were coming out the door.
8 We transported six. We own a
9 level two trauma center in Virginia Beach about
10 eighteen miles away. I'm sorry, about eighteen
11 minutes away as opposed to about thirty minutes
12 away at this time of day to our level one trauma
13 center. So five went to Beach General, one went
14 to the closest hospital, Prince Anne, which is
15 about a six minute drive for lights. Direct
16 shot. That was an uncontrolled airway that we
17 felt best for that patient was to go there and
18 then they were later transferred.
19 But of the six, five had airway
20 issues and two were deceased at the hospital. We
21 did not transport anyone in cardiac arrest, they
22 all had a pulse when they left the scene.
23 So after it stopped, the
24 transports, the days to follow or the hours to
25 follow, we immediately sent an ambulance, we had

1 a family assistance center which was, we started
2 at a church but it turns out there were
3 activities going on at the church so we moved to
4 a school.
5 And we kept an ambulance there
6 until all the patients' families were notified
7 and that was about 1:30 in the morning when the
8 last deceased was notified. We were there for
9 rehab for police officers and in the days to
10 follow there were many memorial services that
11 needed standby.
12 Nonmedical, we had EOC. I'm going
13 to talk a lot about that, but EMS and fire, we
14 staffed the EOC and provided a lot of logistic
15 support.
16 The EOC within an hour, we had it
17 activated. It was actually faster than that,
18 because our folks know we default go there. But
19 within two hours every department was there. And
20 we were open for twelve days. During Hurricane
21 Matthew we were not open for twelve days.
22 This was daytime hours that we,
23 this, this was essential to have the EOC. So
24 emergency managers, fire chiefs in this room,
25 this is where your big, it's not just about the

1 patients getting out of there. That took two
2 hours. We had to staff and support the family
3 reunification center. We set up a center to
4 assist the families for the days to follow.
5 The people in the building and
6 other employees, we had hundreds of cars in the
7 parking lot. How do you get people to their
8 cars, get people to their briefcases? How do we
9 deal with that, return to work. Fortunately this
10 was a Friday, so we had a weekend to work with,
11 but we also had a major JIC and just coordinating
12 for days including donations.
13 This was an interesting, we had
14 millions of dollars in donations, so how do you
15 deal with that? We're pretty smart, but, so we
16 said, hey, let's get the budget office. So we
17 brought the budget director and a couple of
18 analysts and they managed the donation process.
19 So a lot going on and we were
20 supported heavily by the Hampton Roads IMT in the
21 days to follow, because we were pretty whipped.
22 Media as you can imagine, there
23 was a huge media storm. We did formal briefings
24 twice a day. Having media plans, again, if, this
25 isn't about that for this presentation. Anybody

1 that wants a presentation, our communications
2 person can come talk to you about how we decided
3 when to release names of victims and how we dealt
4 with personal information issues or whatnot.
5 But the bigger thing you should be
6 aware of, it's not just the media, it's also a
7 political show. We had the governor was within
8 hours in town, our entire Congressional general
9 assembly delegation was there, neighboring city
10 mayors, Federal Congressmen, you name it, they
11 were all there in some capacity. And you will
12 have to determine very early on what level of
13 involvement you would want them in your
14 community.
15 So continuity of operations.
16 Again, not medical but those of you that are
17 administrators or government leaders here, this
18 is a big deal if it hits your house. This was
19 our biggest office building. Nearly four hundred
20 people that cannot go back and to this day are
21 still not back there, by the way.
22 So Saturday morning we brought in
23 this facilities coordinators for the city who had
24 a list of what offices were where and they
25 started a plan. They brought in IT, talk about

1 phones and drops. They briefed city manager and
2 by Sunday we had crews in building offices.
3 And we had twenty-six different
4 places we put people, empty conference rooms.
5 You see this is just an example of a file room
6 that we stuck a table and phones in, and
7 converted classroom spaces. So fire chiefs that
8 have the training center, that's a room in my
9 office. It's a forty-person classroom. They
10 came in on Friday after the shooting we had forty
11 building inspectors working out of that office.
12 They'd come in and get their stuff and go out.
13 So those were goodie bags my staff
14 put together for everybody coming in. But you,
15 you know, again, it's sort of we weren't involved
16 in the shooting and all of a sudden victims are
17 in our house working for weeks.
18 Other things going on, just quick
19 temporary memorial. We knew people would come
20 bringing flowers and stuff. We were lucky, a
21 staff member had been involved in the Navy yard
22 and he said we've got to get ahead of this, so
23 they picked a spot. Building maintenance came
24 and started building some stands just on Saturday
25 morning. And within days this is what it looked

1 like. To the point of it started to rain, oh, we
2 didn't think of that. So somebody at the
3 Sheriff's Department had a tent. This became a
4 huge operation, got moved, and there's a whole
5 other class on how that was taken down later.
6 But mental health, we did some
7 immediate follow up obviously with all of our
8 crews. There were a lot of crisis response
9 teams. Hats off to the IFF, brought some people
10 in. You could not walk more than a hundred feet
11 around the courthouse complex in the days to
12 follow without running into a counselor of some
13 flavor from wherever.
14 Some we brought in, some we
15 didn't, and that was another big EOC role to try
16 to ride herd on that. We had a mental health
17 person embedded in EOC, every shift. She would
18 go around, very nice, and, but you couldn't go, I
19 nearly got hauled to VA three or four times by a
20 VA crew that was outside. And if I walked by and
21 they thought I looked tired, they wanted to haul
22 me off to the hospital.
23 So we did have an employee
24 assistance center. Originally it was in the same
25 place where we were dealing with the families.

1 We split that for obvious reasons, and we just
2 set up another office where you could go and
3 there were footballs, baseballs, whatever you
4 could go take a break. One department actually
5 went, there's a little nature trail nearby, they
6 brought a bunch of apples and went and threw
7 apples at trees for a morning.
8 We had EAP available. Made that
9 very quickly available and also recommended
10 people talk to their personal physicians. And
11 just this week we opened what we call the V.B.
12 Strong Center. Believe it or not, we have a
13 three-year contract to keep a center open to deal
14 with the consequences, community, family, and
15 employee. We have people, dozens of employees
16 who still have not returned to work.
17 But talking about us, this became
18 kind of an issue and it still is, what responders
19 were impacted. We had six ambulances, when we
20 wrapped up there were six ambulances sitting in
21 staging. They never saw a victim. What's their
22 stress level? How about the people who were
23 manning the concert at the Oceanfront, what's
24 their stress level?
25 And even those that were at the

1 scene that at most they saw one or two victims at
2 a time and these were gunshot victims. We see
3 this. So, you know, it's hard, we can't make
4 judgment calls for those people but it's, as
5 opposed to the five tactical medics and all the
6 police officers who actually got in the building
7 and touched each of the fatalities.
8 So working that, working through
9 everybody, I will tell you this is, there's a lot
10 of pressure to turn responders into victims on
11 things like this. And so trying to find that
12 balance to make sure that our folks are taken
13 care of, but, you know, if you're feeling okay
14 today is it wrong to feel okay today. Just what
15 we kind of talk about.
16 So just real quick, we have had
17 some after action discussion on the EMS, so this
18 is just kind of food for thought for you all.
19 You know, the little things, which side is side
20 A. For those of you in fire service, that's
21 natural, but this building has three entrances
22 and exits and it's building two, it's the ops
23 building, it's at the municipal center, it's at
24 the courthouse complex.
25 So a lot of, that creates some

1 confusion. We did have that initial command post
2 was very close, as I said. It was determined
3 that when the shooter wasn't completely isolated
4 that he could have leaned out of the window and
5 shot where we were at, so that was moved. Which
6 didn't cause much of an interruption, but that
7 was a police decision and we felt right with
8 that.
9 But I will say if you are doing
10 rescue task force or any type of CMCI training,
11 don't forget to integrate patient flow into your
12 training. And what I mean by that is we did
13 really well about getting the cops to get them
14 out of the building. And we did really well
15 about the firefighters to go in and get them.
16 But we didn't talk about what happens next.
17 So that police, that pickup truck
18 with three victims came out driven by a police
19 officer and he pulled right up to our treatment
20 area, one ambulance, unloaded the victim, and he
21 says, oh, my god, my god, there's only one
22 ambulance here and I've got two more victims.
23 And he looks at staging and says, ah, and drove
24 right off.
25 So staging where we didn't want

1 victims plopped, there's two more victims. So
2 and we worked through that. And then later
3 another victim came out and you had a rescue task
4 force at the treatment area. Oh, and I lost, the
5 ambulance attendant, so I'll indict my own
6 people, he disappeared on one of the critical
7 transports.
8 So now it's just the driver and a
9 fire crew. They get a critical patient, my god,
10 my god, there's no EMS people here, so they piled
11 in that ambulance and off they went to the
12 hospital. We grabbed onto it as they're leaving
13 saying where you going and we didn't really talk
14 about the idea. You're going to get to CCP,
15 you're going to say you got a victim, and we're
16 going to come help you.
17 So that was a lesson learned of
18 ours, just a fine tuning. With your rescue task
19 forces, this is another. We didn't really talk
20 about coordination from a command control
21 standpoint. We had a medical group or medical
22 branch and a kind of fire branch and the rescue
23 task forces were the fire branch, so we need a
24 little bit more talk across lines.
25 This is a task force forming, I

1 would say smart guy. He brought a forcible entry
2 tool because the police were calling for a lot of
3 those, so we have our firefighter bring his gear.
4 One of the things with training, in Virginia
5 Beach, State Police for us is basically the
6 Highway Patrol. We don't do much with them off
7 the interstates, but we had a huge State Police
8 contingent come out and some of them were
9 escorting rescue task forces.
10 We also had arson investigators
11 escorting rescue task forces. I know arson
12 investigators went through the training as
13 firefighters, but did they go through the
14 training as gun toters? So we in our follow up
15 training recommend anybody you think that's going
16 to show up with a gun to escort your task forces,
17 integrate them in your training.
18 And mutual aid coordination, we
19 had three different people, EOC, the supervisor
20 on the street, and the incident command post, all
21 calling for mutual aid, cancel mutual aid and
22 adjust, and that created a little bit of
23 confusion. So just something to look at.
24 Anyway, I will leave this. I've
25 gone long and I appreciate your time. But just

1 some points to ponder. As we've studied other
2 incidents and our own experience it's, A, no two
3 incidents are the same. The one in Ohio
4 recently, that shooter was, he killed a lot of
5 people but was taken out instantaneously.
6 Others, access problems.
7 Triage tags, we did not use the
8 triage tags. I think in retrospect if we could
9 have at least gotten the stub off the back as an
10 ambulance left we'd have gotten a little more
11 patient information. But we did know where
12 everybody went and whether it was a male or
13 female.
14 The idea of a treatment area with
15 the regular green tarps and lots of people didn't
16 ever evolve for us because the pace the patients
17 came out, I think that's more in line if you've
18 got your plane crash and everybody's laying out
19 in front of you. So think about that.
20 Body armor, there's a lot of talk
21 about body armor and I know many agencies are
22 actually on their second generation of body armor
23 for the rescue task forces and there's an NFP
24 standard. We had ordered it after we did the
25 rescue task force. In our policy we got some

1 employee pressure and political pressure. We
2 ordered it back in March. It wasn't there and we
3 did a number of successful rescues, successful
4 operation without body armor.
5 So we'll leave you with that
6 discussion, a local decision. We now have one
7 piece, EMS has one set of I'll call it nineteen-
8 pound steel bib. Three on every ambulance and
9 fire's got theirs on order. But we felt pretty
10 safe.
11 So what made this harder? I've
12 alluded to this. This was an attack on our home.
13 Those of us, particularly those of us in the
14 senior staff that had knew people that worked in
15 the building and we'd been in that building, so
16 that was the stress while it was going on.
17 And then in the days to follow,
18 you know, as you're in the EOC you're sitting
19 next to the public works guy you've been in there
20 with three hurricanes who's in there trying to
21 figure out who's dead and who's not. In the JIC,
22 we had PIOs from all the different departments
23 and there was a PIO from one of the affected
24 departments who had been in the barber chair
25 instead of the office.

1 And so this was a lot of waves of
2 emotion going on. And then we're responsible for
3 the recovery and this became a deal of, you know,
4 we're big city, eight thousand, nine thousand
5 employees with us and schools, so it's not
6 unusual for somebody to die in a given year. But
7 the benefits office might process one death a
8 year. And now the benefits office is processing
9 thirteen at the same time because, I say thirteen
10 because the shooter was a City employee.
11 And even the folks who handle
12 customer service, our citizens were great for a
13 few days. But the Planning Department is shut
14 down and no voicemail. So you want to put your
15 swimming pool in this week, how long are you
16 going to wait for somebody to help you? So the
17 customer service people started getting a lot of
18 heat, so and their jobs aren't really very
19 pleasant to begin with. So a lot of, what I call
20 for the weeks to follow, the fog of sadness
21 around the City.
22 And then the anger phase more and
23 more people, every issue somebody had the past
24 few years has bubbled up. So, but it was, we
25 were responsible for the consequence management.

1 It wasn't that it was a private site, which
2 really changed things for us. We knew these
3 people including at least one of these gentlemen
4 was in ICS 300 at Tim's just a few months prior
5 to the shooting, so.
6 So we lost twelve folks and that
7 brought it home for us. With that, I appreciate
8 the lengthy time, but did anybody have any
9 questions for me?
10 **UNIDENTIFIED SPEAKER:** Thank you
11 for taking care of your community and your
12 providers.
13 **MR. BRAZLE:** Well, thank you, I
14 appreciate that. We're very proud of them. Your
15 folks will step up and do what needs to be done,
16 I can guarantee you that, whatever happens. But
17 I did not believe, you know, if not the when, and
18 that's a clichand I didn't believe it. But it
19 can happen. It can happen in your community, so.
20 Thank you, Mr. Chairman.
21 **UNIDENTIFIED SPEAKER:** Chief, I
22 think we have a question for you. Just to start
23 off with a comment, thank you again for your
24 service. Every time we hear this presentation
25 from various presenters it takes us to the heart

1 of the matter and just a note to thank you and
2 all your men and women who responded to the
3 scene. So thanks for that.
4 What I wanted to ask, just
5 interested, after the Virginia Beach shooting one
6 of the biggest lessons learned there was about
7 the family assistance centers and the involvement
8 to support the community. Oftentimes as was seen
9 here, we can't necessarily save the victims
10 impacted, but every individual has a family and
11 the event, as you said, has ripple effects for
12 days on end.
13 I was curious what the role of the
14 EMS was in the family assistance center, if you
15 could talk about that. Because I hear it was
16 quite successful in this response.
17 **MR. BRAZLE:** Actually, in terms of
18 EMS, my department, we were just there kind of on
19 standby the first day. But our fire and police
20 departments, the real heroes of this day, thank
21 you for bringing this up. We made a decision
22 early to put a liaison with each family, both
23 those that were injured and deceased.
24 And so we went to their, we've got
25 really organized honor guards who have a little

1 bit of training in dealing with some benefits and
2 also dealing with the funerals and whatnot. And
3 so we put one member of either police or fire
4 honor guard with each victim for weeks. I mean,
5 we just pulled them out of their regular job
6 assignment and they stayed with these people the
7 whole time and have really become members of
8 their family.
9 And that was a huge difference.
10 They were the advocate when the family started,
11 you know, what's this about benefits or what's
12 this. Or just, you know, there was a lot of
13 pressure for City officials, which, is your
14 funeral public, private, do you want the governor
15 to come visit you at the hospital, do you want
16 the City manager. And there was a lot of
17 pressure there.
18 And having an advocate that could
19 say, ask those questions and then come back and
20 say yes, no, it was a big, big deal. And then
21 we've continued with the family assistance
22 centers since then.
23 **UNIDENTIFIED SPEAKER:** Awesome.
24 Just one other quick question. You emphasized
25 the importance of unified command a couple of

1 times. And so it sounds like you built the
2 relationships with the police department over
3 time. Is that something you practice for other
4 events such as hurricanes and others, or was this
5 a modified version of ...
6 **MR. BRAZLE:** No, it's something we
7 do all the time and it was not, it didn't happen
8 overnight. But it is something we do, there's a
9 lot of joint committees, but if we go like
10 something on the water, a big music festival in
11 April, we were in the same room for the whole
12 weekend working it jointly.
13 **UNIDENTIFIED SPEAKER:** Thank you,
14 sir.
15 **MR. PARKER:** Thank you. At this
16 point we have been at it for an hour. Is there
17 any opposition to taking a quick break? Hearing
18 no opposition, we'll take a ten-minute break.
19 **(WHEREUPON, a brief break was taken from 2:15**
20 **p.m. to 2:28 p.m.)**
21 **MR. PARKER:** At this point we're
22 going to head to the standing committee reports
23 and action items. Kevin Dillard.
24 **MR. DILLARD:** Okay, thank
25 you, Mr. Chair. Our next meeting is tomorrow at

1 1:00 and our grant grading process is ongoing
2 this month. We did receive 112 applications
3 requesting over $14.3 million. And then
4 Thursday, December the 5th, will be when our
5 committee gets together for the award
6 recommendations to the commissioner. And then of
7 course the awards will be effective after January
8 1st. Thank you.
9 **MR. PARKER:** Thank you, sir.
10 Administrative Coordinator Jon Henschel, and you
11 may continue with your rules and regs report.
12 **MR. HENSCHEL:** I have no report as
13 administrative coordinator, nor do I as rules and
14 regs chair since we didn't meet this session.
15 We will reconvene in February and I yield to Mr.
16 Samuels if he has anything further for
17 legislative plan.
18 **MR. SAMUELS:** The only thing I had
19 was I failed to thank Chris for his hard work and
20 everybody on all the committees and the Board who
21 worked to get the State plan passed earlier.
22 Thank you.
23 **MR. PARKER:** Make sure that
24 minutes reflect that it's Chris from the Office
25 of EMS. Not, you know, there's confusion.

1 There's how many Fergusons and now we've got
2 Chrises and I want to make sure everybody gets
3 their due diligence. Infrastructure Coordinator
4 Draymon Chandler [phonetic].
5 **MS. CHANDLER:** I have no report as
6 the coordinator, but I will defer to the
7 committee chairs for their reports from their
8 committees.
9 **MR. PARKER:** Transportation
10 committee Eddie Ferguson.
11 **MR. FERGUSON:** Yes, sir, thank
12 you. Transportation met on October 21st at the
13 Office of EMS. We had a good meeting. We met
14 from about 9:00 to about 2:30, 3:00 in the
15 afternoon. We reviewed the ambulance grants that
16 were passed on to us from FARQ, and so there were
17 thirty-nine ambulance grants that we looked at,
18 two QRVs, and one ATV. So we had a total of
19 about forty-two grants that we took a look at.
20 Having only attended that process
21 twice now, that's a really, really good process.
22 There's a lot of people on that group that know a
23 lot about vehicles and they do the homework and
24 they really put a lot of time into grading the
25 grants.

1 The committee also talked about
2 the committee in general and what we could do to
3 be involved more, not just during the grant times
4 of the year but possibly, you know, the other
5 times of the year. In recent years we canceled
6 some meetings, and so we're actually going to
7 meet in January or February and make sure that we
8 can have some other items.
9 One of the things we talked about
10 as a committee that we could lend some guidance
11 possibly to, one topic was the proper storage of
12 medications on vehicles. Not so much from the
13 lockable compartment standpoint but more from the
14 temperature and just proper storage of
15 medications. And so we'll look at that and we
16 look forward to meeting again. It's a good
17 committee and they do a lot of good work. Thank
18 you.
19 **MR. PARKER:** Communications
20 committee John Korman.
21 **MR. KORMAN:** The communications
22 committee met on October 22nd at the Virginia
23 Association of Public Safety Communications
24 Officials Conference, affectionately known as
25 APCO. This is just a fall conference for

1 Virginia's 9-1-1 professionals. The committee
2 hopes to rotate these meetings between the fall
3 and spring conferences moving forward.
4 Four discussion items came out.
5 One we talked about an avenue for public safety
6 answering points or 9-1-1 centers to receive
7 training and supplies for emergency medical
8 dispatch or EMD training. The, we work with the
9 grants committee to ultimately have, allow the
10 EMD programs have specific elements to receive
11 grant funding from the Virginia Office of EMS.
12 Number two, we talked about
13 electronic versions of EMD applications that are
14 used by dispatchers instead of index cards or
15 Rolodex equivalent. Material, using electronic
16 version of a, of a software type that interfaces
17 with the 9-1-1 center's primary computer system.
18 Discussion centered around some are quite robust
19 and others are not so dynamic.
20 Number three, the, we talked about
21 the EMD accreditation process and review process
22 for re-accreditation as part of Virginia Office
23 of EMS State Strategic and Operational Plan to
24 promote EMD standards and accreditation
25 throughout the, Virginia's 9-1-1 centers. So the

1 communications committee will provide guidance to
2 the Office of EMS to approve the accreditation
3 and re-accreditation process.
4 Of note, Rich Troshak who is an
5 emergency operations specialist with the Virginia
6 Office of EMS, is presenting a session on Friday
7 at 11:00 a.m. on EMD accreditation. It is geared
8 for everyone, whether you're an administrator,
9 ALS, BLS, medical director, whatever role you
10 play. And of course dispatchers are encouraged
11 to attend.
12 And the last thing we talked about
13 was the Virginia Department of Emergency
14 Management shared quarterly and bi-annual
15 training for communications cache equipment. And
16 that essentially allows radio communication
17 inter-operability to take place. So one
18 jurisdiction can talk to another on the same
19 event.
20 **MR. PARKER:** Excellent report,
21 thank you. Emergency management committee, Tom.
22 Not going to try.
23 **MR. SCHWALENBERG:** Not even going
24 to try it.
25 **MR. PARKER:** Nope.

1 **MR. SCHWALENBERG:** Good afternoon.
2 So emergency management met this morning. Pretty
3 good meeting. We talked predominantly on the
4 mental health survey results that were presented
5 this afternoon and basically our conversation was
6 focused on what would be next steps, where would
7 we go from there based on the information that
8 we're giving.
9 One of the requests that we put
10 forward was the ability to replicate this survey
11 at an agency level to make it more pertinent to
12 the individual agency. So OEMS staff is going to
13 look at that and see if that's possible to do
14 that replication.
15 And tying into Chief Brazle's
16 presentation, there's been some discussion about
17 the concept of a working group or a subcommittee
18 for tactical paramedicine and also sort of a
19 subset of that is with the release of the NFPA
20 3000, how does that work. Is there some areas
21 where we can make best practice or standards that
22 can be pushed out throughout the Commonwealth?
23 So that's something we're going to be looking on
24 in further. Beyond that, no other items. That
25 completes my report.

1 **MR. PARKER:** Thank you, sir.
2 Professional development coordinator Jason
3 Ferguson.
4 **MR. FERGUSON:** I have no report as
5 the coordinator. I defer to the individual
6 committees. For training certification we met on
7 October the 2nd. We discussed the advisory board
8 retreat as a potential for the upcoming changes.
9 Bill Acres [phonetic] reported that EMS was
10 included in the first phase of the VCCSG-3
11 initiative.
12 If funding is approved by the
13 General Assembly next session, Virginia residents
14 will be able to take initial certification
15 courses tuition free at community colleges.
16 The committee unanimously approved
17 the revised TR90A presented by the work group.
18 When it was presented to medical direction the
19 following day, several members felt that more
20 time was needed to review the document before
21 voting, so the item was tabled until January
22 meeting.
23 Chad Blauser [phonetic] agreed to
24 be the point of contact for the feedback from the
25 committee members. He is forwarding that

1 information to me and I'll address those
2 questions which each individual to maintain FOIA
3 compliance. TCC will review the feedback and
4 make appropriate changes if needed at our next
5 meeting.
6 There are three committee
7 positions that are up for appointment, VAVRS, EMS
8 for Children, and the Non-VCCS accredited
9 program. I'll be presenting the recommendations
10 from VAVRS and the EMS for Children to the
11 executive committee for approval.
12 As for the non-VCCS accredited EMS
13 program position, Chad Blauser has done a
14 phenomenal job in soliciting educators interested
15 in the position, posting their resumes and letter
16 of interest to a site for education program
17 directors to review candidates and cast their
18 vote. Voting closes on November the 15th and I'll
19 be including that recommendation for appointment
20 as well.
21 The cycle motor work group will
22 meet next month to review BLS cycle motor
23 testing. The committee also discussed the need
24 to promote AEMT certification programs. There
25 seems to be some confusion regarding the scope of

1 this certification level and its benefit to the
2 Virginia EMS system.
3 To the effect of examples were
4 given when at agencies that were discussing AEMT,
5 some providers said, well, EMTs can use AEDs
6 anyway, so why do we need AEMT. And then they
7 confused it with EMTA versus EMTB from the past.
8 So there seems to be some confusion.
9 This level will become
10 increasingly more important as initial education
11 programs for the intermediate level end this
12 year. OEMS scholarships have surpassed last
13 year's total but there have been minimal
14 applications for the AEMT level.
15 So the next meeting has been moved
16 to January the 15th to follow MDC that was moved
17 to the 16th due to a scheduling conflict. And
18 that concludes my report.
19 **MR. PARKER:** Thank you. Workforce
20 development Valerie Quick.
21 **MS. QUICK:** We will actually be
22 meeting Friday the 8th here at 10:00 a.m.
23 **MR. PARKER:** Thank you. Provider
24 health and safety Lori Knowles.
25 **MS. KNOWLES:** We did not have a

1 meeting in October. We did not have a quorum.
2 However, we do have three team applications for
3 CISM accreditation that meet all the
4 qualifications for that. And that would be the
5 Virginia Beach Police Department, the Henrico
6 County Police Department, and the Fairfax County
7 Peer Support Incident Support Services Team.
8 That's all I have.
9 **MR. PARKER:** Okay. Thank you.
10 Patient care coordinator Dr. Yee, and you may
11 give your medical direction committee.
12 **DR. YEE:** I have no report as
13 patient care coordinator. In terms of medical
14 direction committee, we have no action items to
15 bring forward, but we do have some awareness
16 items. We will be coming back at the next GAB
17 with an update to the scope of practice. We
18 have, we've already discussed medical direction
19 approve the change of epinephrine syringes.
20 Before we had dose limiting syringes and color-
21 coded syringes. Now we'll actually include other
22 devices that are clearly marked with dosages.
23 You'll see some other products on the market with
24 only one or two, .15 cc's and .3 cc's.
25 We also plan to bring forward the

1 more integrated healthcare document to the GAB,
2 likely at our next meeting. That's moving
3 forward and we continue to work on the critical
4 care. That should either come back to GAB at the
5 next meeting, at the upcoming meeting, or the one
6 after. That's all I have.
7 **MR. PARKER:** Thank you. Medevac
8 committee, Tim.
9 **MR. PERKINS:** The medevac
10 committee hasn't met since last meeting. It was
11 decided at the last meeting that because of the
12 air medical transport conference happening in
13 Atlanta right now that we couldn't do both. The
14 chair for those who don't know became a new
15 father recently, so that's also kind of had a
16 little bit of effect on meeting scheduling. The
17 medevac committee anticipates meeting some time
18 either at the end of this month or beginning of
19 next month.
20 **MR. PARKER:** EMS for Children, Dr.
21 Bartle.
22 **DR. BARTLE:** We met this morning
23 at 10:00 a.m. I'd like to thank the Office of
24 EMS for allowing us to coordinate our meetings
25 with the rest of the general governor's board.

1 No action items, but there are two items of
2 information. We are participating with the Near
3 Southwest Preparedness Alliance in developing a
4 pediatric annex to their disaster planning.
5 This is looking at the gaps in
6 preparedness for pediatric patients. Using the
7 information from the last National Pediatric
8 Readiness Assessment that EMSC did to see where
9 hospitals stand in their degree of preparedness
10 to take care of pediatrics.
11 The, even though they're using
12 that information, the next level of the
13 assessment is going to be coming out here next
14 year from, starting in January and hopefully to
15 have some information by July with this, to see
16 how well, more prepared we are with pediatric
17 preparedness.
18 The other thing I would like to
19 point out that EMSC sponsored some scholarships
20 for EMS providers to attend this meeting. We
21 provided fees to cover twenty providers to attend
22 the symposium and hopefully that will help speed
23 up along and expand the amount of pediatric
24 knowledge. That's all we have to report.
25 **MR. PARKER:** Thank you. Trauma

1 system coordinator Dr. Aboutanos and tag report.
2 **DR. ABOUTANOS:** Thank you, Mr.
3 Chair. Nothing specific to report from the
4 trauma system coordinator except to say that
5 we're very thankful that Cam is back and we
6 really appreciate the Office of EMS incredible
7 support lately with regard to our trauma system
8 committee. The trauma administrative and
9 governance aspect, the biggest item that was
10 discussed, we met this morning, was really the
11 trauma fund. And this is our biggest worry. We
12 think it's a significant threat.
13 We do appreciate the VHHA support
14 and the letter that they have written and the
15 effort that they're doing. Also appreciate
16 significantly that the letter that went to the
17 governor was signed by all the trauma center but
18 also by ten of the eleven regional council. And
19 I think this is only through these concerted
20 effort and that we're going to be able to find a
21 solution to this significant threat to the trauma
22 fund.
23 This will be ongoing work with
24 regard to that. The second is the main aspect of
25 the TAG committee is the provision of the

1 direction on, for both streamlining and the
2 coordinating the data reporting and analysis for
3 the trauma system at all levels, taking a public
4 health approach, defining the problem.
5 Really defining what is the
6 reporting on trauma at each of the levels of the
7 trauma system from pre-injury to pre-hospital, to
8 hospital, to the post-acute aspect. We have
9 mainly been working on asking every committee to
10 work on a benchmark that each of the part of the
11 system needs to meet. That's the main report for
12 the TAG committee, and let the other committee
13 chairs give their report.
14 **MR. PARKER:** Thank you. System
15 improvement, Dr. Safford.
16 **DR. ABOUTANOS:** So I report to
17 that. Dr. Safford could not be here. The main
18 aspect of system improvement was the provision of
19 a, of our report they put up together already.
20 The V-fib report that we're going to be
21 discussing probably the next meeting providing
22 all the information on the pre-hospital reporting
23 in regard to trauma.
24 One aspect of the report that the
25 system improvement looked at and I'm really

1 appreciative of the significant improvement we
2 have achieved in the reporting of all the basic
3 data with regard to blood pressure, vital signs,
4 and up to, what, ninety-eight percent reporting,
5 which is a significant improvement from before.
6 This is all, goes to all the efforts of all the
7 OMDs throughout the region.
8 The second was the system
9 improvement has provided to the TAG that this
10 report does go to all the regional council with
11 regard to where are we at with all the triage and
12 the data. And I think this will be a very
13 important initial report. However, the committee
14 has put additional modification it would like to
15 see in the report and hopefully that becomes a
16 standard way of providing data and significantly
17 appreciate the Office VMS, specifically Jessica
18 and then Cam and all their work with regard to
19 making sure we get the adequate data and
20 reporting structure.
21 The second most important part is
22 now the provision of the second report that would
23 be working on with regard to the hospital
24 registry data. For the past couple of years as
25 you know we've mainly been providing pre-hospital

1 data. And now with the integration of this
2 information we very important to see what is the
3 hospital, what is the trauma registry putting
4 out. Just because you got a patient to the
5 hospital, how are we doing once they get to the
6 hospital.
7 As the system improved we'd also
8 be looking at the post-acute care, what happened
9 at rehab. And all this is part of the system
10 improvement work. So expect the report to come
11 out the next three months and hopefully on both
12 the pre-hospital and the hospital aspect. There
13 were no action items.
14 **MR. PARKER:** Thank you. Injury
15 and violence prevention, Sarah Dinwiddie.
16 **DR. ABOUTANOS:** Sarah isn't here.
17 **MR. PARKER:** Okay, does anybody
18 have a report for her committee?
19 **DR. ABOUTANOS:** I don't, I have a
20 report, I just want to mention, sort of try to
21 pull this out. The main aspect with the injury
22 and balance prevention committee is also
23 similarly working on their data system and figure
24 out what additional benchmark that would be
25 provided.

1 One thing I have failed to mention
2 I will mention here, that hopefully the trauma
3 system would be taken forth is all the effort
4 that's ongoing with regard to gun violence. And
5 one thing to mention is the, there was a gun
6 violence symposium that was held for clinicians
7 and medical professionals about a couple of
8 months ago.
9 It was really based on the effort
10 of the director of Richmond City and Henrico
11 County Health District, and that's Danny Avula.
12 Who worked with both, two health system, the Bon
13 Secours system and the VSU health system to put
14 together a very important I thought symposium
15 where we had Secretary of Health and Human
16 Services Cary and also the Laurie Hotz
17 [phonetic], the senior director of legislative
18 affairs for coalition to stop the gun violence,
19 along with many other contribution from other
20 professionals to put together this symposium on
21 gun injuries and safety.
22 And this is very important. We're
23 hoping, it was very successful. We're hoping
24 this will be a movement throughout the state and
25 having every aspect of having a combination of

1 both public health and the clinical health system
2 and the health districts coming together to put
3 these kind of grass root effort in essence with
4 regard to gun violence.
5 Looking at it as a disease, not as
6 a political issue. But specifically as violence
7 secondary to guns, not with regard to gun
8 ownership, which always causes problems. So that
9 was a significant effort that we're hoping that
10 will move forward. But there was no action item
11 from the injury and balance prevention.
12 **MR. PARKER:** Okay, thank you.
13 Pre-hospital care, Mike Watkins.
14 **MR. WATKINS:** Good afternoon. The
15 pre-hospital care committee was not able to meet
16 this week due to scheduling conflicts. We're
17 scheduled to meet next Thursday, November 14th.
18 We were able to take the information provided in
19 the quarterly report and we'll be able to digest
20 that and develop the benchmarks at Dr. Aboutanos
21 discussed. As well as outline some of our other
22 specific asks for the system improvement
23 committee. And we've already started working on
24 some pediatric trauma triage criteria. Other
25 than that, we have no other action items.

1 **MR. PARKER:** Thank you. Acute
2 care, Dr. Young.
3 **DR. YOUNG:** Good afternoon. We
4 met yesterday. We're moving forward
5 aggressively with comparing the national of burn
6 College of Surgeons' criteria to the Virginia
7 designation criteria to try to get rid of
8 redundancies and see what areas are different
9 between the two criteria and whether those
10 differences actually add value to the care of
11 injured patients. We expect to bring action
12 items forward at the next meeting.
13 And then the next item that we're
14 looking at is since almost fifty percent of
15 trauma centers at the level one and two level in
16 the state are now American College of Surgeons
17 verified, how can we simplify the process in some
18 sort of way between the Virginia visits and the
19 ACS visits.
20 There are four states around us
21 that deal with this exact same problem. And we
22 are going to get information from those states of
23 how they've integrated the visits and how they've
24 arranged their programs to try to make it as easy
25 as possible and reduce the work that people need

1 to do to do both visits.
2 **MR. PARKER:** Awesome, thank you.
3 Post-acute care, Dr. Griffen.
4 **DR. GRIFFEN:** Good afternoon. We
5 met yesterday as well. We had several things
6 that are going to go forward from the committee.
7 One is we're asking for data as well from the
8 trauma registry from the State just to simply get
9 an idea of, for those patients who are discharged
10 from the hospital where they go. We don't even
11 know the answer to that question yet.
12 We're going to work on getting
13 national benchmarks with regards to where people
14 should go after trauma. That being rehab,
15 nursing care facility, or home. So that we can
16 look at what should be expected if those numbers
17 are out there versus what we observe through our
18 trauma registry here in the state.
19 And then we're also going to
20 hopefully finally be able to get the resources
21 that are available across the Commonwealth for
22 these patients to go to with regards to inpatient
23 rehab versus a skilled nursing versus subacute,
24 which is going to be interesting to figure out.
25 And whether if we even have the necessary

1 expected beds available across the state. So
2 that's what we're going to move forward with.
3 Thank you.
4 **MR. PARKER:** Thank you. Emergency
5 preparedness and response, Morris Reece.
6 **MR. REECE:** The emergency
7 preparedness and response committee did not meet,
8 but I did want to report subsequent to the
9 meeting we've had some conversations about the
10 role of this committee when it's being considered
11 with another committee that reports to this
12 Board, and that's the pre-hospital emergency
13 management committee.
14 So with the chair of that
15 committee and with Dr. Aboutanos' blessings, we
16 will be having some conversations about any areas
17 of overlap, how we might could eliminate a lot of
18 the duplication, or even ultimately perhaps have
19 a single committee structure for that. So we'll
20 keep the Advisory Board posted on the progress of
21 those conversations.
22 **MR. PARKER:** Okay, thank you.
23 Regional EMS Council Executive Director Greg.
24 **MR. WOODS:** Thank you. I do want
25 to mention that we are proud to be a sponsor of

1 the Fortieth Annual EMS Symposium as a group and
2 as has already been reported, we did meet with
3 the Office of Emergency Medical Services this
4 morning to continue discussions on ways that we
5 can improve collaboration and partnership with
6 the Office of Emergency Medical Services.
7 We do have another meeting
8 scheduled in December and plans for other
9 meetings. I do want to mention that we have had
10 multiple conversations and I want to take this
11 opportunity to thank the Office of EMS,
12 particularly Gary, Scott, Adam, Tim, and Chris
13 for their willingness to talk and to engage us in
14 conversations so that we can build and continue
15 to build the best EMS system in the nation.
16 And I want to thank Dr. Jaberi for
17 facilitating those conversations and engaging
18 with us. We look forward to our continued
19 conversations and thank you for all that you've
20 done so far.
21 **MR. PARKER:** Okay, at this point
22 we're down to public comment period. We're
23 following the Board of Health recommendations and
24 policy is for three minutes if there's anyone
25 that needs to come before the Board for any

1 public comment. You'll be limited to three
2 minutes and I'll ask Adam Harold to come forward
3 to work this box.
4 Is there anyone that has any
5 public comment to come before the Board? Any
6 public comment? Hearing no public comment, we'll
7 move forward.
8 There's no unfinished business on
9 the agenda. Thanks, Adam. I like to be
10 prepared. New business there is one item of new
11 business and that is to appoint a nominating
12 committee. The nominating committee will develop
13 a slate for presentation to you for consideration
14 at the February meeting for a chair, vice-chair,
15 and the committee chairs and coordinators.
16 I've solicited some names to bring
17 before you today for your approval. The names
18 are R. Jason Ferguson, Eddie Ferguson, Kevin
19 Dillard, Dr. Allen Yee, and Valerie Quick. All
20 have agreed to being on the nominations committee
21 with R. Jason Ferguson having been volun-told
22 into being chair.
23 So I put the names before you for
24 the slate for your consideration and subsequent
25 approval.

1 **UNIDENTIFIED SPEAKER:** Motion to
2 approve slate.
3 **AUDIENCE MEMBER:** Motion to
4 second.
5 **MR. PARKER:** The motion has been
6 approved and seconded. Any discussion? Valerie?
7 **MS. QUICK:** If you're on the
8 nominating committee, are you still able to be
9 nominated?
10 **MR. PARKER:** Yes.
11 **MS. QUICK:** Okay.
12 **MR. PARKER:** I'm sorry.
13 **(WHEREUPON, inaudible comments from audience.)**
14 **MR. PARKER:** Any other discussion?
15 Hearing none, we'll call for, sorry.
16 **UNIDENTIFIED SPEAKER:** Sorry, one
17 quick comment. Gary Brown had asked me to
18 mention this earlier. Just to say as a fun
19 closing comment, so we have a couple of guests
20 from Rwanda arriving today to participate in the
21 EMS symposium that have been a part, we've been
22 collaborating with them. I as a representative
23 of VCU but really also the Office of EMS and
24 they're just absolutely thrilled to attend this
25 symposium. Again, they want to participate in

1 this symposium every year and they're building
2 that as a part of their growth.
3 But in particular, we're having
4 them, along with a couple of the Germans that are
5 arriving, Kevin Dillard is leading, have them do
6 a global EMS panel on Thursday at 11:00. And
7 part of what that, what we're going to ask them
8 to talk about is also their Ebola response
9 management, which they most recently were
10 actively participating in because it came very
11 close to their border. And so that's the main
12 city in the Congo where it has been contained, is
13 just right on their border.
14 So they have a lot of firsthand
15 experience, sort of leading that effort. And so
16 I thought that would be an interesting discussion
17 for them. So we just wanted to kind of mention
18 that as an opportunity for again how much this
19 symposium really has a reach internationally and
20 how much collaboration there is. Thank you.
21 **MR. PARKER:** Absolutely, thank
22 you. So we'll go back to the motion that's on
23 the floor for a vote. All in favor signal by
24 saying aye.
25 **(WHEREUPON, members responded aye.)**

1 **MR. PARKER:** Any opposed?
2 Abstain? Excellent. The last item that, to
3 bring before you is a reminder of the Spirit of
4 Norfolk cruise tonight. And Ms. Irene has
5 tickets for the Advisory Board members that
6 responded and I believe there's still tickets
7 available on the third floor if you so need to
8 purchase. And at this point we'll take a motion
9 for adjournment.
10 **AUDIENCE MEMBER:** So moved.
11 **AUDIENCE MEMBER:** Second.
12 **MR. PARKER:** Any opposed? Hearing
13 none, motion to adjourn.
14 **(WHEREUPON, the meeting was adjourned at 2:56**
15 **p.m.)**
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1 CAPTION
2
3 The foregoing matter was taken on the date, and at
4 the time and place set out on the title page hereof.
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6 It was requested that the matter be taken by the
7 reporter and that the same be reduced to typewritten
8 form.
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1 CERTIFICATE OF REPORTER AND SECURE ENCRYPTED
2 SIGNATURE AND DELIVERY OF CERTIFIED TRANSCRIPT
3 I, **JULIE CARY**, Notary Public, do hereby certify
4 that the forgoing matter was reported by stenographic
5 and/or mechanical means, that same was reduced to
6 written form, that the transcript prepared by me or
7 under my direction, is a true and accurate record of
8 same to the best of my knowledge and ability; that
9 there is no relation nor employment by any attorney
10 or counsel employed by the parties hereto, nor
11 financial or otherwise interest in the action filed
12 or its outcome.
13 This transcript and certificate have been
14 digitally signed and securely delivered through our
15 encryption server.
16 IN WITNESS HEREOF, I have here unto set my hand
17 this 13TH day of NOVEMBER, 2019.
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20
21
22 /s/ JULIE CARY
23 COURT REPORTER / NOTARY
24 NOTARY REGISTRATION NUMBER: 7814058
25 MY COMMISSION EXPIRES: AUGUST 31, 2023

Q

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