COMMONWEALTH OF VIRGINIA

DEPARTMENT OF HEALTH

OFFICE OF EMERGENCY MEDICAL SERVICES

IN RE: RETREAT, DAY ONE

HEARD BEFORE: RYAN S. STARK, ESQ.

RETREAT FACILITATOR

SEPTEMBER 16, 2019

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I N D E X

(The EMS Advisory Board Retreat discussions commenced at 10:00 a.m.)

MR. STARK: Good morning, everyone.

BOARD MEMBERS: Good morning.

MR. STARK: That one requires a response. Good morning. I know it's Monday morning. I get it, I get it. You know, tough loss. Apologies -- any Redskins fans in the room here?

BOARD MEMBER: Yeah.

MR. STARK: Yeah. I'm a Steeler fan, so it's going to -- it's looking like a long season for us, you know. This is going to be tough. My name is Ryan Stark and I'll be today's facilitator.

And I'm with the law firm of Page, Wolfberg and Wirff. I'll get into it a little bit more about who our law firm is in just a few moments. But we are based in Harrisburg, Pennsylvania. See a couple of

familiar faces here from our conferences that we run. We operate exclusively and represent exclusively folks in the EMS industry.

And you know, we represent folks all across the United States. And you know, I was just talking to them about, you know, the whirlwind of travel that I've been on recently.

Seems like this is, you know, conference time and we're really gearing up for everything. So having said that, I want to thank everybody for being here today. I know all of your time is valuable.

I think what we're going to do here today is very, very, very important. It means a lot to the folks of your state. It means a lot to the providers that you serve and, you know, the other folks that you represent within the -- the Commonwealth of Virginia.

With that, I'd like to just go around the room, just have everybody just state their name and where they're from. We will start with doctor -- and I'm going to

butcher your last name, sir.

DR. ABOUTANOS: Go ahead.

MR. STARK: He's clever, this one.

DR. ABOUTANOS: It's Aboutanos.

MR. STARK: Aboutanos. Aboutanos. Okay, Dr. Aboutanos, we will start with you and then just go around the room in a clockwise fashion.

DR. ABOUTANOS: Mike Aboutanos. I'm the medical director at VCU trauma center.

DR. BARTLE: Sam Bartle. I'm the pediatric emergency medicine physician down at VCU Medical Center.

MS. CHANDLER: I'm Dreama Chandler, representative of the Virginia Association of Volunteer Rescue Squads.

MR. DILLARD: Kevin Dillard, I'm the president of the Virginia Ambulance Association.

MR. BOLLING: John Bolling, representing Southwest Virginia Emergency Medical Services Council.

MR. TANNER: Gary Tanner. I'm from Appomattox and I'm representing VACO.

DR. O'SHEA: I'm Jake O'Shea. I'm the division chief medical officer for HCA's capital division. I'm here with VHHA.

DR. YEE: I'm Allen Yee. I'm the operational medical director for Chesterfield Fire and EMS. And I'm here representing Virginia College of Emergency Physicians.

MR. SCHWALENBERG: Tom Schwalenberg, City of Chesapeake Fire Department. And I'm representing the Tidewater EMS Council.

MS. MARSDEN: I'm Julia Marsden. I'm from Burke, Virginia, and I'm the consumer.

MS. ADAMS: I'm Beth Adams. I'm quality manager for Fairfax County Fire and Rescue representing Northern Virginia EMS.

MR. HENSCHEL: John Henschel from Newmarket, representing the Lord Fairfax EMS Council.

MR. PARKER: Chris Parker from Lynchburg. I represent the Virginia ENA and the Virginia NA and chair of the Advisory Board.

MR. R. J. FERGUSON: Jason Ferguson representing Blue Ridge EMS Council.

MS. FERGUSON: Pier Ferguson representing Old Dominion EMS Council.

MS. QUICK: Valerie Quick representing Thomas Jefferson EMS Council.

MR. CRITZER: Gary Critzer, EMS representative to the State Board of Health.

MR. LAWLER: Matt Lawler, Augusta County Fire and Rescue representing the Central Shenandoah EMS Council.

MR. D. E. FERGUSON: Eddie Ferguson, Fire and Rescue Chief, Goochland County, also representing Virginia State Fire Fighters Association.

MR. SAMUELS: Gary Samuels. I'm a retired fire fighter from Henrico County and I represent the Virginia Professional Fire Fighters Association.

MS. DANIELS: Valeta Daniels. And I represent the Virginia Association of Volunteer Rescue Squads.

MR. W. B. FERGUSON: Billy Ferguson, director of public safety in Franklin County, Virginia, and I represent VAGEMSA.

MR. STARK: Great. We may have a few folks join us a little bit later this morning. But by and large, we have a pretty good representation here today, so good to see.

I -- I said that I was going to talk a little bit about my law firm. Yeah, we're based in Harrisburg, Pennsylvania, but we really -- I mean, we ought to open up an office in Texas and California.

And we do a lot of work in Virginia as well. One of the things that we do is EMS system evaluations. We do a lot of that in California. They operate on EOA's out there, exclusive operating areas.

But we do it both on the statewide level and county level. Interesting fact about Virginia that I learned.

You guys have the third most number of counties out of all the states in the United States. That's -- that's crazy. That's a lot of government, right? So I -- I was just looking at county data -- I was

doing my research. You know, I went through board training and everything before I came down here. So I was looking for everything.

On the way down here, I didn't know this, but iPhone, it has an option to dictate just about any screen that you want. So I was listening to your Board meetings last night on the drive down here.

So thankfully, I stayed awake for the most part. But -- but yeah. And it's funny when -- when iPhone dictates to you, you know, how each -- each page is -- or each line is numbered.

So it will say, one, and then it will say the -- the phrase. But you know, I've been familiar with some of the innerworkings and what's ongoing.

I'm going to let Chris, in a little bit here, tee up sort of the agenda for today. But we have some, you know, broad objectives that we want to accomplish.

And our law firm, like I said, we represent clients all across the United States. And on from, you know, mom and pop volunteer operations up through large EMS

systems. I've been with the firm -- I am a partner with the firm. I've been with them, gosh, 12 years now.

And just a quick history, a lot of our folks -- a lot of the attorneys in our firm have, you know, experience as providers and as -- as administrators.

Other interesting fact, the Page in Page, Wolfberg and Wirth -- for those of you who are familiar with the show 'Emergency!'. If you remember the character Johnny Gage, right?

BOARD MEMBER: No.

MR. STARK: No. The heart throb that is Johnny Gage. That was actually based on Jim Page, one of our founding partners. And Jim Page -- if you look him up, he's got a Wikipedia page.

They call him the father of modern EMS. And he was one of the guys who thought, why shouldn't e have -- I know I'm going to trip over the cord sometime today. Why shouldn't we have a paramedic first do

-- in England, every fire engine. And he was one of the innovators of that idea. But he -- when they started the show, Jack Webb -- the creator of the show -- approached Jim.

And Jim was a technical advisor on the show. He wanted to name the medic Johnny Gage, Jimmy Page. And Jim said, no. In case the show tanks, I don't want my name associated with that.

So with that, let's move on. And I just want to give us, you know, a little bit of historical context. I was thinking about this last night on the way here.

And you know, we've talked about EMS 2050 is sort of the backdrop and we're going to allude to that in just a moment here.

And you know, just how different things are going to look years down the road. And one of those things we need to keep in the backdrop is what is -- what is EMS going to look like in the State of Virginia, you know, even in a decade from

now. You know, last night when I was on I-95 on the way down here, I was actually in the State of Maryland. So I won't hang out any Virginia providers.

But ambulance got on the -- the interstate and I saw the lights -- red lights and sirens on. And you -- what does everybody do on the interstate when red lights and sirens go on?

BOARD MEMBER: Slow down.

MR. STARK: They slow down, or they go all over the place, right? And I was just thinking, one of the things in the EMS 2050 is that, you know, decades from today we may do away with that practice.

You know, point being the things that we're doing today, the rationale and the reasons behind what we're doing today may cease to exist, or may not need to exist today.

The more we hang onto, well, that's the way it is. It's the way it should be, the more we're going to get

caught flat-footed. And I don't want to over-state the importance of this retreat, but this is really for you folks.

We can come in here and air grievances and air gripes, you know, talking about current problems. Or we can be responsible for the people that we serve.

A couple of weeks ago -- I was thinking this last night. I stayed at a Marriott just like this and -- and all Marriotts look the same.

You know, I walk in, I see the same vase in the room that I walked into. And it was actually in Gettysburg. And one of the things I like to do when I go to places, I go out and I usually run around the town.

Well, I ran around the battlefield that morning. And I saw the place where Abe Lincoln gave the Gettysburg Address and I read the Gettysburg Address that morning.

And you know, one of the things he said -- and I'm paraphrasing here. He's like, folks years from now aren't going

to remember what we said here today. But they're always going to remember what we did. I want you to think about that context. Like I said, I don't want to over-state the importance of today's meeting, but I don't want to under-state it, either.

Folks aren't going to remember what we did. But I want you to lay the foundation of folks -- or something that's going to be long and enduring in the State of Virginia.

You know, Virginia is a very complex state. You have beaches, you got mountains. You are geographically diverse. You have 35,000 plus providers in the state. 130 PSAP's, 674 agencies.

And you guys have always been at the forefront of EMS. It's always mentioned in the same vein as a lot of state systems who are at the forefront.

You guys have -- I was reading you have disaster relief teams that bring dogs to help with stress. You guys are doing resilience training and things that are on the forefront right now. But if you

read through this, you know, and we think about the context that we were in the last time we were at one of things. Last time they wrote an EMS agenda, they foreshadowed the beginnings of local integrated health care. And we're there today.

The stuff that's being foreshadowed in here is that we're only going to be transporting about 10% of the time in the future.

We can hang on to what we've hung onto for years, or we can think about the reality and where we're going. And think about ideas and ways to streamline what we're currently doing, whether or not it works for the folks that we serve.

So couple of principles that I took from EMS agenda that I want to sort of guide us today is let's avoid the temptation to wallow in the current problems. Okay?

If you have an issue, state it. We'll address it. But let's move on. Let's think, you know, more broad -- more broadly. Let's focus on ambitious ideas for the future. I want you to commit to be open

and inclusive. Everybody's going to have a chance to be heard today. Okay? I can't promise you that everybody's suggestion that is offered today is going to end up in the ultimate recommendations that we prepare.

But everybody's going to have a chance to be heard. And I want you all to openly listen to one -- one another and the criticisms and the critique. I also want you to ask before talking here today, too.

Ask two things; one, does it help. Does it help, okay, or am I just venting. And number two, is it respectful. Those are our ground rules for today. We're all here for the same reason.

You're all volunteering your time on this Board because you feel a stronger calling to help others. You know, we are beholden -- we are the eyes and ears of OEMS.

We're beholden to the folks that we serve. So with that as a backdrop, I want to thank you all for having me here today. And I'm going to turn it over to Chris to talk broadly about the agenda and

-- and get us tee'd up for the morning.

MR. PARKER: So when we think back to where we were in August at the Executive Committee and at the Advisory Board meetings, we kind of had a general theme towards why this retreat was happening.

And a lot of that stems from, are we doing today what we need to be doing in the future, as we alluded to in the -- from the EMS Agenda 2050 document.

So over the course of today and tomorrow, we want to look at everything from committee structures to composition. Look at Board structure, kind of figure out where we need to go.

And then hopefully by the end of this, we'll have some kind of document or idea of where we can take, both this Advisory Board as well as the principles forward.

In talking to a lot of the folks over the last couple of weeks, some of the same things that we find out -- and I'll kind of pick on John for a moment. When you

get on the Board it's like, here you go. What guiding documents do we have? And so as you look at the Board composition documents, some of that needs to be updated.

Not necessarily to reflect what we're going to do in the future, but to reflect what we have right now. And so, it's kind of what we look at and what we want to think about for this. So first off, let's start discussing where we want to go.

MR. STARK: Yeah. One of the main things that we want to talk about is, you know, the current composition of the Board, you know, and whether or not -- you know, any suggestions regarding the current composition and whether or not it needs to be streamlined.

Whether or not we open it up, and there are other issues that we need to address. So Chris, we talked this morning a little bit. So I'll offer it up to you to start the discussion regarding, you know, areas that you think -- you know, just to get the ball rolling here, that we can see

some streamlining.

MR. PARKER: So let's start with the committees. I think that would be a great place to consider starting. There's been some discussion from folks, I've received some emails about overlap on some of the committees.

And I think that might be a good place to consider, are there committees that are effective? Are the committees actually -- do they have defined goals and objectives?

Because if you look at the Trauma Committees that we have, they have defined goals and objectives -- some of which are things that are already being covered by other committees.

The standing committees of the Advisory Board, the previous committees actually didn't have goals or objectives. And so when you're trying to figure out do we need to have actual streamlined goals and objectives for all. Kind of make it uniformed throughout. What do you guys

think?

MR. STARK: Do we see some overlap? Nobody -- nobody wants to be the first to -- to chime in here.

MR. R. J. FERGUSON: Yes, we do.

MR. STARK: Yes, we do. There's a start. Can you be specific?

MR. R. J. FERGUSON: Well, Chris gave a couple of examples. And just the -- that there is a bit of disconnect from some of the guidance documents and bylaws that we currently have.

Even if you look at the -- the make-up of the committees compared to what's on the web site, it was a bit -- so there's a little confusion there for maybe an outsider looking in.

And then as far as some of the meetings, I -- I try to make it a point to attend different committee meetings over the last couple of cycles here. And you know, a

lot of it you do -- you hear the same, exact -- we're trying to do this and we're trying to do that, you know. But you know, how -- do we really need so many different groups?

Or maybe -- maybe it's something to the effect of maybe some of these other committees just need -- need to restructure and put a seat on the existing committees, so that there's representation of different groups. But yet, not a whole separate committee for that group.

MR. STARK: Well, we're seeing duplication --

MR. R. J. FERGUSON: Yes.

MR. STARK: -- of purpose here. That's also indicative of lack of communication, too, among these committees. I think, too, as an outsider and one of the things that I can make -- or my objective is to just look at the current, you know, objectives of each of these committees and subcommittees and, you know, determine

whether or not we're seeing a lot of duplication here to the extent that you folks can identify some of this stuff for me.

We'll have somebody collect comments and we'll do sort of a central depository. You know, but where we have duplication overlap, there's no reasons for that.

This is always a problem in EMS, by the way. Do we do it more centralized or, you know, more regionally? And the trend is going to a more centralized administration of the EMS system, both nationwide and per state.

We're seeing, you know, the adoption of national standards with REPLICA, Compass and you know, with reciprocity among providers and things like that.

So I want you to think also about can this function be more centralized as well. We always need to be accountable to, you know, the regional groups. And we also want a physical, you know, connect with the providers in -- in areas and things like

that. But can some of these things be more centralized? Appreciate the comments, Mr. Ferguson. Yes, sir.

DR. ABOUTANOS: You say comment. Again, as you say, I don't mean to offend anybody. But please don't take any offense on what I say. So the -- I'm confused a little bit.

Because we started this as a community structure, not what is our function, what is EMS? And EMS is just a different way, in my understanding, that the -- there's a -- I heard you multiple times say the word provider.

We're provider of EMS. And Gary and I had this thought a long time ago as far as what is EMS to the State? And does EMS only pre-hospital?

If it is, then that's a totally different discussion than the understanding that EMS goes all the way -- involves the entire system. And pre-hospital is a dominant and very important part. But from the system

approach, you know, is -- is the role of -- of this Advisory committee to address the entire system or is it only the pre-hospital?

Because that -- we know that's fundamental. Once you look at that, then you look at the committee structure and say, do the committee structures fulfill the true vision and mission that exists.

So I think that's kind of -- I mean, that's where the piece where trauma have come in and we decided -- I just don't want to cause too much of a -- maybe you were getting there. That's okay. I just want to make sure that's -- that's understood.

MR. STARK: Sure. So what context are we working from here? Yes, sir.

MR. CRITZER: Gary Critzer, State Board of Health rep.

MR. STARK: Thank you.

MR. CRITZER: The Code of Virginia's pretty clear. This Board represents the EMS system, all components of the EMS system. Whether that's pre-hospital, in -- trauma care, all aspects of EMS are represented by this Board. So that's what this Board is to focus in on.

MR. STARK: Yep, that's a broader focus. So I'll just ask you, you know, to dovetail on the discussion that we're having this morning. You know, what about the current composition, you know, of the Board and of committees right now?

What are your thoughts on the current composition and do you see any rooms for changes, improvements, etcetera?

MR. CRITZER: I like to be put on the spot. As with anything else, I think there's always opportunity to review how we've done it and how things need to be done in the future. EMS -- this Board has evolved over the years from larger in size to the size it is now. We've added seats,

taken seats away. And the system around us has evolved significantly since the last opportunity to really comprehensively look at this Board.

So I think there's an opportunity here to look at our system make-up, and how this Board fits into that make-up, and how you -- the representative that set on it.

So I do believe there's an opportunity to -- to evolve our -- bring our Board in line with the -- the make-up of our system, both now and for the future.

MR. STARK: Other comments?

MS. DANIELS: Valeta Daniels. So my -- my current concern about do they have all of the Board -- just a quick show of hands. Who's an actual EMS provider in the street right now?

BOARD MEMBER: You mean every day?

BOARD MEMBER: Yeah, and how long?

MS. DANIELS: Every day, intermittently.

BOARD MEMBER: Yeah, yeah, this is true.

MS. DANIELS: But it's more -- to me, it didn't act as -- does not accurately reflect our system. And even our system -- fire-based, EMS-based -- 80% of the calls with EMS.

And it doesn't seem like every -- obviously our positions, our -- you know, our nurses associations, those are all very important.

But I don't think it accurately reflects what we do in the street as far as EMS-wise. And that's -- I feel like we're kind of losing that.

MS. ADAMS: Beth Adams, can I ask a follow-up question? Are -- are you seeking to have more active providers on the Board -- on the Advisory Board?

MS. DANIELS: I -- I would -- I would personally like to see that, but I also want to see someone from southwest Virginia. I want to see someone from Northern Virginia.

Kind of a dichotomy or big scope of it. So if you just add a couple seats and you had southwest Virginia EMS provider and, you know, vary through the state so it's an accurate reflection of what we have across our state.

MR. PARKER: So we currently have that. Because we've got the councils represented across the state.

MS. DANIELS: A lot those council members don't still provide in the street.

MS. ADAMS: So -- so what you're seeking is representation of the people out there on the front lines each and every day, not people who are more, perhaps, administrative or --

MS. DANIELS: Correct. Then not pose we're not important because they are. However, when it comes to making broad scope decisions for southwest Virginia and for Virginia Beach and Metropolitan Richmond, those could be three different goals with three different issues going on that maybe someone did not think of.

MR. SAMUELS: Gary Samuels, so I -- I understand where everyone's going. But the current make-up of the Board, as we see it today -- each of those regions have a seat at the table.

And they have the ability to put active providers on that seat for the Board. And it's decided by their region, i.e, ODEMSA picks their person to put on the Board.

Southwest picks their person to put on the Board. But all of those issues that person reviews goes back to their region to -- to have discussions. And the regional directors also have input for the regional directors meetings. So these

things kind of -- it -- you build a funnel and you kind of start with all of the things happening up here.

And then when it gets to the Board, even the docs have their -- they funnel things down to where we're looking at what's coming from each of the regions or from each of the interests groups, whether it's trauma, whether it's fire fighters, whether it's paid, whether it's volunteer.

So the make-up of the Board needs to be diverse, yes. But it needs to be looking -- and -- and I kind of agree with Gary on this.

It needs to look at the whole system -- the system as a whole so that when we make decisions as a Board, we're recommending things to the Board of Health.

We're not a policy Board, but we're recommending to the Board of Health that what we see the future may look like. Or how we want to have our rules and regs and -- and so we kind of funnel things to -- to the Board of Health for them to, you know, fill all the big items, I think. But

we set kind of a guideline with all the different interest groups. I mean, if you really created a board that only looked at one single piece of the picture, then that would be from the time we get the 911 call to the time we drop the patient off at the emergency room door.

That would be -- that would be provider-focused. Because after that, we wouldn't worry about how that patient got through the hospital, when they -- when they came through to physical therapy or rehab.

You know, we wouldn't be worried about it on the back end. We wouldn't be looking at evidence-based practices. We would just be looking at from the call to the drop off. That would be a solely pre-hospital focus.

DR. YEE: So -- Allen Yee, VACEP. So I agree with Dr. Aboutanos, you know, in terms of how do we define the system. Are we in -- I hate to use the term, but are we talking about paramedicine, which is the out of hospital component? Are we going to

include the in-hospital and post-hospital component, which is absolutely important. But is it part of this? Because then we've limited it to trauma.

But there's pediatrics, right? There's strokes, STEMI, regular internal medicine, family practice, OB/GYN? Are we going to have all these different -- you know, neurosurgery, neurology, all that.

All these subspecialties involved in our -- in our Board now. So it's a slippery slope.

MR. STARK: Comments.

MR. CRITZER: Gary Critzer, State Board of Health. I'd ask for you to think of it even in a little bit broader scope. Right now, our Board is representative of a lot of associations and organizations.

Think of it more -- similar to what we did with the trauma system in terms of how it relates to the patient. You know, injury prevention. You have trauma surgeons. You have EMS physicians. You

have EMS providers. You have fire service EMS providers. Not so much organizational-based, but more look at the system as a whole -- the components of the system, and then provide representatives for each one of those components.

And what does the system represent? You might not have to have all those different positions. Maybe you can -- collectively you do that for your committee structure.

But that's something this Board's going to have to work through. And that would be a drastic shift in the way we've done this.

We'd be moving from VAGEMSA has a seat and BARS has a seat and regional councils have a seat and the nurses association has a seat, too.

There's an emergency nurse, there's an EMS physician, there's a trauma surgeon, there's a pediatrician. There's an intensivist. There's blah, blah, blah, blah, blah. A lot of Board have driven themselves in that direction. The State

Board of Health has done that. It's -- it's made up more of position-specific versus organizational-specific.

So you may want to think -- and I'm just putting it out there as food for thought. As a different way of looking at how this -- what this Board truly represents.

MR. PARKER: I want to echo Gary real quick and then I'll send it over. In discussion, both this morning and previously with Gary, one of the problems that we had is finding someone that represents said organization on each committee.

There are several committees that have open seats or they may have someone that'll fill a seat from that organization that never shows up.

That's how I ended up as chair and L&P for a while is because the person that had represented that on the Board did not come to any of the meetings. And so we've found ourselves backed into -- backed into a corner in that aspect. So...

DR. ABOUTANOS: I just want to kind of, I guess, echo a little bit of what Gary said, also. And sort of back on what Allen said. I think there's a little misunderstanding. It's a slippery slope if you look at the field, I believe in that.

But that's not -- well, it isn't trauma. We were very careful in saying we need someone that will bring -- you know, before the -- the event happened and before the hospital, hospital, and then post and acute phase.

And then looked at getting epidemiologist that we could have -- getting better to make them that space. And I think that -- it just applies more to the system.

I'll give it to you, if we started going with each field, then at this that was started. If you are headed from in the hospital, where is the hospital representative truly?

And that -- and that may change. Some times our composition may be -- may be a trauma surgeon are badly needed physicians. Other time, it may be -- you

may need somebody -- a pulmonologist. Somebody with that -- you know, like I think it's a system approach to it.

And that was acting -- that's the main thing in trauma that we try to avoid doing was the big feeling that I will just go with just trauma surgeon. And then it'll be a acute phase and that's it.

MS. ADAMS: Beth Adams, Northern Virginia. Perhaps we are premature in our discussion of committee structure. Maybe we should -- I kind of feel like we're figuring out carpet and drapes when we haven't figured out the floor plan.

MR. STARK: Sure.

MS. ADAMS: So maybe we would be well served to back it up a little bit and look at the legislative structure for why we exist, how we exist and -- and then decide if we're going to use a one size fits all or are we going to develop a structure that recognizes the diversity of Virginia, from

the coast to the mountains, from the cities to the hamlets.

MR. STARK: Sure. No, it's a good point. Let's start with legislative structure. Why we exist as a Board? What is our mandate? What do we do? What are we tasked with doing under the law?

MS. ADAMS: I defer to the Department of Health on that.

MR. STARK: Sure. Yes, sir.

MR. R. J. FERGUSON: Items one through four --

MR. STARK: Yep.

MR. R. J. FERGUSON: -- under the Code of Virginia, 32.1-111.10.

MR. STARK: 32.1-111 --

MR. R. J. FERGUSON: .10. There

are four items. That section of the Code --

MR. STARK: Yep.

BOARD MEMBER: -- speaks to the make-up of the Board and what they're charged to do.

MR. STARK: Okay, go ahead.

MR. R. J. FERGUSON: Advise the State Board of Health on the administration of this article.

MR. STARK: Advise. Okay, two.

MR. R. J. FERGUSON: Review and make recommendations for the Statewide Emergency Medical Services Plan and any revisions thereto.

MR. STARK: Okay, three.

MR. R. J. FERGUSON: Review annual financial reports of Virginia Association of

Volunteer Rescue Squads as required by 32.1-111.13.

BOARD MEMBER: It's current?

MR. STARK: Okay, and four?

MR. R. J. FERGUSON: Well, four with the [inaudible].

BOARD MEMBER: I want to ask because when I look at that section specifically, it says it's been repealed.

MR. R. J. FERGUSON: Okay.

BOARD MEMBER: That's the only reason. Okay?

MR. R. J. FERGUSON: I stand corrected.

MR. STARK: Well, hold on just a second here.

BOARD MEMBER: How is it -- I came up with 32.1-111.4 as the -- the current.

MR. CRITZER: That's correct.

BOARD MEMBER: Okay.

MR. STARK: Okay.

MR. R. J. FERGUSON: It's .4?

MR. CRITZER: 32.11 -- 32.1-111.4:1, State EMS Advisory Board, purpose, membership, duties, etcetera.

MR. STARK: Okay. So what -- let's read from the current section then.

MR. PARKER: Hereby created in the executive branch, the State Emergency Medical Services Advisory Board for the purpose of advising the Board of Health --

MR. STARK: Okay.

MR. PARKER: -- concerning the administration of the Statewide Emergency Medical Services System and emergency medical services vehicles, maintained and operated to provide transportation to people requiring emergency medical treatment and for reviewing and making recommendations on the Statewide Emergency Medical Services Plan. And then there's a whole lot more about the make-up of the Board.

MR. STARK: Okay. I actually made some notes this morning I think this accurately reflects. So basically, you know, in my reading -- first and foremost is what I distilled here, is you are the liaison for OEMS to the public.

You -- you review and make recommendations -- review and make recommendations for the Statewide EMS plan. Review reports on the status of the system. And what was the final one that you had there?

MR. PARKER: So under D it does

state the Advisory Board shall establish an Advisory Executive Committee to assist in the work of the Advisory Board.

The Advisory Board Executive Committee shall, in addition to those duties of the Advisory Board Executive Committee, review the annual financial report of VAVRS as required by the Code of Virginia.

MR. STARK: Okay. And then the exact reviews. Okay. So this is our -- this is our -- the mandate of the Board. So we're out there, you know, we're a liaison to the public. Who does that currently on the Board? Who's our liaison to the public?

MR. PARKER: We all are.

MR. STARK: You all are? And the regionals? You guys also review and make recommendations to the State EMS plan. Well, so we need to look at the constituent components of the EMS plan, right? And whatever those constituent components of that EMS plan are, are those that probably

need to be represented on the Board. And I think we have a copy of the EMS plan in here as well. So -- and I want to go back to, too.

Do we want this to be -- can we all agree, you know, these are sort of -- these are the statewide mandates of -- of the Board. Is that correct?

Let's talk about -- you know, we can't go outside of that. This is what we're mandated by law to do. Do we think that, you know, we need to work from this in developing Board structure, you know, broader concepts?

Or are we going to continue with the organizational-based constituent parts of the Board as a -- as a broader goal?

MS. ADAMS: Beth Adams.

MR. STARK: Yep.

MS. ADAMS: Northern Virginia. The organizations are actually specified in the

statute.

MR. STARK: Okay.

MS. ADAMS: The organizations at this table. And to Valeta's point, it also says that each organization and group shall submit three nominees, from among which the governor may make appointments.

Of the three nominees submitted by each regional EMS council, at least one nominee shall be representative of providers of pre-hospital care. So in my own case, I was new to the Board as of the last Board meeting.

I was the only non-practicing -- non-practicing on a continuous basis provider. Yet I was the one the governor picked, even though the other two were much more active in their provision of care to patients than I was.

So you know, then each council needs to stack it if you want more -- more workers -- more direct providers on this Board.

MR. STARK: Yeah. If we have the -- if that's statutory, then -- and I -- you know, I apologize. I didn't look at the statute.

But if that's statutory -- if it's specifying organizationally who is currently on the Board, that's something that we have to think about, you know, tackling initially.

And Beth's right, you know, if we want more provider representation, that's going to be up to, you know, the regionals or -- or whatever component that is to get providers into those roles. Yes, sir.

DR. O'SHEA: Jake O'Shea.

MR. STARK: Yep.

DR. O'SHEA: The language in the -- in the statute says at least one nominee shall be a -- a representative of providers of pre-hospital care. And I -- I think -- I would hope that we would all agree that those who are, you know, administrative

leaders in their EMS organizations are certainly able to serve as representatives of providers, whether they are providing the care today or have provided it in the past.

MR. STARK: Sure. And that's up to the administrators, then, to have their finger on the pulse of the providers and those issues.

So you know, that is by and large, I think -- you know, could be a function of how well they're operating within that -- that subset there. Other thoughts about that? Yes.

MR. CRITZER: I think it's probably been said -- Gary Critzer. I think it was said earlier, but it's important for whatever composition this Board has today and in the future is that while you might represent either an organization or a position -- trauma services is one -- an EMS provider. You don't represent just that narrow focus. You represent the EMS system in the Commonwealth. And sometimes the

system needs outweigh your individual organizational needs. It's what's best for the system in the Commonwealth and, ultimately, the patients that we serve. And that needs to be the focus that this Board always tries for.

MR. STARK: Okay. Yes, sir.

MR. R. J. FERGUSON: I just want -- R. Jason Ferguson. I just wanted to tag onto that. And you know, with all the comments that have been made -- if we're looking at where we want to be, we also have to consider the -- how things have changed and kind of some of the changes that will be there.

When we keep referring to like councils, for example, right? How our councils -- what they serve 20 years ago and what they do today.

What will they need 10, 20 years from now? You know, I -- I started in EMS back in the early '90's as a proud volunteer. And VAVRS was the -- the big

thing. Everybody -- we -- we competed, we went to the conventions. We were all really engaged in that. And then, you know, it's sad that over the years, that's changed in the EMS in Virginia and nationwide --

MR. STARK: Nationwide, yes. I'm sure.

MR. R. J. FERGUSON: But as we -- as we continue to talk about this and talk about the organizations and things like that, considering will -- will these organizations or anybody in this room be the same 10 years down the road. Right?

MR. STARK: That's general trend. I foresee that as the continuing trend across the United States. I mean, we talked this morning.

You know, there's still 55% make-up of the lobbies, organizations or hybrid organizations, you know, we're seeing the same thing in Pennsylvania, New York. And that is going to continue to be the

general trend. So point being, we need to structure the Advisory Board in a manner that will reflect that in the future. And as you well know, legislation moves at a snail's pace.

So if we need to change things legislatively, now is the time to start thinking about, you know, some of those changes. Yes.

DR. O'SHEA: Jake O'Shea. What -- how would we approach components that the Advisory Board currently would contemplate performing that are not included in this legislative mandate.

So one of the things that's not in there is any form of oversight, to use a generic term. But our EMS plan talks repeatedly about accountability.

And some of that accountability in a draft is designated to some of our committees that are part of the EMS Advisory Board. Can we go beyond the scope of our legislatively mandated activities?

MR. STARK: That depends on what the law says. Generally, you can't go beyond the scope of anything that's mandated by statute or regulation.

So if there are other functions -- if there are pre-defined functions of the Board, we generally can't step outside of that.

If the mandate is -- is general in nature, we may have some discretion in terms of -- you know, if it doesn't talk to -- are you talking internal oversight, external oversight?

DR. O'SHEA: Well, there's pieces in this that talk about oversight of EMS operations to a certain degree, assuring quality -- some of the -- to promote -- it's around triage -- trauma triage reviews.

That would be under a committee. And perhaps we can say that because that's in the EMS plan, that's in our scope and so that makes it okay. But I just -- I think it's important to clarify that piece of it.

MR. STARK: Yeah. If -- it generally states, you know, a review of the EMS plan. It says review and make recommendations concerning Statewide EMS plan.

You know, there's always going to be a check, obviously. The EMS plan goes to OEMS and, you know, is eventually approved. So that's sort of that additional step.

But I think that would probably be well within your mandate, you know, in terms of if it's part of the EMS plan. Yes, sir.

DR. ABOUTANOS: Mike Aboutanos. I think if I understand what they're saying, I kind of agree -- agree with you. We wrestled with that before with the trauma system oversight.

And then we really had no true oversight and accountability. And so if we're going to go -- if this eventually -- if it goes through -- towards the change and fix and needs legislative -- and you're

saying, why don't we look at a little bit more broader and say what -- what should be within the scope of this Advisory Board.

And can we have a true -- true accountability so this Board will be not just simply -- be just there for dressing. I don't know if that makes sense.

MR. STARK: Other thoughts?

DR. O'SHEA: Jake -- I'll just say -- I'm Jake O'Shea. If I state that a little globally, it's how would the Advisory Board like to see all emergency services care in Virginia, I guess, measured -- for want of a better term -- and insure that best practices are adopted.

What's the current structure? But then as we talk about, you know, EMS 2020, what would the future structure look like?

MR. STARK: What do you guys think? You know, one of the things -- one of the studies a few years ago -- national study

was talking about EMS protocols. And basically what they said is that, you know, never before had they seen such a lack of evidence-based standards, you know, and -- and doing things just because we've always done that.

So what does that -- what's that going to look like in the future and what's that oversight going to look like? You know, how are we going to prove that we're acting pursuant to evidence-based standards? What do you guys think? Yes.

MS. QUICK: Valerie Quick, TJEMSA. I -- I'm going to throw something out there that actually is probably a little controversial.

I -- my biggest concern in -- I started in the early '90's, too, in the volunteer system and sort of migrated through that.

One of the things that I saw about 20 years ago was that information, especially at the State level, was disseminated to the councils that had a much

larger role 20-30 years than they do now. Now when I go to council meetings, the -- the people that are at the table -- the people that are really doing the work aren't there.

So what you find is that the localities are individually doing those -- they're doing the protocols, they're doing the work. And some -- like some statement that I think from -- from the Beach end.

And I think that's really what we're missing is that the big part of the work that needs to be done in 20 -- 20 years ago as the regional councils. And now it can not be quite that any more.

So if that's the case, how do we communicate, how do we pull together and collaborate in a system that is set up for an old -- an old structure that isn't there any more.

MR. STARK: Yeah. We're seeing that currently with respect to regional EMS councils unable to support operations, you know, aimed at staff -- you know, the folks

that need to do the job. What do you guys -- I apologize. In Virginia, protocols, do you work regional protocols?

MS. QUICK: We used to work regional protocols. I can -- I can speak at least for TJEMS. We used to have one regional protocol.

And now that has sort of been disbanded and each locality is starting -- or agencies have started to have their own protocols.

We're still some -- most of the volunteer agencies that adhere to the TJEMS protocol, but they're all slightly different. Which can be a difficult thing. Like I -- I work for -- for UVa.

And when you're trying to figure out what one institution is doing, one agency is doing versus another one, that can make -- that can make an impact on what we, at the hospital, are sort of looking for and what we have to sort of push out to them. So it -- it can be difficult. And even knowing what those protocols are very

difficult.

DR. YEE: Allen Yee, VACEP. So I don't disagree with you, Valerie, that there's differences between the -- between the agencies. But that's no different than let's -- let's take that in a hospital component with trauma in particular.

This visit -- what Mike and I are, you know, are familiar with. So if you look at all our different trauma centers, we all do things differently. Right?

You know, whether we do automatic CTA's of the neck or not. I mean, not everyone's doing that. So every -- it's not just EMS.

It's health care in general, we're all doing something a little different that may be unique to our organizations. Right?

I can tell you that -- that, you know, I was a very -- I was a skeptic on the CTA necks, but we've -- VCU has found some occult entries that we would've never found if we didn't do these studies. So --

but that doesn't -- that lesson is not spread across. And -- and it maybe not, nor should it. Because maybe the -- the differences in trauma patients are different at VCU than, let's say, Norfolk.

MS. QUICK: I think the -- I just think that the trauma systems tend to collaborate and communicate much better together. I wouldn't say that necessarily for the EMS.

We -- we -- the regional councils used to be our -- our communication hub. It used to be the place where everybody got together and discussed some of those differences. And at least in our council, that doesn't occur.

DR. ABOUTANOS: Mike Aboutanos. You kind of agree and disagree. I think that where we've been talking about trauma system committees, where we'd like to go with where -- what you're saying, at least in trauma. I am -- if my daughter, who is injured in east Virginia should not get

different care than when -- if she is injured in Richmond. So I have -- as a matter of fact, we have -- we're going to -- that's our next step for us to look at our protocol and just see why is it valuable?

What -- and you know, how come -- you know, UVa has a totally different -- if you broke your ribs, what they do for you than what we do. I do agree that are some -- you have to allow for variances that should be there.

That should be an essential part. Eventually, we can say -- we have admitted on a patient who -- let's just say got injured, and if they should get a pre-hospital, hospital, post-acute.

This is what our expectation is in Virginia. I hope we can get to that level. We're not there yet as you know. So it's kind of basic, but not impossible.

DR. YEE: Allen Yee, VACEP. But I think we're there on EMS, right? Because we actually have the national model guidelines, which are not evidence-based. But we do

have, what, eight I do think by last count that I would hope that all our councils have implemented. I mean, I know ODEMSA has.

MS. QUICK: I think that's the bigger -- the bigger issues. There are some councils that are, I think, a lot more interactive than other councils.

I would say for the most part -- again, I'm speaking from the TJEMS point of view. There really isn't a collaboration between what goes on in the council and what goes on in the agencies.

So where this may be a great organization to bring together the statewide resources and -- and groups together, I don't know that we have that down at the regional council levels in all the different areas.

And -- and I -- I think that you're going to see vast differences between, you know, Council A and Council B. And I think that's where the breakdown occurs. It's -- it's where we meet, you know, come down from a level here. And how

do we collaborate and communicate at that level. I think that's what probably needs to be looked at a little closer.

MR. STARK: Yeah. And so how do we fix that? How do we, you know, do better outreach at that local level? Or you know, is that a task that becomes, you know, a more centralized function and -- and you know, what outcome you want.

Through online communication and then through other means. I'm interested to hear your thoughts on that.

MS. QUICK: Yeah. I mean, I -- I -- a way to communicate, I think, is very important. And certainly, thinking a lot of different areas, a lot of different needs.

I think that we -- the regional councils are contracted out to do a certain amount of services. And I think that sometimes those services are just kind of rubber-stamped. I don't like our regional plan. But they may not have the input like some of the agencies around. And

I think that that's what we need to be looking at a little bit closer is, are you participating in statewide initiatives and then bringing that back to the regional councils.

And are the people within the regional councils really being proactive in that? I can tell you that in our council, that is not the case.

MR. STARK: Yeah, go ahead.

MS. ADAMS: Beth Adams, Northern Virginia. So Valerie, is -- I understand your distress, I think. But I'm not sure that disfunction on -- on a council of lack of cohesiveness and collaboration is under the responsibility of this body to fix it.

It seems like if there used to be good function and now there's not, then the -- the efforts to mitigate that need to come from the -- from the -- from within the council, you know. If I have a bad relationship, I need to -- to do what I can to work on it. And it seems like -- I know

that we've -- we've seen it in the -- almost 30 years that I have lived and worked in Virginia, we've seen an evolution in the degree of collaboration and coordination in our council.

It was always -- it was always a lot of people who liked one another. They didn't always -- they didn't always work for the good of -- you know, the good of the mission.

And I think we've come a long way with regard to that and -- and a lot more collaboration. So maybe some of it just needs to be agencies saying, hey, you're not meeting our expectations. Step it up.

MR. PARKER: Can I add a point of clarification?

MR. STARK: Sure.

MR. PARKER: So Chris, representing Virginia ENA. Looking at the Code of Virginia, item three. Review on a schedule

as it may determine, reports on the status of all aspects of the Statewide Emergency Medical Service System, including the Financial Assistance and Review Committee, rescue squad assistance fund, the regional emergency medical services councils, and the emergency medical services vehicles submitted by OEMS. So it does give us, in Code, the ability to discuss that.

MR. STARK: Yeah.

MR. R. J. FERGUSON: R. Jason Ferguson, BREMS. So in looking at everybody's comments and kind of talk about -- I think Valerie was trying to say how the system structures have changed.

Things have changed over time. And not that we're set to fix that, but should we take the approach that maybe look at where we want to be, start from there.

Forget the committee structures now. Forget everything that we've been discussing. Where do we want to be? And then reflect -- start from scratch.

And then we look at, okay, what committees would we need, what individuals with representation will we need to meet that? And then kind of assess where we are, what we have and how that needs to be tweaked.

I think we've identified, obviously, that change needs to take place. That's why we're all here. So maybe look at it from that perspective.

MR. STARK: Yeah. That's exactly where we want to look at it from. Yes, sir.

MR. CRITZER: Gary Critzer. And to echo your comments and -- and Chris's, the responsibility of this Board is all aspects of the Statewide EMS system from a local, regional and state level.

And that has been relayed up-line even to the Board of Health, who's the regulatory agency that works with this Board to make those things happen. So regional councils, the regional system, the local systems are all part of what this Board needs to have their fingers involved

in. And that's what we should be thinking about if you're looking at the composition of the Board, the committee structure and the work that this Board produces.

MR. STARK: Our regional councils, anybody want to -- anybody think that regional councils are over or under represented currently? Yes, sir.

MR. SCHWALENBERG: Tom Schwalenberg, Tidewater EMS. I -- I won't answer your question. However --

MR. STARK: That's okay.

MR. SCHWALENBERG: What I will say in relation to what you're asking is, is I think the regional councils play a role. And I think having the regional councils represented on this committee is important.

And whether we say the percentage is over or under, you know, we'd need to discuss that. And -- and I agree with -- with what we're saying in the fact

that maybe there -- there is disparity between the way the regional councils work. And there is, and I think part of that is part and parcel to where they're located and the agencies that -- that they work with.

However, again, just to -- to offer a counter is that some councils are very engaged and they're very engaged with their stakeholders, both hospital and pre-hospital.

And -- and at least in -- in my situation, we -- we use the council to bring information from this Board, from -- you know, from the state level back down to those localities and those -- those other partners that may not necessarily be here.

For example, you know, our trauma system. They're not -- they're not represented on this Board. But we make sure that that information gets relayed back to them.

So I -- I do think the regional councils have a -- have a role in this, insofar as disseminating that -- that information.

MR. STARK: Yes, sir.

DR. YEE: Allen Yee, VACEP. I mean, I -- I agree that the -- the councils have some faults. But it's not only transmitting -- one of the big benefits of them is, at least in ODEMSA is the bigger agencies, we get to share our lessons learned because we are -- we do have individual protocols.

So we -- we share with the region and create best practice for the region. Because at the agency level, we tend to be much more nimble. So it's a big -- that's a huge plus.

Another thing -- another -- and I'm not going to say the value -- other values of the -- of the councils are, are we over -- over-represented?

But the councils are a -- a structure that we can use to get representation from EMS providers and agencies from across the state. It is set. And there's 11 of them. We represent all parts of Virginia. So that's how we get the

-- the stakeholders in.

MR. STARK: Yes, sir.

MR. SCHWALENBERG: Just as a follow up to what Dr. Yee said -- I'm Tom Schwalenberg, Tidewater EMS -- is that similar to -- to his region, you know, we have five primary localities that tend to drive most of the localities in the region.

But we have a lot of small agencies that really depend on the council to do things, like set protocol. Because they just don't have the staff and the ability to do it.

So they kind of look to the larger agencies to -- to help -- to help with that. And that's all done through the council.

MR. STARK: Sure.

DR. ABOUTANOS: Mike Aboutanos. So there is the what we think we are and what we really are. And I'm just sorry to tell

you that. I said that and it's not negative. Couple of years ago, we had a premise for what you said. But that's not what you have on this Board. We meet 90% of their discretion is limited to one part of the EMS system.

So the regional councils, whether they exist or not, you know, is pretty much geared toward the pre-hospital realm. And so this may be just a function of the system -- of the council, not solely the composition.

So how do you force that change? Do you change the Board or do you change the responsibility of the -- you know, of the councils? So for -- for -- I'm representing trauma, so I'll talk about trauma specifically.

So for trauma is -- it's irrelevant whether the EMS council have only one representative or they change their composition or their representation on the -- on the Board. It's not as relevant. What is relevant is that there are other things need to come through -- pre-injury,

pre-hospital -- well, you already have that. Acute care, post-acute, a possible fall, a burn, trauma nursing care. All these we've already requested as part of the plan.

And so it is -- how this -- even if this Board may believe that we are going to be that. And EMS council individual representations absolutely necessary.

I hope the discussion extends beyond to the other things that need to get in to be discussed adequately. Because right now, there's no room for that. You know, there isn't.

We're -- we're pushing trauma, but trauma is only just one way of -- of looking at different parts of the system. So I keep on us wanting to come back a little bit.

Yes, we can look at every council. And -- but should -- sometimes where -- where you think you are and it makes sense, but it's still not working. You may have to change what you are in order for it to work. Not -- that's -- that's

kind of the main -- the main aspect, I think, that we're -- at least, I'm looking at it from -- from the trauma standpoint.

MS. DANIELS: So -- Valeta, VAVRS. So there's a couple things I want to point out. Dr. Aboutanos, I agree with you totally that if something happens and your daughter is in southwest Virginia.

But when you're talking about a small 15-bed hospital to be able to do what a trauma center does -- because they've got to do something while they're waiting for the helicopter.

If the helicopter can fly, that would be great. However, it's -- it goes back to our OMD's. When I first work -- started working at Richmond Ambulance, let's just say 20-some years ago, we did stroke protocol.

VCU started the whole thing. You'd call a stroke in the field. When I got off that truck before it got to you it was in Chesterfield, that doctor said no. We don't treat strokes as emergencies.

Well, you know, fire me but I would approve my ambulances over the stroke patient and take them where I thought they would go. So that when Dr. Yee came in, luckily, he has been at the forefront of -- of really stepping up the game.

I mean, why are we doing this? Let's look at this. And his protocols -- protocols are drastically different. And there's three other -- four other agencies with -- how many you down to now -- two other OMD's or just one?

DR. ABOUTANOS: We have two in the system.

MS. DANIELS: Yeah. So anyway -- but on paper, there's -- there's other ones. So -- but if -- if Dr. Yee hadn't been at the forefront going, we need to do this, this and this, other people may not have been led there.

So he has made the system a lot stronger -- and don't let that go to your head. I know you can't get out the

door.

DR. YEE: I don't know about that.

MR. STARK: We're going to strike that from --

MS. DANIELS: But there's still agencies where they rarely see their own team. There's little interaction there. And -- and those agencies are further behind.

But that's why it's kind of nice having someone at the forefront in different counties, different areas to be able to say, okay. I'm doing this, I'm doing this, I'm doing this.

Did it and has proven through time that that was the -- that was the best thing to do for EMS. And he brings his findings back to the -- to the regional council and people can talk about them.

MR. STARK: Sir, you.

DR. BARTLE: Sam Bartle, American Academy of Pediatrics. To support that comment -- the comments that she is making. And especially in pediatrics, there's a lot of areas if they have pediatric-focused guidelines, they may or may not be as developed as in other areas.

And having the -- being clear where we can see what those guidelines are, see what different areas may be doing. Support it -- support those efforts that are -- are reasonable and are truly supported through evidence.

And that's something that's going to be important. And it's led to individual areas that may not have that, even though that's basically how it is now.

Each individual regions have their own guidelines and some of them are better than others. But if we use this guidance of when to look at how it's run, what's being done. Even when to violate, you know, what is recommended. That's one of the purposes, you know, as I see it, to get this -- the line connected with

information to the street level. And I think that's where we need to -- you know, that has a more -- Mike has more of the gab ability of sharing information that's relevant.

MR. STARK: Yes, sir.

MR. D. E. FERGUSON: Yeah, Eddie Ferguson. Virginia State Firefighters Association. You know, I think it's going to be hard to balance the Board without knowing the future of the regional councils. I think there's an undercurrent or an undertone here and I don't think we're going to be very successful unless we figure that out. I do agree with the system-wide approach. I know some members didn't get aboard for some time now. But I agree with what Valeta said as far as having EMS providers on the Board that actually touch the patient and do the work. I think the regional councils can facilitate that representation if they so choose to. I

think they do in most cases. But obviously, we've got -- let's just get right down to it. We've got so many seats on the Board. I think it's one of the biggest boards in the State. We're trying to merge more seats into the Board.

MR. STARK: You guys have 28 seats right now.

MR. D. E. FERGUSON: Yeah. And the regional councils -- obviously, if you've looked at it, it has the most seats on the Board. And it might be -- it probably is those that -- how much -- 11 seats.

Right, is that right, Chris? So in saying this comments, I support the regional councils. But I think possibly that's the issue that's -- it's got to be known.

And in order to know how we want to go in the future, I think that's -- that's what won't allow us to balance the Board. And I agree with what Gary says as far as the system-wide approach and care.

And I absolutely believe the hospitals are definitely a part of it.

MR. STARK: Yeah. So -- go. Yes, sir.

DR. YEE: So I'm going to play devil's advocate here. It's just -- I do that. I'm going to argue that -- let's just take -- take this Board council composition, regional council versus non-regional councils, right?

Two groups. Right? If you're going to lump regional councils in one group, we're going to lump everyone else into the other group. So that means the non-regional councils have the lion's share of representation.

You know, it -- it is not 11 regional councils as a block. It is 11 different individual organizations. It is not different than VACEP partnering with MSV. We -- we're two separate organizations. Two separate mindsets. Two separate boards who we answer to. Same

thing with the 11 regional councils. It is 11 different organizations, it's not one.

MR. PARKER: 11 different areas of the state.

DR. YEE: Yes.

MR. PARKER: Very different.

DR. YEE: So we can not lump them.

MR. STARK: Other comments? So you know, is it the job -- I mean, what do -- what if we do have a -- you know, let's go back to your point on regional council, who is struggling to a certain degree.

How do we remedy that and where do we see that in the future? Do we see that as continuing -- a continual trend, you know, where there's less for this patient at that regional? And then, what needs to happen -- yeah.

MR. R. J. FERGUSON: Jason

Ferguson, BREMS. Like -- like Dr. Yee was saying, though, that's irrelevant to what you're saying.

Because basically what we're doing is we're finding 11 different geographical areas that are represented, not individual agencies. Not the councils themselves, right?

So that's fair representation. So back to Valeta's point that, from one end of the state to the other, there's fair representation. So it's just the -- the --

MR. STARK: Just that your pulse is on -- on that region.

MR. R. J. FERGUSON: Yes, it's that geographic region that's been defined, but not necessarily specific to the council itself.

MR. STARK: Yes, we have a couple -- I don't know who's hand was up first. Yes, sir.

MR. SAMUELS: Gary Samuels with VPFF. It -- it's interesting. My organization has about 7500 members. I represent 7500 firefighters in the State of Virginia sitting in this seat.

And we have folks that are on different boards throughout the state that do different things. But the -- it's -- it's interesting. There are 11 geographical regions. That makes sense.

But from my seat, we'll move around depending on who is selected by my organization to fit the seat. The gentleman previous to me was from Northern Virginia. And I'm more from the Central Virginia area.

But I -- I -- I'm just kind of thinking that, you know, a lot of the -- the groups that are filling these spots, they're -- they're not only -- they're not -- they're not city mice or country -- or a country mouse.

They're -- they're representing a larger group of people coming together. And I frequently go to the meetings for my organization and discuss

with the different leaders from their seven -- or six different districts to try to find out what each person needs and what's going to be best for the -- the majority.

And I'm sure Eddie does the same when he goes to his meetings with -- with the State Firefighters. So you're -- we're all representing bigger areas, not just where we came from.

We're representing larger groups of people who have an interest in providing care in the state pre-hospitally [sp] and in the hospital.

And the make-up of the -- the make-up of the Board, it's important to have the interest groups and the people from all over the state making up the Board, and having the input of the different -- the different groups.

Because not everything that's good for -- for one part of the state -- you have to look at it -- we're looking at it in a bigger aspect. And I think -- I look at everything I do in a bigger aspect. I don't -- I don't care how it affects one place. I

worry about how it going to affect everybody that I'm representing. And I get feedback from a lot of different people and input, even right when we're looking at the new regulations.

We -- we have folks that sit on different committees that -- they're giving input. So I just think, you know, when we think about the regions and we think about the different -- the different people that are at the table, let's think about what they represent and who they represent.

Because you'll find that they -- we -- we've did a pretty good representation from across the state. As long as each of us our doing our homework, like Valerie said, and participating in the process.

Sometimes we looked at thinking that different. Associations are associations. But every association has -- as a group. And if you really lay that group out, it is much bigger than you think. I mean, me, one person presenting over 7500 people. And there are other people that

will be taking my place in a few years and it'll -- it'll kind of groom along and teach them what we're doing here if we want them to be -- be part of the solution.

MR. STARK: Yeah. I like what you said about, you know, let's look at what you represent as well. Because, you know, in looking at what we're tasked to do -- to carry out, you know, for the State, we need to look at all of the members.

Figure out, you know, what -- what do you represent and is that something that meets appropriate representation for us. This gentleman.

MR. LAWLER: Mr. Stark, when you started this -- I'm sorry, Matt Lawler, CSEMS. When you started this meeting, you know, you alluded the geographical diverseness of the -- of the state.

And I've long felt that the -- the representation of the regional councils is intended to purposely infuse that diverse representation from across the state. And

then it's incumbent on each of those regional councils to select an appropriate representative. I mean, I know that it's three and then the governor selects one. But again, I think it's the council's responsibility to select somebody who's representative of that region now.

Is that the best way to -- to achieve representation in the committee through the regional council system down from central Shenandoah -- and Gary's sitting here from Chesapeake with us, too.

And we -- we struggle, as a regional council, we struggle to have representation or collaboration from our -- our stakeholders in our region.

But we also roll up our sleeves and -- and recognize that a regional EMS council system failed to kind of stay up to date with the model that was developed in 1970.

And have endeavored to redefine or restructure the way we do business through this hybrid EMS council approach. And as a Board member of the EMS

council, I'm hopeful and encouraged by what we've done in that we might be able to resurrect the council. Which, quite frankly, is sort of dead and non-functional at this point but for the new way that we're doing business.

The thing that continues to concern me is one of the things that's been, you know, alluded to in this meeting already is that I wonder if we're going to be able to pull the -- the regional stakeholders, the agencies, the localities back together.

Because they have kind of peeled off from -- from the regional approach and pigeonhole themselves into, we're going to develop our own protocols, we're going to set our new scope of practice for our agency, which is remarkably different than the neighboring agency.

And I wonder if they've gone too far to -- to pull those people back together. So I think, you know, no matter how you do it -- whether it's the regional EMS council system or some other system, I think, again, it's -- it's really important

to have the diverse represented group here in this. But it's also critically important that we set ourselves up to have representation on the Board that's able to go back and engage the players in the region or areas or group that -- that you represent.

And also to find a way to make sure that those players participate. Because quite frankly, I think that there's some organizations or agencies or EMS agencies in the State that willingly choose not to participate and build their little -- you know, build a little empire to live in.

And -- and feel like they can be self-sufficient and not be a part of the collective EMS system with regard to, you know, regional protocols, regional quality performance, improvement, those sort of things. So I think would be a subject that we spoke to.

MS. QUICK: Valerie Quick. Again, I kind of would completely second what he's saying. I think it is very important to

keep regional -- regional influence and regional voices in there. So when Valeta talked about the individual person and the individual provider, that really is what the regional councils and their seats on this Board represent is that they represent their individual areas in how they function.

I think that the -- the real problem is when you look at the actual purpose of each of the councils. That has changed so significantly and we already now have a split in how we even perform that.

So it's the new CSEMS structure is very different than some of the other structures. And I think that's where we, as a Board, need to kind of look at what are our regional councils responsible for.

Who should be overseeing that? What is the communications supposed to be like? How do we get Virginia Office of EMS to be able to -- to function within those set entities so that we can provide some sort of consistency from the state level to the regional level to the provider level.

DR. YEE: Allen Yee, VACEP. I agree with Valerie in that we do have a gap between what, I think, OEMS's vision is to what the products are at the regional council levels and the communication to the agencies. I think that maybe more oversight into --

MR. STARK: Could you go into detail, maybe give, you know, just an example of what --

DR. YEE: I mean, many of us have been involved in the regional council systems for -- for a long time. I mean, how many of our -- our deliverables are just rubber-stamped, right?

Just, oh, it's -- it's June. These are the deliverables. All those in favor, say aye. Right? We have. Maybe hold us -- hold the regional councils more accountable to -- to actual measures, core measures, right? Not only the -- not only the deliverables that is in all our plans, but actually some measurable -- something

that we can measure. What do we want out of them? And it may be different for each of our regional councils because we are diverse. Right?

MS. QUICK: And from that end, too, from an agency level, we need to be able to have them participate in the process. So I think at this point they feel like they're completely independent and not necessarily claim overall within the region.

And I think that's really important especially when we're talking about regional protocols, but also district -- regional emergency planning.

Just regional initiatives that may or may not collaborate with the -- with the State. So we have to have some -- some way to entice the individual providers and agencies to be a part of that. And right now, I think that there is no acceptance there.

MR. STARK: What are the functions of the regional councils?

MR. PARKER: I think Gary's got --

MR. STARK: Oh, I'm sorry. Go ahead, Gary.

MR. CRITZER: Oh, that's fine. Gary Critzer. Put on my CSEMS hat for a moment and serve as a regional council president longer than probably some can remember.

But probably close to -- going on seven years. And have been intimately involved in what we've done at Central Shenandoah to try and move to a different model.

The regional council system was developed in a different time when the needs of Virginia EMS were dramatically different than they are today.

It was built on a model based on the predominant volunteer system, where the majority of EMS was delivered by independent, non-profit volunteer rescue squads. Which is a wonderful thing, I grew up that way and -- and support those. But I

know in our region, that's evolved. And it evolved -- it's evolved into more local government involvement. Government fire-based EMS, even at the transport level.

And slowly, fewer and fewer non-profit volunteer EMS agencies delivering that service. In that, those career agencies do much of the work that the regional council was formerly doing.

They do their own plan, their own policies, their own procedure. They have their own regional MCI plans between their -- their neighboring jurisdictions.

They don't need that work from the regions any more. And -- but yet, the regions are still doing it. Why? Because it's part of the contract that says, it's a deliverable that has to be provided.

Looks great, nice plan, gets rubber-stamped and set on a shelf for the next period until it's done again. The regions need to evolve. Do the regions need to exist? Absolutely. The hallmark of Virginia EMS is insuring from the provider level up there's involvement in what our

Statewide EMS System looks like. Whether it's the physician on a region -- regional level, it's an EMT at a regional level, it's an agency leader. It's important.

You don't ever want to do anything that loses that. But the regional council system, as a whole, has got to evolve.

Now maybe in areas like -- like Allen's and Tom's, in larger areas where they have the resources, they may have moved their regions along internally based on the needs of Northern Virginia and -- and Metro Richmond and Tidewater.

They may have evolved on their own without -- but they have a lot of resources to be able to do that, both financially and manpower-wise. But that doesn't exist in other parts of Virginia.

And I know it was a struggle for us. And as those agencies develop those plans and those policies and those procedures and started doing things on their own, they drifted away. And it became, well, I'll catch it from my council. Why do

we need to contribute money to the council? Why do we blah, blah, blah. So again, overarching Statewide EMS System, regional involvement was critical.

Making sure that the work that the regions are doing, number one, provides a valuable benefit to that particular region.

Because then my needs in Central Shenandoah are entirely different than Tom or Allen's needs in Richmond. It can't be cookie-cutter. It's got to be based on the needs of the individual region.

That it spends the taxpayer's dollar in the most efficient manner, which while we don't have a checkbook at the Advisory Board level, we should all be focused on, there's a limited pool of money to deliver EMS in the Commonwealth.

And we should be spending every penny of it to insure that it benefits the people. And it needs to engage those regional trauma systems, making sure that -- in our area, that's UVa. UVa is well engaged in our region. VCU is well engaged

and they're catchment area and so on. That's where the regional councils need to be. They do have a purpose, they do have a focus in regional planning, quality assurance and performance, regional protocols.

The list can go on, but it's based on the needs of that individual region. Again, what I need in -- in Central Shenandoah and -- and the Shenandoah Valley is much different than what Tom or Allen's going to need in their metropolitan areas. Sorry, I got on my soapbox.

DR. YEE: So a lot -- a lot of the deliverables --

MR. STARK: Just name, sorry.

DR. YEE: Allen Yee of VACEP. So a lot of the deliverables that the regional councils to, in my humble opinion, should be very strategic. Right? Because at the agency level, that's where we do the tactical operations. So -- and ODEMSA's

plans are very generic. They're very relatively broad. And this way, I as an agency, Henrico, Richmond -- we all develop our tactics that -- with our -- our known resources to meet those strategic objectives. So that -- there is some value in the regional councils in that.

MR. CRITZER: Absolutely.

BOARD MEMBER: It's okay. I'll defer.

MR. STARK: Okay. I'm sorry. I'll look.

BOARD MEMBER: I'll defer.

MS. DANIELS: Valeta. I just -- so what I'm hearing from most everybody is keep the regional councils. We just need to redefine or give maybe a directional or informational memo with some sort of accountability at the end of it. Is that -- are we pretty much on the same page with

that? Because then we can stop talking about the regional councils and we can just move on to what -- what do we want to see with that.

MR. CRITZER: It's going to take more than --

MS. DANIELS: Absolutely. But you know what -- you know what I'm saying. We can come up with help that meets with their objectives and with their input so we can sit listening while they talk about their -- you know, what they need. But if we get some -- get some input from them as well.

MR. STARK: And we can, in some of our recommendations after we distill all this stuff -- I don't -- I think everybody's agree -- in agreement with the utility of regional councils.

How -- you know, how much involvement they have within their communities is going to vary based on the needs of that. But you know, there's -- you

guys should start thinking about -- we can't solve the needs of individual council, obviously, here today nor do we want to tackle that.

But there are some recommendations that can be made. And you know, other states are struggling with the same -- the exact same issues.

So it might -- in my own State of Pennsylvania, we have a lot of regional councils located in rural areas of the state who are really evolving into different roles. I think she was next.

MS. ADAMS: Beth Adams, Northern Virginia. Well, the discussion about regional councils has been interesting and I understand the passion behind it. I really think we need to -- I'm going to borrow Allen's devil's advocate hat for minute.

But I really think we need to move our discussion back to how does this body, as the EMS Advisory Board, take a system at -- look at the system of care across the Commonwealth to create a

structure that ensures that everybody gets what they need. Both me as a provider, me as a patient, me as a taxpayer, me as a health care professional.

And I think if we do that -- if we are consistent in our delivery of that, then at least -- I mean, everything I've known about Virginia EMS and my work both locally, regionally and nationally speaks to the fact that Virginia EMS from the day Susan was -- Susan McHenry was here was about making sure we have a place that not only takes care of our patients in the best possible way, but creates a system to support the people who provide that care.

Because if we don't do that, our patients will get crappy care. And then we're all just wasting everybody's time and money. So I'd like to see us put it back to the Board focus, please. Thank you.

MR. STARK: Okay.

DR. ABOUTANOS: Mike Aboutanos. I am the -- I kind of feel about the same. My

main aspect is this, I was worried about this. I said, okay. We all agree we're going to keep the regional council. And now let's talk about the function and possible role now. Wait a minute.

You just have -- you have one part of the proposition of this committee. If you're going to keep regional councils, you know, we have to look at all the other groups.

And what's the best -- the request for the additional members. And then go back and say, is this Board can be functional in its feasibility.

If it can be feasible with best policy. Because it's -- I think that's extremely important. Both are not the same.

MR. STARK: Beth, what are your comments about what -- what he tee'd up there? Pivoting back, I'll let you start the discussion on how -- how this Board fulfills that role of being responsive to patients and the providers and the administrators in the system.

MS. ADAMS: I think that recognizing how challenging it can be to make legislative change. Seems like there's been some forethought about that process with regards specifically to our bylaws, which I'm sure were done in consonance with whatever's on the looming legislative calendar.

So maybe the place to start is to see what has been keyed up, either by what L&P Committee -- Legislative and Planning Committee? Does that work -- I -- new to this -- new to this game.

But is Legislative and Planning things that we, as a Board, are interested in? Or things that we're researching because we know it's in the pipeline coming from House District 13 or Senate District 87.

Somebody care to clarify that one for me? What does Legislative and Planning Committee of this body do?

MR. PARKER: Historically, L&P has the view towards the General Assembly time

of year, what's on the docket.

MS. ADAMS: Okay. So when the docket comes out, we look at it for the impact on us. So who then created the proposed bylaws that were mentioned in the pre-meeting materials. There weren't any included.

It's just that we're -- one of the things we were to talk about is proposed bylaws. If the bylaws are amended in a way that makes it easier for all of us to represent the citizens of -- of the Commonwealth, whether those are citizens providing care or receiving care, or being educated so they won't need care, or caring for the caregivers and caring for the patients. Then maybe that's the place to start.

MR. STARK: Okay.

MS. ADAMS: For now.

MR. STARK: No. I -- I think -- I

wanted to tee up and kind of air some -- a few thoughts initially. But let's go ahead -- let's get right into the bylaws here.

And I don't know who is who -- do we have a representative from the bylaw -- you have a bylaws committee. Is that correct? No. We have -- who's in charge of general oversight of the bylaws?

DR. ABOUTANOS: Mike Aboutanos. I'm confused. Why do we jump to the bylaws now when the discussion on the committee is finished. Is it? We only discussed the regional council, that's it. Unless that's your way of getting to the same question.

MR. STARK: No. What we're getting back to -- I -- I want to draw us back to agenda at hand here. We -- we did and we can -- if you want to go back to -- what we were talking about before is composition, I think. And you know, role of -- of regionals. If -- if we want to continue down that track, that's fine. I think Beth just wanted to move -- you wanted -- you

wanted to move through --

MS. ADAMS: I think we should get back to the Board piece. I realize the councils do important work and in support of.

And -- but I think we need to focus on the Board -- if -- if we're going to -- to my point, if there are people that are not -- entities that are not represented in this group, we need to figure out who they are so that we can find a legislator advocate to amend this statute so that it can be -- so that we can be more inclusive and more represented. Is that were you were going, Mike?

DR. ABOUTANOS: And so -- Mike Aboutanos. I was going to -- we're looking at the composition. I didn't want to get off the subject. It's half --

MS. ADAMS: Okay.

DR. ABOUTANOS: -- half discussed.

If we don't look -- we already made one decision that EMS councils are fine. They're very much needed, okay. Put those there. Let's keep on going. Let's go to the rest of this and talk about it.

Everybody else is important and needs to be there. Fine. And let's make that discussion. And then we'll be -- we can move to the next discussion.

Because I have to address that, which is the -- the request for additional members. I think that needs to -- you know, I feel like we're surrounded by --

MR. STARK: So we -- we want to get back to the -- you want to get back to your composition.

DR. ABOUTANOS: I want to just finish it.

MR. STARK: Okay.

DR. ABOUTANOS: And then it -- it

goes into what Beth is talking about.

MR. STARK: Sure.

DR. ABOUTANOS: And definitely you got to look at your bylaws to see what you can change. And you change it --

MR. STARK: And the bylaws, like I say, are retrospective document, ladies and gentlemen. So once we come up with a structure that we want, the bylaws should never drive, obviously, the structure or anything else in any organization.

If they are too restrictive, they're too -- you know, confined, then we'll amend the bylaws. But let's come up -- I -- I think you're right, you know, we need structure as well.

So you know, we -- obviously, we all agree on regional councils. I want to get back to, you know -- I'll we'll get into that in the recommendations in terms of their -- their make-up on the Board. But -- so let's get into -- we have, you know, 28

constituent members of this Board. I realize at one time there were 37 members on the Board. Folks, it's difficult to fill a Board with that many members.

Even with 28 members, you know, this Board is mandated to meet -- what -- four times a year? It can be difficult to wrangle folks, you know, if not impossible sometimes to get folks together, you know, when you have that big of a board.

Having said that, nothing's on the table. Nothing's off the table at this point. So if we want to continue on the discussion, I -- I think we're all, at least, in agreement that -- yeah, we can discuss the make-up of the Board.

Is that right? And do we believe -- you know, should the make-up of the Board -- this was a discussion that was had by the Executive Committee.

Do we think that the make-up of this 28-member Board should be driven by more purpose or should it be driven by constituent organizations? Yeah.

BOARD MEMBER: But I -- I argue the point that every one of the constituent organizations is engaged in the purpose --

MR. STARK: Okay.

BOARD MEMBER: We're -- we're --

MR. STARK: Then -- then we -- we always -- we need to look through and make -- make that argument. That's -- yeah.

BOARD MEMBER: Yeah, I mean, I'm -- I'm engaged in my -- my piece of it.

MR. STARK: Yep.

BOARD MEMBER: And I might be one of 28 people, but I represent over 20% of the certified, trained and educated EMS providers in the state. Over 20%.

MR. STARK: Right.

BOARD MEMBER: So we're, in my mind

--

MR. STARK: We're -- we're talking about one and the same.

BOARD MEMBER: Yeah.

MR. STARK: If you fulfill that purpose, then you're there.

BOARD MEMBER: I'm engaged, yeah.

MR. STARK: Yep. Absolutely.

BOARD MEMBER: And I would say that anybody that showed up today and is at the table, that could make it today is engaged in the same purpose.

DR. ABOUTANOS: So I think -- I agree with that. I think if you -- everybody isn't here to be fashionable. Now engaged versus represented are two separate things.

MR. CRITZER: Correct.

MR. STARK: That's right.

DR. ABOUTANOS: So -- and those have to be -- but -- but definitely, the ones who are represented must be engaged. So I'll just put it that way. But I want to add a little bit more to that for your opinion.

I'm just dragging this a little bit. It's 28 plus requests that says it's more positions. This -- this is what's on the table, you know, more. So that's -- that's not a talking -- not just for me,34.

MR. STARK: 34 members.

DR. ABOUTANOS: And if -- I mean, if eventually this plan has been accepted, now what are you going to do about it? And so -- and that's only -- see, I think that's what's forcing it, first of all, is the Board by itself, large by -- as it is. And now trauma just adding more to it, which

makes it even more big. So this is how I -- I see it, both -- kind of both -- both aspects. So -- but everybody is engaged at all levels.

MR. PARKER: Which is -- I'll bring in the discussion, Chris, from Virginia ENA. We're just bringing the discussion of -- back to the committees, honestly.

If you've got committees that are overlapping, and each Chair -- by bylaws -- has to meet a[n] imagined Board member, do you need those committees?

If -- if they're overlapping and you -- or you can restructure committees, then potentially, do you need to add more seats?

MR. STARK: Yes.

DR. O'SHEA: This -- just two question -- Jake O'Shea -- question based on that. The bylaws state that the Chair of each committee is, by default, a member of the Advisory Board or that only members of

the Advisory Board can be chairs of committees. And I -- I realize that's retrospective, but I think it's an important clarification.

MS. CHANDLER: Yes, it is. Dreama Chandler. That every advisory -- the committee members have to be members. Only Advisory Board members can chair.

DR. ABOUTANOS: Well -- Mike Aboutanos. That's not -- the bylaws that were accepted for trauma don't say that. So we have discrepancies in our bylaws.

Allen has pointed to that multiple times. So we have to come up with something. We have -- we have chairs of committees in the trauma system that are not a part of the Board.

And so, how do you -- something has to change or -- the bylaws, I don't think we need right now.

MR. STARK: Yeah. That's something that we can correct. And I mean, it will

reflect whatever structure you guys want to put into place. You know, right now we're talking about -- and Chris brought up the point of do we have overlapping roles.

And let me give you -- you know, this sort of analogy. We have a census coming up in 2020, right? So we count the constituent members of population. And the census drives funding and representation and other decisions concerning that particular area.

And it really doesn't, you know, discriminate based on, you know, what was the existing structure. It says, what is right for the constituency at that moment in time.

So that's really what needs to be driving this is, we have the structure right now. But is this going to be representative?

Is it currently representative -- a good representative, you have a cross section of what we need on the Board right now. And then in moving forward, are we instituting the structure that -- that can

endure as well?

MR. TANNER: Gary Tanner, VACO. Listening to all of the discussions. But can you -- Chris, can you give us examples of -- you said y'all have had discussions. What committees are overlapping, as an example, that --

DR. YEE: So can I address that for Chris?

MR. STARK: Yep.

DR. YEE: So Allen Yee, VACEP. I think we do have overlapping functions of committees. But that was done as -- we're part of the infancy of bringing in trauma into it.

I was a huge skeptic of Mike's plan, but it's working, right? It'll mature because there are committees that do the same things. And I think that as part of our maturity as we, you know, crawl-walk-run, some of those will combine. And we're

talking a number of years. Yeah. Emergency Preparedness and the Disaster -- I forgot what we call it. You know, but we have two things that -- that almost do the same thing. They'll eventually merge.

DR. ABOUTANOS: They'll have to.

DR. YEE: Yeah. And that was -- that was done because we had a structure under the trauma side of the -- of that house. And we just, essentially, imported into the -- they refined it and imported it in.

So we knew there was going to be overlap from the beginning. There's nothing wrong with what the -- the GAB did. This is just part of the maturation process.

MS. DANIELS: Ryan.

MR. STARK: Yes.

MS. DANIELS: Valeta. Can we just get down to the nuts and bolts?

MR. STARK: Yes, please.

MS. DANIELS: Who and what position does -- do other people want to see on the Board? And then we can discuss that from there.

MR. R. J. FERGUSON: Jason Ferguson, BREMS. So I go back to my point here. And again, I think -- you know, I mentioned the councils and the organizations, as is now, as an example of to look to the -- to look to the future, not focus on where we are now.

That's what kind of started this. We opened Pandora's Box on all this conversation, right? But you know, I still think we start with -- forget who's here now and say where -- where do we want to be?

And what -- what stakeholders will be tee'd to that. And then, we start looking at that versus going by each table, each person, you know. Going down the list, do we need this person, do we need that person, do we need that person, their --

their organizations represented? Versus where -- what do we want to do here, right? And then build -- build around that, instead of build that around who's at the seats now.

BOARD MEMBER: Yeah, I agree.

MS. DANIELS: All right, I can start the discussion. Valeta. So -- I mean, yeah. Here I am throwing -- throwing them under the bus. But Dr. Yee has been on the -- the revolutionary edge of doing acute care by facility.

And I think that it goes with everything, from the start of the patient -- and I've said this a long time. We're the only ones in the house that's seen that house, that's seen the environment.

Then it goes to taking them to the hospital. What do they have to go through? Where were they discharged? Do you go back and check their weights? Do you go back and do, you know, blood at the side of the bed? What if it's just that person and you stop at their house every week. It

needs to be integrative, not just the hospitals, not just EMS. But an overwhelming patient support system.

MR. STARK: Yeah. Getting back to Jason's point and looking at -- at the future, too. Like I said, the last EMS agenda that was put forth foreshadowed MIH. Back in, you know, whenever -- I think it was '96 when they wrote that.

They said this is going to be the model. What this says, if you read it -- at one point they say, transports are 14% of what we do at this day and age. 14%.

We deliver care to the patient where the patient most appropriately needs care. If we don't need to move the patient, we don't. But that's where it's going.

And the other thing that I read was that you guys have a $4 Fund in Virginia. It's now like $4.44, they made an amendment to it. And this is something we need to consider. The way -- does anybody know the way that money's apportioned?

MS. DANIELS: Per capita.

MR. STARK: Per transport vehicle. That's how it goes back.

MS. ADAMS: Well, it's per licensed vehicle. That's how it's run.

MR. STARK: Yeah. So back to vehicles. If we are going -- if we're going to evolve and going to a non-transporting system, we need to look at, you know, whole picture. But going back to your point, where do we want to be, where are we going to be?

MS. ADAMS: But -- but to that point, recognize that the 1996 Agenda for the Future was the 30-year later look at the 1966 white paper that led -- said, oh, my gosh.

More people are dying in -- on the highways in -- in Northern America or in the United States than are -- God forbid -- died in the jungles of South Vietnam. That

proved. Anyway, so 30 years later when the team -- when Greg Margolis and Ted Belridge [sp] and all those folks worked on the agenda -- the 1986 agenda.

The focus was creating a systematic approach that used data to drive system development. And -- and we have gotten there. And they foreshadowed community paramedicine.

And then 2050 says, okay, this is where we -- this is where we've been. Now here we are almost 30 years later. Where are we going next? But in the meantime, EMS had its origins because of trauma. That's why EMS exists.

MR. STARK: Sure.

MS. ADAMS: That's why EMS still in -- in the federal government is within -- it's not an HHS entity, it's a Department of Transportation. It's a NITSA organization. So there --

MR. STARK: It's NITSA and it's a

kind of hybrid we have.

MS. ADAMS: And I don't know, even with my enhanced enlightenment crystals and a heavy load of single malt scotch, I don't know that I'm ever going to get to the point where I foresee us taking care of trauma patients at home. There will always be a need to transport patients.

MR. STARK: Absolutely.

MS. ADAMS: Is it becoming less? Yes. If my guys have anything to say about it, we've lessened it already. But -- but the fact of the matter is that we need to -- to create systems of care that enable us to provide the services that our citizens need.

MR. STARK: Sure.

MS. ADAMS: On the whole spectrum of wellness and --

MR. STARK: I agree --

MS. ADAMS: -- broken.

MR. STARK: I agree with all that. Transportation's never going to go away. And we need to take into account currently reality as well as prepare for where we think things are going is -- is the point.

MS. ADAMS: By courier, six people that want to be on the board.

DR. ABOUTANOS: It's -- it's interesting. It's not people, it's functions.

MS. ADAMS: Okay, it's functions.

DR. ABOUTANOS: So that's a good thing. But thank you for helping -- helping to answer that -- that question. So this has already been vetted over the past three years when we all got together to figure out what's the best. Number one, someone on the prevention aspect. We said -- we call it bridging, because it's no longer

treating, it's prevention. Whether it be a stroke or it could be trauma or whatever. Somebody does -- doesn't exist here on the Board.

And for trauma, we actually -- we suggested reset and injury within the Office. Because it -- so it led to epidemiologist, someone that -- that looks at it from a different -- I know that was one.

Pre-hospital is I've already covered. For acute care, we -- we have requested a -- someone that understands the acute care components. And we brought up the trauma system.

And -- and that could either be physician or non-physician. So that was the second, acute care. Post-acute care, same thing.

Representative of the post-acute care component to be familiar with the turning -- good outcomes or the patient with the highest level or quality. And suggested a representative from the physical, occupational and speech therapy, rehab

facilities or skilled nursing facilities. It's very broad, but somebody can give this Board a different look at how to put a patient back into the community.

Then the other request was for hospital quality component for the system that assured quality control. And the next one, and this is very specific, the next one is burn care.

Representative of burn component in trauma system should be familiar with all aspects. So that was another person that could be -- again, it could a physician or a -- or any kind of provider.

Then we did put trauma nursing care in that. We were looking specifically for trauma program manager because those -- they are the drivers of the -- the trauma systems.

And then finally, just making it clear what we have, which is the committee on trauma represented. But -- so pre-injury, acute care, post-acute care, hospital quality, burn care, trauma nursing

care. This is what -- what it says.

MR. STARK: Yes.

MS. QUICK: Valerie Quick. My -- my concern would be -- when we look at the Board as a whole, trauma is very much represented in vital community arenas.

However, the vast majority of what EMS does is in the -- not trauma. You know, to -- to not have stroke or STEMI or just general medicine, I think, is really missing out on a big -- a big portion of what we do.

I do think that some of those committees or some of those members that Dr. Aboutanos talked about, like prevention, could be something that could span all of the different preventative measures that EMS should be a part of.

And I certainly would agree to that. But I would take a little caution when -- when making sure that the -- that the Board isn't weighted too much on trauma, which I think that it -- it certainly is.

MR. STARK: I don't know who's up next. Go ahead, ma'am.

BOARD MEMBER: To get to that point -- as Allen Yee said, some of these committees, as we go along, are going to naturally merge.

So to change the bylaws and give all six clinicians a seat and then they eventually merge, then there's going to be two representatives doing the same thing.

So I think we need to get back to, as Jason said. Do we want this Board to stay the way it was originally formed as agency? Or do we want to move towards the 2050 plan as patient driven representation?

If we do go in that direction, then I think trauma and everyone will end up having a seat. Not necessarily trauma and then all six subcommittees under that.

Because as I said, I -- I personally don't see where all six need a seat. Because eventually, some of them are going to merge. And then we're going to be back here in a few years saying, okay, we've

got too many on the committee. If we can move that and have the -- again, like he said, this is new. It's just shaping up. You know, we need to kind of get the opportunity to -- to work.

MR. STARK: Yes, sir. Oh, I'm sorry. You were next.

DR. YEE: So -- Allen Yee, VACEP. Love the idea of hospital quality. But is that a role of the EMS Governor's Advisory Board. Love the idea because I -- I -- it is -- it is related.

But should that be focused here? But we're also missing two -- two other things. We're missing public health. Right? Public health is a huge part of what we do, or should be doing, right?

It's in 2050. It's all over the place in 2050. So why don't we -- why don't we have them here? And now I'm being self-serving, but EMS physicians. We don't have them here, per se. We have MSV, we have VACEP, but we don't have the National

Association of EMS Physicians here.

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

DR. O'SHEA: Jake O'Shea. I guess I go back to Jason Ferguson's point of what do we want to be doing, what do we want to be. I mean, I think we've talked about a proposal on the table for expansion without having a concept of the end results. Figuring out the composition is maybe one step early.

MR. STARK: Yeah. And they lay out sort of the six guiding principles in 2050 here, you know. Adapt -- adaptation, innovation, sustainability, socially equitable model, safety, integrative, reliable and prepared.

Those are some pretty good -- a lot of systems, you know, you go out to California right now, all of those EMS agencies are hooked up to an HIE now. I was just down in Arizona last week. Most of

those EMS agencies are hooked up to an HIE. And when they respond, they have to full picture the patient. And then they dump their data into that HIE.

So I think you're right. We need to get down to defining what our -- the guiding principles, what -- what do we need to be? What does this Board need to be?

And focused -- patient-centered, yes and provider-centered as well. The people that work in the EMS system because one of the things -- Southwest Airlines, okay?

I -- I -- pardon me in this minor digression. But their CEO was interviewed once and they said you have such great quality customer service for the most part.

And he said, you know what the trick is? We put our people first. He said if you put your people first, they will put the customer first. And you know, that's -- same thing with our system as well. When you put your people first, they want to care for -- not just for, you know, the victims

of trauma and things like that. But the folks who just need a ride to dialysis and things like that. Because that is the reality of EMS today.

And a lot of it, you know, we always train and we're ready for the Level I. But we also need to be prepared and responsive to the community for the low acuity stuff.

And be better, you know, customer service folks, you know, in the field. And you mentioned transportation. Your point's well taken.

We only get reimbursed currently unless you're participating under the ET3 model, if we transport the patient. But let's not trivialize the importance of the patient getting to where they need to be.

There are patients -- 20% of appointments are missed throughout the year because patients just can't get there. They can't get to see their provider. So that's just --

MS. ADAMS: But are we the ones who should take them there? Is this part of the EMS to take them there, or am I better served by calling Medilift [sp] or Medi-Uber --

MR. STARK: Uber, yep.

MS. ADAMS: -- or put them in a cab?

MR. STARK: That's the reality. There are a lot of offices right now, physicians' practices that are going to the Uber Health model. And that's going to cut out some of EMS.

So that's -- that's a function, too, of EMS. Do we want to get into the business of, you know, different transportation types -- you know, other than ambulance, other than wheelchair van.

You know, and reimbursement's always going to drive things. And I -- we, right now -- you guys are at a unique spot because ET3 was just launched. We are at

the forefront when they're reimbursing, finally -- for the first tine ever, for non-transportation services in EMS.

So I think, you know, a unique opportunity right now to strike, you know, when -- when they're starting to innovate this model. Yes.

DR. ABOUTANOS: Mike Aboutanos. The -- I'm -- I'm puzzled why we're -- why are we going through everything reimbursed. I don't care. I'm sorry. Just -- I don't care where the money's going for.

This is -- this is maybe naive. But just what our system needs for the patient that's being -- that is in trouble with stroke, with trauma, with cardiac.

I mean, what is the function of our Board that we have adequate representation that can -- that this Board is effective. And to take it into the councils, whatever way -- downstream and upstream. This -- this is really, I think, what should be our focus, you know. And so

it's interesting that -- so the -- this is why I went back earlier when they were saying a lot of folks are on trauma. I don't see it at all.

The reason being is because the focus is pre-hospital. See, it's not the -- it's not the -- it's not the field work trauma. Very much -- very much we need to bring in.

Where is stroke, where is everybody else that -- that is needed? Trauma is just a system-based. If it's Level I trauma center, then Level I function is what's happening at a non-trauma center.

What's happening at Level II's, Level III's, because it's a system way of thinking on what is your function. But that's just one way, you know. And I just -- so trauma pushed to have adequate representation.

That's what we're pushing for. But it's as member of this Board, I'm fully expecting other people to push. That's what they're supposed to do. You got to advocate for your responsibility. So if stroke's not

represented, it needs to be here. So this Board has to think outside of, you know, what I need is -- because this is coming.

So next thing we know, it's somebody else want to endorse and then, we want this to represent us because you didn't -- you didn't do this and that.

So by thinking forward with regard to where we need to be, you know, ahead of time. And all I see -- it's almost like us saying, we need to already have -- we should be going out to strokes, not you.

Or somebody else can just say, hey, what does this Board need? And then -- then we scale back and just say, okay. In trauma, how do you structure it that whether they're on the Board or not on the Board, that they -- that information gets down to them.

And -- and stroke kind of the same thing. But it does go back to the identify of this Board of not being only heavily based on pre-hospital. That's -- that's my only aspect. That we truly be system-based.

MR. STARK: Yes.

MS. QUICK: Valerie Quick. I -- I would agree with that. It's -- when you mention those specific areas like the -- the rehab, the quality -- I feel that from a broad perspective, there are individuals on the Board that can speak to that.

So the -- the trauma representative on the Board could certainly speak to some of those others. Because we can look at the committees and how they're structured to be able to represent that.

So when I think of the -- the actual make-up of the -- the Governor's Advisory Board, I would like for it to be as broad as possible. So if it's -- it's like physicians or emergency physicians that, you know, we're representing all of that.

We don't have like every little individual -- there has to be a trauma nurse. I mean, there has to be a STEMI nurse. And you know, it gets a little bit too -- too -- I guess, too individualistic if we -- if we look at it

that way. So what do we do to kind of double back and have a representative here and they can represent a lot of different areas. So like a nurse, they can represent various aspects of nursing.

The -- the hospital to represent quality and also the various aspects of every individual type of service line within its system.

MR. STARK: I don't know who was up.

MR. PARKER: Probably Matt.

MR. LAWLER: Matt Lawler, CSEMS. I feel like we're going to sit here and spin our wheels until we address that question up there, which is where do we want to be.

And I don't think we can address that question until we define what the components of our future EMS system are going to be. And then, how we represent each of those components. You can represent a component by having a seat on the Board.

You can also represent a component through a committee, to deal with that at a committee level. And I think that -- I think, you know, in -- in that, it needs to be weighted.

They're -- they're -- yeah, the pre-hospital side of this is kind of like what we all do, you know, every day out in the field.

And I think, you know, the Office of EMS did the structure of the Office of EMS and we're trying to reference that. So I think that there's a lot of value to that.

And there's a lot of value to the entire system. And I think we have to define the system, weigh the system and how we want to implement the system. I don't think we're going to get anywhere, again --

MR. STARK: Let's -- lunch is coming in right now. And that's -- I feel like that's a good point. Let's, you know, find a more --

DR. YEE: I was just going to kind of say something similar to what Matt was. What -- I mean, trauma represents what? One, two percent of our call volume? If we use a census model, we should get two percent of our -- of our representation.

And I don't think that's fair. But trauma represents a function. So maybe we need committees and we -- we need to de-couple the chairs and the GAB. Just de-couple them. Right?

Anyone can be a Chair of the committee, but they still got to report out, right, like FARC does. All right, FARC reports out and they don't sit on the Board.

Yeah, so we -- we have to -- more pediatrics, because I think they are under-represented in our community. We need stroke, STEMI, trauma -- obviously -- how infectious disease because infection is a big killer, right?

Geriatrics, you know, as we all get older in our communities, right? All our communities are getting older. So why don't we have those functions as

committees and de-couple the GAB.

MR. STARK: Let's -- let's break for lunch right now. When we come back, let's talk about this and let's slay that dragon first off this afternoon.

I want you to think about components of what this Board needs to -- you know, what this Board needs to consist of and where -- where we want to be. And let's define those in a general sense.

You know, I'll take all those down and distill those. And we'll start with that. So good comments, guys. I really appreciate it. Good discussion so far.

Everybody's, you know -- a lot of view points here, but a really good discussion. I think everybody's committed to the greater objective here. So thanks a lot, guys.

(The EMS Advisory Board took a recess for lunch at 12:06 p.m., and resumed at 1:00 p.m. The Board's agenda resumed as follows:)

MR. STARK: Let's look at the Code right now, the part of the Code that defines core responsibilities of the Board. And we'll bring that in to distribute to everyone.

So that's the framework with -- which in we will work. And when we get into the agenda, you know, we're talking about, quote, composition of the Board and then core responsibilities of the Board.

As we said before -- as Jason mentioned, you know. Until we know what core responsibilities we want for the Board, you know, what our purposes are, we don't really know what those constituent members are.

So that's what we're going to start with. And I'll just recite the current provision of the Code here, just so we're reading directly from the non-repealed version of the Code.

And we'll get you guys all a copy here. So hereby created in the executive branch, the State Emergency Medical Services Board for the purpose of

advising the Board concerning the administration of statewide emergency medical services -- and that's pretty broad -- and emergency medical vehicles maintained and operated to provide transportation to persons requiring emergency medical services.

And also reviewing and making recommendations to the Statewide Emergency Medical Services Plan. And then it goes into the composition of the Board. And that's actually based in the Virginia Code.

It talks about -- which, in a perfect world, that would be period, and that's it. And we wouldn't get into there are 28 members appointed by the governor, one from each of the following.

We get into the nitty-gritty. It looks like -- and in looking at this, 2015 was the last time this thing was revised. So that was when, I guess, some of these changes were built into the Code. What that means is the -- is that we can develop a frame work today for where we want to go. And then, you know, we can determine

who that wants to be. But eventually, we're going to have to amend the Code. And what -- that goes through the Virginia Department of Health.

There's a process for that, but let's set up the frame work for that. And maybe what we do in amending that Code is the recommendation be that we just define the core functions.

And we don't necessarily have to pigeon ourselves into 28 members or members from, you know, specific organizations, either.

I'm not saying, you know, the Board's going to be greater or fewer members. I'm not saying, you know, currently existing members are -- are -- either won't be there.

All we're saying is let's tee up the frame work first, like Jason said before. And let's go from there. So I asked y'all to think about, you know, sort of what you would like the core purpose and responsibilities -- yes, sir.

DR. O'SHEA: Can I add one other thing, Ryan?

MR. STARK: Yeah.

DR. O'SHEA: Jake O'Shea. In that section of Code, it actually goes -- there's a definition section which defines what emergency medical services is. Do you mind if I read that --

MR. STARK: Yeah, go for it.

DR. O'SHEA: So emergency medical services, or EMS, means health care, public health and public safety services used in the medical response to the real or perceived need for immediate medical assessment, care or transportation and preventative care, or transportation in order to prevent loss of life or aggravation of physiological or psychological illness or injury.

MR. STARK: Pretty broad.

DR. O'SHEA: Yeah, it is.

MR. STARK: So I don't know what you guys want to call it. But you guys want to call it core purpose of the Board? Or you know, core purpose/responsibility? Yes, Gary.

MR. BROWN: Yeah. I figured I'd start injecting myself here, if you guys don't mind.

MR. STARK: Sure.

MR. BROWN: Just on that -- what Dr. O'Shea just read, that's the current Code language. Actually, we went to the General Assembly a few years ago to actually broaden that definition of EMS to include preventive care and public health.

So we could also focus on mobile integrated health care and then do paramedicine. Because we believe that EMS is broader than what -- what the acute care definition was previously. So again, just

to give you some perspective of things like that. That -- so we -- we are thinking that way. We are thinking towards the future.

And we -- we needed to with the concurrence of our Assistant Attorney General, who gave us an interpretation of our language prior to that change, that we could not get into the business of mobile integrated health care. With that change, we can get into that business.

MR. STARK: Perfect. All right. Yes, sir.

MR. HENSCHEL: I been quiet a long time, so --

MR. STARK: Yeah.

MR. HENSCHEL: -- I might as well go. Couple points. And this is my perception of this Board and what we're engaged to do. You know, when I look at the stakeholders around the room and I see various physicians in various fields and all

this -- all these different facets, it still comes back to what we're doing on the front end as EMS to address patient care. Am I mistaken in that?

So when I look at what we're talking about, I'm looking at, you know, down the line certainly, we want to do things that are going to be better for the patients long term.

And how you address them, how you care for them, their outcomes and so on and so forth. But that's what I feel like you all, as stakeholders, should be providing us with the information on best practices on things we should be doing on the front end to enhance that.

Does -- does that make sense, or am I -- is my thinking out of line? Does that sound right? Okay. So that's where I see this -- the folks around the room that aren't necessarily on that front line fitting into this. That you are -- you are our stakeholders that we lean on for information to tell us what is working in your particular field that we need to do on

the front end to enhance patient outcomes. So the -- the other piece that I'll -- and actually, when I looked at 2050, the one vision really kind of sums that up.

The entire EMS system and how care is accessed and delivered besides the inherent -- the safe minimize exposure to people through injury, infection, illness or stress.

Decisions are made to the safety of patients about their public -- public and practitioner is a priority, from how people are moved to hygiene practices in the field and in the ambulance.

Medical care operations and other aspects of the system are based on best evidence in order to deliver the most effective services that focus on outcomes determined not only by the EMS service, but the entire community and the individual receiving care.

So I feel like, the way I see this is exactly what's listed here in the vision for EMS 2050. In addition to that, the other thing that I've -- I've heard

going around the room -- and I'll share an example from -- from myself. I serve as the president of Lord Fairfax EMS Council. I work for the City of Winchester.

One of our board members happens to be my direct supervisor. So when I'm in that role, I have to step out of my Winchester role and look at what's best for our entire region.

We have had many issues that have impacted all of the other jurisdictions because they're far more rural than what impacts Winchester.

And I've had to go in that direction to do what's in the best interest that involves them, not my own jurisdiction, to some conflict with my own supervisor, if you will.

But I don't care because that's what I was tasked to do. I feel like when we step into this role, it's even more broad. Because now we have to look at what's in the best interest of everyone we're going to encounter statewide. So a much broader role. Now while I have my

little piece of the pie, I represent Lord Fairfax and I know some of the specific needs there. That may not be what's in the best interest throughout the rest of the state.

That may be something we have to address at a regional level. So I think we have to set aside some of our -- our specific desires to make things solely to -- whether it's neuro or trauma or cardiac or your specific EMS area and look more broadly at the state and what is going to best define what we do to enhance care for our citizens and visitors and enhance their outcomes.

Is that fair? I mean, there's stuff I can tell you that we've talked about in the past few years that I know is not in the best interest of Lord Fairfax.

But when you look more broadly and you say -- you step back and you say, what are we going to do here to -- to best -- would be in the best interest of the majority. Then you have to go in a different direction. So I think if we stay

open-minded and we don't -- you know, I understand. I see the passion. I see the passion from Dr. Aboutanos. He is passionate about trauma. I love it.

But we have to look more broadly at all of the different facets we're going to talk about and encounter. Or we're going to spin our wheels and we're not going to get to this point. Sorry, that was my piece.

MR. STARK: No, let's go.

MR. HENSCHEL: I'm Jon Henschel, Lord Fairfax.

MR. STARK: Appreciate that. I mean, you know, one of the questions was not just, you know, what's in it for me and my jurisdiction?

You know, what's in it for the greater whole here? So well said. Let's start defining and we can get to, you know, constituent members after we get to the core purpose and responsibilities of the Board.

BOARD MEMBER: Mission and vision.

MR. STARK: What's that?

BOARD MEMBER: Mission and vision.

MR. STARK: Mission and vision. You want to elaborate on that at all for the -- okay. That's very straight-forward. Do you guys agree with mission and vision?

BOARD MEMBER: Yes.

MR. STARK: Yeah, absolutely. What other core purpose and responsibility should the Board serve or have?

MS. ADAMS: Advocacy. Beth Adams, Northern Virginia.

MR. STARK: I'm sorry.

MS. ADAMS: Advocacy. What else? Yes, sir.

DR. BARTLE: Sam Bartle. Best practices.

DR. YEE: Friendly amendment to Sam's. Maybe not just best practice, just quality care. Right?

DR. BARTLE: Give the best, keep it up to date. Everyone called a student.

MR. STARK: Best practices, consistent -- consistently improving quality.

MS. MARSDEN: Julia Marsden. Data-driven.

BOARD MEMBER: I like that.

MR. STARK: Does Virginia currently have an initiative on the books right now to -- for HIE and inclusion of EMS? Anybody know? Health Information Exchange? No?

DR. YEE: I believe we're part of

the later phases of the ED project, aren't we?

BOARD MEMBER: Yeah.

DR. YEE: I think we're in Phase III of the ED. Does that sound familiar?

DR. O'SHEA: Yeah, yeah. So Jake O'Shea. There -- there are multiple different HIE efforts in the state. There is one coordinating information between emergency departments and hospitals.

There's also some individual efforts at HIE at the state level of -- of multiple layers of records. But I would not -- I don't know that there's necessarily a state-sponsored effort so much as there are multiple efforts within the state.

MR. STARK: Yes, sir.

MR. HENSCHEL: Jon Henschel. Insuring sustainability.

MR. STARK: Sorry. One second. Yes, sir.

MR. DILLARD: There is a coordinated effort with the Health Information Exchange from the Virginia Department of Health. It is the Emergency Department Care Coordination Program that came through, I believe, two General Assemblies ago.

And EMS is part of those discussions as it relates to the Department of Health establishing that statewide network of emergency department care coordination and what that ends up being.

So I can forward out information on that, look at it now and see where we're at in that process. But that -- that is one that we are aware of that's coordinated from the state level.

BOARD MEMBER: And I'm on that -- that council. And I'll be honest with you, I have not heard EMS coordination specifically mentioned as a piece of that.

So I think there's a lot of potential benefit there, but I just haven't -- we have -- that hasn't been their -- hasn't been their focus for that group.

MR. HENSCHEL: Insuring sustainability.

MR. STARK: Insurance sustainability.

MR. HENSCHEL: Insuring sustainability.

MR. STARK: Yes, sir.

MR. SCHWALENBERG: Tom Schwalenberg, Tidewater EMS, would be fiscal responsibility.

DR. YEE: So just -- Allen Yee, VACEP. I'm not trying to be sarcastic, but why don't we just write the six fundamentals of 2050 down?

BOARD MEMBER: It pretty much is that.

DR. YEE: Yeah.

BOARD MEMBER: We're getting there.

DR. YEE: I mean, we're only one short, for crying out loud.

BOARD MEMBER: Socially equitable.

MR. STARK: I mean, that -- that could be our core principles as well if we want to do that. It's up to you guys. What -- what do we need yet?

BOARD MEMBER: How about reliable, prepared and integrated -- yeah. So we can elevate --

MR. STARK: What about -- yes, sir. Thank you. Quality improvement. Just thinking safety.

MS. ADAMS: Could you re-read that because red is really hard to see in that --

MR. STARK: I'm sorry. Mission and vision. Advocacy. Best practices, consistent improvement of quality. Data-driven. Insurance sustainability and fiscal responsibility.

DR. ABOUTANOS: So -- Mike Aboutanos. We -- I'm going to say the word equity and it's been more than represented. Because every one of those -- mission, vision, advocacy -- take all those and make it apply with one part of the system.

Then we're right back where we started. If we don't define its core responsibility for -- for what advocacy? For what -- is it for the --

MR. STARK: And we'll -- yeah, we can -- we can move further and define these as well.

DR. ABOUTANOS: So that's why --

that's why I went with equitable representation.

MR. STARK: We want to add equity up here. And --

DR. ABOUTANOS: Unless you get -- unless it's -- unless it's understood, kind of what Gary said at the very beginning. This is what -- how EMS is understood, you know.

And so if it's -- if it's inherent and understood, then we don't have to add it. But if it's not -- because we don't know -- and you see, I just come on right back.

MR. STARK: Okay. We'll just say an over-arching principle, use equity.

DR. YEE: And it's different than social equity.

DR. ABOUTANOS: Yeah.

DR. YEE: Yeah, I know.

DR. BARTLE: Sam Bartle. I think a lot of this would depend on what the -- the mission of the group actually is.

MR. STARK: Let's get into that. Let's get into what -- we know what we're tasked to do under the law. Within those parameters, let's -- and I apologize.

It's not easy to read some of this stuff for you folks. So let's get into mission. No, we're going to use black. I'd use my shirt, but my wife would kill me. Okay.

What's the mission? Or if anybody -- better than that, does anybody have, you know, a nice succinct mission statement that they want to offer up? Or we can go through --

BOARD MEMBER: To provide quality emergency medical services care for the citizens of the Commonwealth of Virginia.

MR. STARK: Is that the mission of this -- this Board? Okay. Provide quality --

BOARD MEMBER: Quality emergency medical care.

MS. QUICK: Well, we don't provide the care.

BOARD MEMBER: We oversee it.

MR. PARKER: We don't really oversee.

MR. STARK: Yeah, that's why I asked about -- do you want to say oversight of the provision of or is there -- yes, sir.

DR. O'SHEA: I just was -- any mission that we have has to, I would think, start with advising the Board of Health. Because at the heart of it, that's the purpose of this group is advising the Board of Health. What -- what we're advising them

on, I think, is the picture we have to figure out. But --

MS. QUICK: I think it -- this is Valerie. It's nicely already written in the bylaws where the Advisory Board provides advice and counsel regarding methods and procedures for planning, developing and implementing a Statewide Emergency Medical System.

MR. STARK: You guys like that?

DR. YEE: Yes.

MS. QUICK: It sums it up.

MR. STARK: Okay.

MS. ADAMS: But do we?

DR. YEE: Yes.

MS. ADAMS: Methods and procedures? Okay. Say that again.

BOARD MEMBER: That would be the practices and guidance, data-driven quality.

DR. ABOUTANOS: This is Mike Aboutanos. I mean, you know, I mean what I say is that, this is fine as long as we add to it emergency medical -- understood as. Because currently, EMS equal pre-hospital, period. No matter how you put it in the state.

MR. STARK: So do you -- do we want to define what emergency medical services is?

DR. ABOUTANOS: Otherwise we're -- we're going to say the same thing here. So if we're really going to say emergency medical services and everybody got to be honest about it.

When you say EMS, no matter whether you are ED physician, you know, whether you are -- you know, any kind of physician, we hear pre-hospital. That's all we hear. So that's the reality of it.

MR. STARK: So what is EMS? What do -- what do we want to see in this? What is the constituent component of EMS? We know the traditional notion of EMS and what that conjures up. You know, lights and sirens, convey the patient to hospital, pre-hospital.

BOARD MEMBER: We already have a definition. We just need to -- we have a definition for this.

MR. STARK: Okay. So we'll just work with the definition from -- yep. So we'll work with definition from the Code.

DR. YEE: So I think there -- this is Allen Yee. So I think when we created this definition, we were really looking -- still looking at the out of hospital component.

DR. ABOUTANOS: I don't see the definition of the Code in here.

MR. STARK: It's not in that one. It's -- it's part of the -- you got to look to G4. It's in a different --

DR. ABOUTANOS: So, my bad.

MR. STARK: -- section of the code, yeah. You got to basically scroll up from where this is at, where they define EMS. Could you read the definition for us again?

DR. O'SHEA: Sure. Emergency medical services or EMS means health care, public health and public safety services used in the medical response to the real or perceived need for immediate medical assessment, care or transportation, and preventative care or transportation in order to prevent loss of life or aggravation of physiological or psychological illness or injury.

DR. YEE: So back in -- this is Allen Yee again. So back in 2015 when we changed this definition, we were all focused

on the out of hospital component, right? The pre-hospital component. We didn't really envision that that definition -- and I may be wrong.

There's plenty of other people in the room that were there. When we created this definition, we didn't really look at the post-acute care, the acute care.

DR. ABOUTANOS: We meant to.

DR. YEE: We -- we had the preventive because we knew that was one of the Stars of Life to -- quite honestly, we didn't really do well. Right?

But we didn't really look at the acute care phase, the in hospital. So I think the intent behind the definition is changing a little. And I don't know how to express it here.

DR. BARTLE: Are you talking about this integration of care?

DR. YEE: Mm-mm. Because --

because when -- this is pre-ACS, right? When the ACS review came in, we added trauma as a -- as a function of the GAB.

So that -- that limited all the inpatient care and post-acute care that -- you know, the rehabs side of it. We didn't envision that in 2015, shame on us.

DR. ABOUTANOS: This is Mike Aboutanos again. I think the -- this is so true in the sense that even when the trauma lawyers got together, one of the asks we had for this -- for this Advisory Board is to even change the name.

EMS/Trauma, you know only because they didn't think EMS represented. So it's -- it's a tough balance because everybody, you know, yes, we know what EMS should represent.

But the common way is EMS is pre-hospital. And that's -- so -- so we could state that implicitly at the -- I think this definition does state it. It's very broad, it's very good definition. But this --

MR. STARK: Is that -- was that definition broad enough for post-acute as well? It gets the whole spectrum, you think?

BOARD MEMBER: Mm-mm.

MS. ADAMS: I don't think so.

MR. STARK: You don't think so?

MS. ADAMS: No.

DR. YEE: It does not include post-acute care.

MR. STARK: Yeah.

MS. ADAMS: No, the focus in 2015, having been outside the body looking in was this was an effort to get past the prior Attorney General read that, no, you are only going to people's houses if they've called and asked you to come, or someone has called on their behalf. It didn't take into the

account the fact that people were starting to do transitional care or follow up for the hospitals or mental health follow up's or any of the mobile integrated health care discussion.

That was what the intent was, to pick that -- to make sure we could do that and not be breaking the law, was -- was my sense of that.

MR. STARK: So do we need to broaden -- based on that definition, do we need to broaden even further the definition that of EMS?

DR. YEE: Devil's advocate. Do we need to narrow it?

MR. STARK: That's a good question.

DR. YEE: All right. Because --

MR. STARK: Or -- or state it more generally maybe is what you're saying.

DR. YEE: No. Just -- do we need to be -- does this GAB -- it's a rhetorical question. But do we really need to be involved in the ongoing -- inside the confines of a hospital or nursing home or a rehab facility? I'm not sure --

BOARD MEMBER: I think we're -- I understand what you're saying. But maybe not within the confines of the individual components, but the interaction between them.

It's -- maybe -- a flood of ideas here. If it's not emergency medical services, it's the system of medical services. Systematic approach.

DR. YEE: So -- so this is Allen Yee again. So maybe we're looking at it wrong, right? I'm -- I'm going to just throw this out there. Maybe we have the EMS governor's advisory -- EMS Governor's Advisory Board. We have the hospital -- EMS Governor's Hospital Advisory Board and then one for the post-hospital. And then there's

a steering group on -- on all three. Maybe we need to -- we need to silo off a little bit more and then come together in a bigger board.

DR. ABOUTANOS: So -- Mike Aboutanos. So it's interesting, right, what -- what you're saying because this is where we started. We started that on trauma -- I can only speak for trauma.

We looked at -- and they said there's no way this could be absorbed by the EMS Advisory Board. There too many things on the agenda, you know.

That was kind of one aspect. So we actually had to make a decision. We go one way or the other. And it was a lot, a lot of work really.

And so to be able to say no, we want to be integrated -- only an integrated system that would function better, you know. So -- and it took us three years to really absorb that, to accept that. And how do you make this integrated thing work? Because we got to -- can't just

say that we integrated, just say it. We got to do it. And this is where -- where we're at. So it's -- you're -- what you're either saying, you're either narrow and just say, this is -- that's actually all you -- we were at.

And you have to create a separate body that integrates. Or you stop, you pull back and you just say, this EMS Advisory Board will have room for integration and representation.

But we're going to change the structure of where we're at, how committees meet. That's a big body, kind of what you're saying, and come -- come to this.

And this way, you don't have -- the -- the problem with not integrating is that you don't have assurance that those bodies will talk to each other.

They'll be competing bodies whenever -- for anything on the -- on the Board of Health, whatever, etcetera. And so, it's just us being -- being smart of how to restructure. Because what you said is actually the -- this is what will happen,

you know, where things can't come through. And -- and everybody has to -- we say, well, we have to be comprehensive. Okay. If you have to be comprehensive, there's so many things in each one, you know.

Then you're going to have everybody asking for, hey, this -- we're not serving it adequately. So to make up the answer, we have to restructure. Does that make sense to you?

DR. YEE: Yeah.

MR. STARK: Yeah. We're -- go ahead.

MR. R. J. FERGUSON: Jason Ferguson. The question that -- you know, I think like the things that Dr. Aboutanos and the group did with the different levels -- like the prevention, acute care, things like that. I think the concept is great. I think that was very visionary. But I think it kind of -- because you just said yourself, Dr. Aboutanos, I'm trauma. So

everything in the conversation for you is trauma. But if we look at it more as a acute care committee, for example or group.

And now you bring in the stroke and you bring in MI and you bring in that group for acute care. And then you have prevention and public health. So now you bring in the epidemiology, you have the trauma component.

But you have others like mobile integrative health and things like that to where things are combined so it's not so overwhelming, but with one particular specialty.

But the same concepts that you guys have already come up with were, you know, very good. Just brought that out of it.

MR. STARK: Okay. So as part of that mission, are we good with, you know, the Code definition as is? Or do we want to write that our own way in terms of the Board's mission? Do we need to be -- would you -- you guys want to be more specific

within the confines of what we're currently doing or -- what are we going to be doing in years to come. Yes.

DR. O'SHEA: So I guess -- Jake O'Shea. I would say we should be as clear as possible in our mission statement. And I think the definition in the Code contains enough broadness that may not be narrow enough for our mission statement, for us to focus on what we're doing.

I mean, I'll go back to what others said, which is if we think conceptually of the role of the EMS Advisory Board, most of that role is pre-hospital. I wouldn't say all, but I would say most of it.

I think if we broaden the scope to say -- and I know it's encompass pre-hospital, but in the acute care hospital post-care -- for all components of care -- the scope becomes so broad that it becomes almost unmanageable. We have to keep focused on what the ultimate goal is, which is -- from my perspective -- to insure that

as a state, we have the appropriate services to manage people outside of the hospital and requiring care from a pre-hospital perspective.

And to make sure the systems are in place to insure that we can scale to the needs of the Commonwealth, whether that's for disaster relief, whether that's for trauma care and interfacility transport.

I -- I guess I -- I get -- if we start talking about a very, very broad scope, I get concerned it becomes too broad to be effectively successful in anything.

MR. STARK: Okay. So it would be -- you would be happier with sort of when we talk about, you know, when it refers to EMS and our general responsibilities here and the bylaws. You would be more comfortable with a out of hospital, pre-hospital focus.

DR. O'SHEA: Primarily. Again, not exclusively. But to say that -- that is the main focus of this group. It doesn't mean there can't be some examination of acute and

post-acute, post-hospital care. But I think that's -- that's what most of us see as the -- that's what I see as the primary body. I won't speak for most of us, but it works.

DR. BARTLE: Sam Bartle. I -- I have a question and I don't know if there's going to be an answer readily available. What exactly is the Board of Health wanting us to advise them on?

About the EMS, the paramedic based system or an integrated system or more global -- what -- so I think that's probably one thing we need to know for the next step with the Board of Health.

MR. CRITZER: Gary Critzer. They're expecting you to advise them on all things related to emergency medical services. An EMS system. If you look at the EMS system of care, it includes trauma. It includes all those aspects. It's not just pre-hospital.

DR. BARTLE: Okay. Well that --

there's emergency medicine services and there's emergency medicine.

MR. CRITZER: Not emergency medicine. That's regulated by the Board of Health Professions and other organizations.

DR. BARTLE: Okay.

MR. CRITZER: Emergency medical services.

DR. BARTLE: Okay.

MR. CRITZER: Which is what's charged by the Code of Virginia to the Board of Health to the Virginia Department of Health. Sorry.

MS. ADAMS: And that -- Beth Adams, Northern Virginia. That's also defined in 5-31-10 of the definitions of the Virginia Administrative Code and says, Virginia Emergency Medical Services System means the system of emergency medical services,

agencies, vehicles, equipment and personnel, health care facilities, other health care and emergency services providers and other components engaged in planning, coordination and delivery of emergency medical services in the Commonwealth, including communications and other services necessary to facilitate the delivery of emergency medical service in the Commonwealth.

So maybe what we need to do is broaden it to say that this emergency medical service will be integrated into the continuum of care. And then we kind of covered all of those transitions.

Because the reality is, at least in my system, we may run 65,000 EMS calls that were dispatched as emergencies. But probably only -- I don't know -- 25-30% on a good day are really emergencies.

There are some acute care needs. There's some, gee, you should've seen a doctor 20 years ago things. Then there's kids -- it's more about the section of emergency. So if we really are doing emergency medical services, that's a pretty

narrow niche of care that consumes people 24/7-365.

MR. STARK: Okay. Yeah, the mission needs to be based on EMS system and what, you know, that definition is. And I'm going to take this, work with that and we can -- do we have sort of a general sense, though?

I -- okay, two sides of the coin. But I'm seeing more consensus on -- on the side of this is sort of more of across the continuum of care when we talk about the EMS system.

I heard mentioned in the vehicles, facilities, communications. So talking more about the integration with other parts of the health care system. That's -- is that fair to say? Yes.

DR. ABOUTANOS: Sorry. Mike Aboutanos, Richmond. The -- I think I said this earlier. I'm going to say it again. So it does go back to how -- not what we're supposed to be, but what we are. And

because it's -- and I'm a little bit in thinking the way Allen is thinking, I think, is that if -- and I know Jay also said this.

If this Board truly represents pre-hospital or it's not what -- it's not really supposed to, but that's what it is. That's what components do.

You know, I don't expect anybody in the -- if you look, everybody sits at the 11 councils and everybody else, that only few can speak on hospital care. And if -- nobody can speak on post-acute care.

I haven't seen anyone can truly speak in true prevention in -- within a logical standpoint. It don't -- we don't -- this Board doesn't do that right now.

And so if -- so we either -- you either say this Board is now a component of a larger board that need to exist. And this Board you don't touch because it does truly represent the pre-hospital. And now let's re-think it in a real way, you know, or this -- it has to be some really tough decision-making. I -- I think we can't play

it both ways. It just -- we're going to waste all our minds.

MR. STARK: So we need to either go out of hospital/pre-hospital or the more integrative realm. And with that comes -- when we go through all the other factors that we're going to talk about here, it's going to entail, you know, more seats at the table perhaps.

You know, different groups that need to be involved as you mentioned before. The way that things are going, the way they're predicting is, you know, more integrative model, of course.

And we really need to decide -- you know, you folks need to decide -- you know what you're tasked with. But what's the EMS system that we desire, that we want control over?

Do we want -- and again, I realize that's a function of what we're doing currently but can we expand it? Yes, Gary.

MR. BROWN: Yeah. I -- I will submit that the definitions have already been provided for us. And it's much more broad and comprehensive than we might think.

Because one of the primary responsibilities of the Advisory Board is to advise on -- as Gary Critzer said -- all matters of EMS. But also the statewide State EMS Plan.

And it's very clear in the Code of Virginia now that the Board of Health shall develop a Statewide Emergency Medical Services Plan that shall provide for a comprehensive, coordinated emergency medical services system.

And that -- it also goes so far as to say the objectives of this plan and the emergency medical services system shall include the following -- not may, shall -- establishing a comprehensive statewide EMS system incorporating facilities, transportation, manpower, communications and other components as integral parts of the unified system. Key word there. And thereby, decrease

morbidity, optimization of skill, and so forth and so on. It talks about the verification acutely ill or injured patient and the definitive treatment.

That's the second objective. We've got 19 objectives in the boat. 19. I just hit on the first two. Increasing the accessibility of high quality emergency medical services to all citizens.

Brings in the whole health equity. Promote the continued improvement and system componency including, ground, water, air transportation, communications, hospital emergency departments and other emergency care facilities, health care provider training.

Health care service delivery and consumer health information education. That was number four. Five, insuring performance improvement in emergency medical services system and care delivered on scene, in -- in transit, in hospital emergency departments and within hospital environments. Working -- that was five. Six, work with professional medical

organizations, hospitals and other public and private agencies in developing approaches whereby persons who are presently using the existing emergency departments for routine, non-emergency -- non-emergent primary medical care will be served more appropriately and economically.

It goes on, conducting, promoting, encouraging programs in education and training designed to upgrade knowledge and skills.

It goes further, consulting with and reviewing the agency's mobilizations, development of its application, development for sources of training time -- which we do.

Establish and maintain a process for designation of appropriate hospitals as trauma centers, certified stroke centers and other specialty care centers for our -- and performance improvement system -- system. Collection -- collecting data and information, preparing reports for the sole purpose of designation and verification of trauma centers.

Establish and maintain the process for curricula in stress management, a program of Emergency Medical Services for Children. Statewide health and medical emergency response teams.

Identify and establishing best practices for managing and operating emergency medical services agencies. It goes on and on and on. So if you look at this, this is already in the Code.

It is a Code mandate. It talks about a comprehensive, unified, integrated system of everything that I just read. You already have it down here.

BOARD MEMBER: Gary, what Code were you referencing?

MR. CRITZER: This is 32.1-111.3, State EMS Advisory Board.

MR. BROWN: That's it.

MR. STARK: That was 32.1- -- .111-3.

MS. ADAMS: Dot three.

MR. STARK: Dot 3.

MS. ADAMS: 32.1-111.

MR. STARK: 111.3. Yeah.

MS. QUICK: Valerie Quick. So all of what Gary is describing here is -- and I'm pulling from NITSA and the 2050 guidelines here. Really following your three major categories, which is public health, health care and public safety.

So if you look at the intersection of those three areas, that is really where EMS sort of lands in. So if we're looking at an advisory board that's looking at that -- what best represents those areas.

So for public health, are there entities that would better represent the public health version? Are there better entities for the public safety and certainly health care? Health care in itself, I

think, is broad enough to incorporate everything that you are discussing. It's -- it's the acute care, post, rehab, all sorts of other systems that are -- are integrated in that.

And how do we best get to good health care? It's through good education. It's through evidence-based guidelines and protocols. It -- you know, that -- that could be sort of subset -- subsetted [sp] down from -- from that perspective.

But I mean, we really could take it as broadly as that. Look at those three areas and who represents those three areas. That's who should be on this Board.

MR. STARK: What do you guys think about those three areas? Gary, do you have --

MR. BROWN: Well, I was going to just follow up with what Valerie said.

MR. STARK: Yep.

MR. BROWN: That was actually defined in the 1996 Agenda for the Future, is that EMS is at the intersection of public health, public safety and health care. And it was that old light. And that was a vision that was provided -- I think it's now 23 years ago.

MS. QUICK: And there are going to be some entities, like if I think of the preventative health care, that certainly can fall both within public health and public safety. Somebody to represent those type -- those two types of areas.

But I think in general, you could really think about it very broadly and then say who of us really have the -- a good say and a good representation in those areas, and who isn't being represented currently from those -- those entities.

MS. MARSDEN: Julia Marsden, consumer. The only question I would have is when we look toward the future, how is that going to change the name -- or the

disciplines we're talking about. Who should also be incorporated into this vision that we're talking about in the future. And I'm sure we are missing some.

The technology that's changing so dramatically and quickly that, you know, as you said we're -- we're starting now. But we need to start looking even further ahead.

MR. STARK: Yeah. And I think the broader we are in -- in defining these things, the better off we are long term, you know. And if you read through the 2050 agenda, it talks about it.

It posits like certain scenarios of what may occur and talks about, you know, them bringing them up on the dashboard. And they're actually watching patient with a respiratory therapist, somebody that's from the hospital currently.

So -- and before they arrive on scene, having full medical history, things of that nature. So yeah, we -- with that in mind, knowing that, you know, when

they -- you know, back then, cell phones were just new on -- on the spectrum. And I -- you know, even health care integration back then.

So we need to think as broadly as possible. And we need to -- I think, the way things are going are for, you know, integration of the entire health care. Yeah. Yes.

MR. R. J. FERGUSON: Jason Ferguson. Maybe you guys can clarify this for me because you know I'm a little slow at times.

When we went back to the Code section that Gary read from, and in reading that, it -- it's entitled the Statewide Emergency Medical Services Plan, then semicolon, trauma triage plan, semicolon, stroke triage plan.

So in reading over this, it seems that Part A is kind of spelling out what what -- more of a pre-hospital, out of hospital-type of plan for what's intended there. And then when you go to B and C when

it talks about the trauma triage plan and the stroke triage plan, that kind of supports Dr. O'Shea's interpretation of out of hospital as a whole with other components that relate to it to provide some integration.

And -- and in my mind, I'm trying to wrap my head around everything that -- Gary, what you said and -- and Gary, what you said as well. And then I -- and I set there and think of it from that perspective.

And then I think of my role and it's like, the Chair of the TCC, which is the Training and Certification. Well, what do we address?

Do we address the training and certification of pre-hospital providers in Virginia? So if the intent of the entire Board is to be more than that, then the sub-components of the Board -- all these sub -- the other committees, where -- where do we draw the line? And where -- you see what I mean, where do we define that?

MR. STARK: That gets defined here. And that will drive who the subcommittees are. Like you said, you said it best yourself. Let's not look at what's already here. Let's look high level to what we want to be, where we think our role is.

And then we'll define what committees need to be included and what individuals/organizations best represent the purposes and fulfill the mission of -- of this Board.

MR. R. J. FERGUSON: Yeah. I'm just really back to the Code, where we say Code. It's driven by Code. Is that right?

MR. STARK: Yeah.

MR. R. J. FERGUSON: What's the -- what -- everyone's interpretation is a little bit different than that.

MR. STARK: Yeah, for sure. And look, the Code can be amended to whatever we decide. You guys don't write, you know, the

legislation. But this occurs at the regulatory level, which is at the Department of Health level. You know, all we need to do -- you know, we need to talk to the powers that be within that department and go through notice of comment.

But these are these are the sorts of things that you guys can drive. And you know, enact changes to the Code that meet your needs.

I don't want to get too static and see a Code provision that talks about 28 different, you know, static members of the Advisory Board. Yes.

DR. YEE: So Allen Yee, VACEP. What are other states doing, right? We are one of, you know, 50-odd something states and territories, right? So I know most of our states deal EMS as in the out of hospital.

We've engaged the trauma triage system and stroke triage and STEMI triage into EMS. But how many of -- how many states and territories are actually

going into hospitals and nursing homes and -- and assisted livings, rehabs and going like, show us your numbers. Show us your plan. How do you -- how do we work together? Are we the first or is the other states chosen not to go down this route? I --

DR. ABOUTANOS: It's Mike Aboutanos. So we -- we reviewed multiple states when we first did the plan. And you're right, there is -- there is variability.

But there are states that have a trauma system plan, you know. And that -- the definition of trauma is not hospital. It's a trauma system, you know. And -- and there are states that are integrated.

We're not the first. And in just the -- well, there is -- and I wish someone was here because Ohio went through the same thing right now. And they re-looked at that whole thing. I think we're unique in our composition. I've not seen anybody with this much composition.

And so, yes, we can go back and re-hash and bring those back and -- so we don't -- see how others have done it. It's a good point.

MR. R. J. FERGUSON: Dr. Aboutanos, the -- where it says, like in the Code it says trauma triage plan. So in my interpretation, it would mean triage was the acute portion of that.

How we get folks from the -- from the field and integrated into the system in general, right, versus how does that -- how does post-care relate to that. That's what I was missing.

DR. ABOUTANOS: Mike -- Mike Aboutanos. Just to -- just to reply back to you. That was one of our criticisms. Our criticism is that for all these years, trauma existed only as a triage and a [inaudible] designation.

And that's not what a trauma system is. This is what prompted this whole thing for, is that we're -- that narrow focus on the pre-hospital system of trauma.

So that's why you -- why you see would be seeing that. You know, and so it was not bringing all the other aspects. When you talk about trauma system, everything comes into play.

The -- injury prevention to the post-acute. But that's doesn't have to be trauma. Just -- that's one part of it all. You know, stroke can be the same, every else can be the same.

DR. BARTLE: Sam Bartle. I think -- the term triage, actually, we have to apply it to broader sense because it means to sort.

You know, if we're figuring out how to sort all this -- patients that are in the system all throughout the system. We sort them to go one place or another, sort them to -- for post-care, pre-care.

So I don't think we need to narrow our definition of triage. But maybe we ought to broaden it. We are -- we're -- by the way, it's the triage system. The health care triage system that -- of our

population.

MR. STARK: Yeah.

DR. YEE: So this is Allen. So to play devil's advocate. How -- what authority -- I would never do that, right? Right, Sam?

So what authority does the Office of EMS have to go to the inpatient side of pediatrics at VCU to say, you need to go to these facilities.

DR. BARTLE: Well, I don't know if you looked at -- Sam Bartle again. I don't know if you --

DR. YEE: You don't.

DR. BARTLE: If you don't need it. Do you really need that, look that in-depth. Or do you say, this is the -- what we expect from a system. This is what we expect to have to be called a pediatric acute -- acute care center. Or this is what we expect to

have for a stroke center or this is what we expect to have for a pre-hospital system. Now that's what -- to me, what the Board -- it's not going in and taking -- going through the details. But we're setting the guidelines on what's -- what's the general purpose.

DR. ABOUTANOS: Mike Aboutanos. And what -- what authority do we have now from the pre-hospital side?

DR. YEE: We're all -- we're all licensed through the Office of EMS.

DR. ABOUTANOS: Okay. And so there is a huge void then. So the Office of EMS pre-definition was function. You know, so we defined that authority. Right? I mean, because that's what it sounds.

BOARD MEMBER: I don't --

DR. YEE: I don't think so.

DR. ABOUTANOS: We do it to the information inherent to a trauma system, right, as far as the trauma hospital, you know.

MS. ADAMS: Beth Adams, Northern Virginia. Sorry to interrupt, but as I read this section that outlines the State EMS Plan, semicolon, semicolon, semicolon, it says that the Board of Health shall develop and maintain as a component of the EMS plan, trauma, triage, stroke, STEMI, etcetera, that -- and the pediatric inclusion is -- is linked specifically to the trauma piece.

How we get -- or then you include STEMI. So it's trauma and stroke. I don't -- I don't see -- I don't see that we have authority over -- yes, they are part of the broader part with -- with the health care facilities, etcetera.

But we don't -- we can have opinions in several circles of influence and circles of concern. I have opinions about a lot of things, but I can't influence them. And I think we need to -- in all the time

I've lived and worked in Virginia, the Office of EMS has focused on what happened from the point of injury to getting them to the right place.

It was appropriate destination. It was licensure and education of those people. Certainly I think we need to have integrated systems of care, but we're the safety net.

And I -- and I don't know that we can -- we can say what we want, but this is still legislative code. And it's going to need to be enacted by people in the General Assembly come January -- or next January. Or the January thereafter because things move slowly with regulatory change.

MR. STARK: Not if we have a plan, though. The sooner we get on board with what this needs to look like, it only takes one notice and comment period. It's when we stagnate here when we don't drive.

MS. ADAMS: But aren't there also already those sorts of things in progress?

I mean, my understanding is there's always something kind of hanging out there waiting for review and comment.

MR. STARK: There could be.

MR. SCHWALENBERG: Point of -- point of clarification. You keep referencing it as though it's regulatory code. This is in the legislative -- this is in the -- so there -- this is --

BOARD MEMBER: It's law.

MR. SCHWALENBERG: This is law. So this does have to go through the General Assembly --

MR. STARK: Oh, these are -- these are statutes, not administrative code.

MR. SCHWALENBERG: Yes.

MS. ADAMS: These are laws.

MR. STARK: Okay. Yeah. Well, then it will have to go through the amendment process and through committees. But like I said, same thing applies.

The sooner we get it done here, the -- the more we stagnate at this level, you know, the further the delays and we're going to kick the can down the road. So if we can come forth with --

BOARD MEMBER: Which is why the next table -- the next chapter of regs has been tabled until we figure out where to go.

MS. ADAMS: Right.

MR. STARK: Yep. A gentleman down here has been diligently --

MR. CRITZER: That's okay. It was between a stretch and wanting to say something. So this is a lot more complex, I think, than everybody is -- is looking at this point. There's already a number of regulations out there that govern all these

other entities that we've been talking about, whether it's hospitals or nursing homes. A lot of those are promulgated through the Board of Health.

Board of Health Professions takes care of all you licensed practitioners that are out there that we have no purview over.

And then there's the EMS regulations for the -- the regulations of the Board that get promulgated through the Board of Health through a very detailed administrative process.

I -- the Code of Virginia, which these -- the language that we're talking about with the composition of the Board, our plans, etcetera, would require legislative action that would need to -- the best way to do it is we don't want to be going out selecting a -- a legislator to carry a bill for us.

It really would need to go up-line through the Board of Health, through the -- through the -- VDH's legislative process which is going to take time. If

you're targeting something for next session, you're probably way ahead of the game.

MS. ADAMS: I think we're late.

MR. CRITZER: Because we got to get this right. Because anything we take to the General Assembly has the ability for every fish in the sea to nibble at it. And I can assure you they will. So we need to think about what we want this to look like.

It needs to be modeled and articulated and insure that we have the support of the organizations and entities that it affects, so that we have the best chance of it going through the General Assembly and coming out on the other end looking something like we want it to look like. So --

MR. STARK: So we need to --

MR. CRITZER: -- that's the landscape.

MR. STARK: Yeah. So today, this -- what we want to establish now is what we want it -- what do we want it to look like. Okay? And then we look at the current Code.

We look at, you know, all the other applicable authority and are we constrained in that way. And then look where we need to amend and where we need to propose things. But --

MR. CRITZER: And as far as these other entities like nursing homes and hospital regulations and those things, I don't know that we necessarily have to get in the business of regulating them, so much as we need to get in the business of having them at the table collaborating as partners in our system.

That doesn't require us to have the authority to tell them, you will take this patient from Point A to Point B. That authority might already exist in some other set of regulations. It's a matter of us having the right people and the right players at the table to insure that we meet

this Code requirement of a comprehensive system of care.

MR. STARK: Yeah. Yes, sir.

MR. BROWN: I think Gary is completely correct. If the language says unify, the language says collaboration, we -- there are entities we do not regulate nor do we have the authority to regulate.

But it is very specific in terms of -- in my opinion, what encompasses the system and therefore how that -- how that should be composed eventually in the Code of Virginia, who's representing those components.

MR. STARK: Yeah, I don't think that's what -- you know, I agree. I think it's more about the integration and then having a seat at the table, who we want to involve in that process. Having a sharing of information, outcome data, things like that. And you know, I have seen a lot of states go to more of that model where they

don't -- you know, OEMS doesn't get in the regulation of those sectors, but more of just integrating them as able in some part of the -- the integral part of -- of health care.

I -- I want to soon move on to advocacy based on -- I think we're coalescing around more of an, you know, I believe I said before, an integrated model.

And having other folks at the seat here is fair -- fair enough. Or do we still have, you know, folks that think that -- yes.

MS. CHANDLER: Did we ever establish a mission statement or --

MR. STARK: No, we didn't.

MS. CHANDLER: Did we cut it off?

MR. STARK: Yeah. Let's -- let's --

MS. CHANDLER: Do we need to go

back?

MR. STARK: Yeah, we're going to do that before we go on to --

MS. CHANDLER: Okay. I was thinking I missed something somewhere.

MR. STARK: No, no. We're going to -- we're going to establish that before we go on here -- go onto advocacy. But let's go back and establish what that is in light of the discussion that we've had here. And you know, where we think we coalesce around. I will let --

MS. CHANDLER: Dreama.

MR. STARK: What's that?

MS. CHANDLER: Dreama.

MR. STARK: Dreama.

MS. CHANDLER: Mm-hmm.

MR. STARK: So why don't we discuss -- let's take this off. Okay. We know what our bylaws say. What's our mission?

MS. CHANDLER: I found something, like I said, since we seem to be pulling a lot from 2050 that -- that sounds like, our mission should be to advise the Department of Health Board on the EMS system that includes processes, protocols, technology, policies and practices designed to provide the best possible outcome for individuals and communities every day and during major disasters. And it says, EMS system. And it does say pre-health to deceased. All of it.

MR. STARK: All right. I didn't get everything down there from what you said.

MS. CHANDLER: Processes, protocols, technology, policies and practices designed to provide the best possible outcome for individuals and communities every day and during major

disasters.

MR. STARK: Is that the mission of the Board? The processes, protocols, technology, policies, practices. To deliver the best possible outcomes for the community.

DR. YEE: So protocols is too strong a word. All right, if we're talking about patient care protocols, it's probably too strong. It's probably patient care guidelines.

DR. BARTLE: Yeah.

BOARD MEMBER: Now this is encompassing into a delivery of care altogether.

MR. STARK: I'm sorry. Say that --

BOARD MEMBER: I said -- to me, all of this kind of encompassed into a delivery of care to the patients. I don't know if

that's necessary, but helping me to think about it.

MR. STARK: To affect the delivery of care.

BOARD MEMBER: None of it's going to mean anything if it's not brought to the patient.

MR. STARK: It's a patient-centered mission. What do you think? So advising the Department of Health on the entire EMS system, we define what, you know, the EMS system is on processes, guidelines, technology, policies, practices, achieving the best possible outcome for patients through the effective delivery of care. What do you guys think?

DR. YEE: I think it's too broad. This is Allen. So I think it's too broad. Now we're going to -- it doesn't -- where are we going to focus? I mean, let's get -- our bread and butter, our 90% is out of

hospital. Right? This definition doesn't even focus us on that.

MR. STARK: Well, isn't that what --

MS. CHANDLER: But a mission doesn't necessarily --

MR. STARK: Isn't that -- yeah.

MS. CHANDLER: -- give you a focus. It's the mission --

DR. YEE: Point well taken.

MR. STARK: Right. And that's where we're -- and this is fairly broad from the authorities that we're reading.

BOARD MEMBER: We're going to need it to be broad to carry on -- to -- for -- it can expand later.

MS. CHANDLER: Yeah. That within

all --

DR. YEE: Okay.

DR. O'SHEA: Just amend Department of Health to Board of Health.

MS. ADAMS: Board of Health that presents it. How does that sound to you? Is that what you want to be advised on?

MR. CRITZER: Well, what would be broad?

MS. ADAMS: I said you're -- you're the Board of Health rep. Is that what you want to be advised on?

MR. CRITZER: Redefine.

MR. STARK: All right. Mission is to advise the Board of Health on the overall EMS system, including all processes, guidelines, technologies, policies, practices, achieving the best possible

outcome for patients through effective delivery of care.

MR. CRITZER: That's close. It needs maybe a little more massaging.

MR. STARK: We -- we can do that. But are we getting there?

MR. CRITZER: Use the word comprehensive in there somewhere. Comprehensive system of care.

BOARD MEMBER: The last sentence. The last --

DR. O'SHEA: Comprehensive delivery --

MR. STARK: Comprehensive --

DR. O'SHEA: Or delivery of comprehensive care. Somewhere down there.

MR. STARK: Okay. Comprehensive

and integrative? I apologize. I was never a school teacher, so my handwriting's horrible. Yes, sir.

MR. SCHWALENBERG: Tom Schwalenberg, Tidewater EMS. Where -- where we have best possible outcomes for patients, understanding that all these are patients.

So if we look at the 2050 document, it says individuals and communities --

MR. STARK: Yep.

MR. SCHWALENBERG: -- which I think is more inclusive.

BOARD MEMBER: Yeah.

MR. STARK: I agree. That was my word and I apologize. This is what's going to drive the other stuff. Look, this -- this is all part of the process. After this happens, we're going to put something

together. Everybody will have the chance to digest that, okay? We're not looking for perfection.

DR. YEE: If we're going to put in stuff -- this is Allen -- we're talk -- we need to talk about -- add something about sustainability and social equity in here. Because you know, that's one of the biggest gaps we have in Virginia is inequitable -- inequitability across our system, right? So...

MR. STARK: In an equitable, sustainable manner.

BOARD MEMBER: Mm-hmm.

MR. STARK: I like it. All right. Okay. Let's move on to other components here. Let's talk about advocacy. What we mean, maybe even who it includes. What do we mean with advocacy? It's one of our four purposes/responsibility as the Board.

DR. YEE: So taking out of 2050, we need to be keeping our individuals, their families as well as our providers very centric. Our system need to be centric on those three groups.

MS. ADAMS: People centered.

DR. YEE: People centered. I think we all should just create our own group like Redfish.

MR. STARK: Yeah. Notice how we see a shift. You know, it was always -- it was obviously and always about patients and it should always be patient-driven. But notice who else we've folded into that are the family.

And I think we can expand that to family/caregiver, you know, whomever is assisting with the patient and -- and you know, receiving care. So...

BOARD MEMBER: Or actually, the community.

MR. STARK: The community as well. So the folks that are involved are the individuals, their families, patients and communities.

DR. O'SHEA: Jake O'Shea. Providers, I think, is a key group for whom we -- this body advocates.

MR. STARK: Do we want to -- does that fall under individuals? Is that who we mean there? Should we replace -- individual's a very broad concept here. We have specifically patients. Who do we want to replace individuals with -- providers?

DR. O'SHEA: I -- whether you call them out as under individuals, I would specifically recommend that we include providers as --

MR. STARK: Yep.

DR. O'SHEA: -- as a group.

MS. ADAMS: I'd take patients out.

MR. STARK: I'm sorry?

MS. ADAMS: Individuals, delete patients, add providers.

MR. STARK: Fair enough. We talk about -- when -- when I say the word provider, what -- what does that conjure up for you? What is this -- what do you think? We talked this morning about active providers, right? Do we also want to include in that, you know, EMS staff in general? That would be --

MS. ADAMS: Aren't they providers?

MR. STARK: What's that?

MS. ADAMS: Isn't EMS staff providers?

MR. STARK: Well, what if you -- admin staff would've --

DR. YEE: They have providers.

MR. STARK: What if you are, you know, a part of an agency but you are not a provider. You know, you don't go out as -- actively as an EMT or a paramedic.

BOARD MEMBER: So that's care provider, this is just provider. I can provide -- I provide education.

MR. STARK: Okay. So when we say provider, you guys are thinking the whole gamut? Okay. That's fine. Yes.

MR. SAMUELS: Gary Samuels. A lot of the document uses the term people-centered. People-centered. All of the things that we just wrote there are people-centered.

Anybody that can come into contact with the system, whether they're giving or receiving services. It needs to -- advocacy needs to be people-centered on both sides because the health and safety,

the mental health and those aspects of the providers, whether they're nurses, doctors, medics, EMT's. And it's also people we're providing the care for and their families and anybody that could be injured.

And the injury could be -- put that in the mental picture of what happened, and PTSD -- PTS-type of symptoms. So everything in advocacy has to be people-centered, not to break it down into one or another level. Because everybody that we touch and everybody that touches is a person.

BOARD MEMBER: And for the providers, should we add pre- and post-hospital? Or do we -- are they --

MR. STARK: What do you guys think?

MS. ADAMS: -- pre- and post-hospital?

MR. STARK: Does that fall under advocacy?

MS. ADAMS: Is that going to -- since it will connect system-wide before and in-hospital?

MR. SCHWALENBERG: We're providers, everything. All of us.

MR. STARK: I think when we -- if we were to, you know, put it into a document, it'd probably be -- the implication would be those that are pre-hospital. So we might want to separately include --

MS. ADAMS: No. Because -- because the more -- Beth, Northern Virginia. The more -- the more we break it out, the less inclusive it becomes.

MR. STARK: Okay.

MS. ADAMS: Because there are those in the whole spectrum of care who don't have a license, but they provide care each and every day. So if we are mindful of, as Gary

said, the people. People may be patients. People may be teachers. People may be a housekeeping lady who, nine times out of 10, knows more about my patient than I do. Because I'm too busy and she takes time to chat.

So if we just say providers and -- and don't put a door or a gate on it, everybody who's involved in the provision of care is part of the health care team. So I would be disinclined to put pre-/post-labels.

MR. STARK: Okay. Is that -- I see a couple heads nodding.

DR. O'SHEA: One way to phrase that would be to say people involved in the provision of emergency medical services.

MR. STARK: Do we want to --

MS. ADAMS: The provision of care. Because we talked about we were doing delivery of care. Every time we go back to

EMS, it sounds like ambulances and Roy and Johnnie and shining lights. And I don't think EMS is going to look like that in 10 years, let alone 40.

DR. O'SHEA: I guess it's the EMS Advisory Board, it feels like having EMS in the terminology makes sense. Unless we're --

MR. PARKER: But who knows if that name's not going to change?

MS. ADAMS: Because we really very 'e'. What is it -- what is it that Brent Myers always said, it's unscheduled medical care.

DR. YEE: It is. Our emergencies are actually six or seven percent of our call volume.

MS. ADAMS: Yeah.

MR. STARK: Well -- you said your

emergencies are --

DR. YEE: Probably six or seven percent.

MS. ADAMS: That are truly emergent.

BOARD MEMBER: Life threatening?

MS. ADAMS: Life threatening.

DR. YEE: Mm-hmm.

BOARD MEMBER: You mean like life threatening?

DR. YEE: Yeah.

MR. STARK: So --

MS. ADAMS: Yeah, 10% of my calls are kids, 10% of adults that need the service are critical.

MR. STARK: So do we want to change this to individuals involved in the provision of care? Or are we just going to -- are we good with providers at this point?

If we have individuals separately listed here, do we want to qualify that with individuals involved in care? Okay?

MR. LAWLER: Matt Lawler, CSEMS. I hate to -- hate to backtrack here, but the discussion over the past couple minutes, I think, is centered around the idea that the discussion that we had in the previous hour -- I don't know that it came to a consensus on what is the true definition of an emergency medical services system.

I think there was a lot of discussion about how it's very encompassing and not what traditionally we viewed EMS as. And that is actually the pre-hospital, you know, spoke of that wheel is one spoke many spokes. Although there are some that, you know, have argued that -- that we should be -- we should be focused on that. But the

need -- if we're trying to -- to repurpose the definition of emergency medical services to be comprehensive and be more of a comprehensive health care system for these people, it makes me wonder if this is even the appropriate body to be sitting here doing this.

Because if -- you know, I think the people that are sitting around this table are, quite frankly -- if you adopt that comprehensive definition -- probably two spokes, pre-hospital and trauma of -- of a bigger wheel that might need, you know, 15 or 20 more spokes on it to -- to do that.

And is this then sort of a -- what -- what should be more of a subcommittee to report to the -- our grander committee that -- that takes on that, you know, comprehensive look.

When you ask about providers, I think a lot of people are sitting here thinking, well, that was us that we asked providers. You know, like people in the fire department and the rescue squads. And

then we turn it around and -- and say, no, that's everybody in the system. But we don't have -- we don't have people representing everybody in the system in here. So --

MR. STARK: They may not be here today, but that doesn't mean they can't be --

MR. LAWLER: That's what -- yeah. But I'm --

MR. STARK: -- a year down the road. And it doesn't mean that they don't become part of the overall composition at the end of the day.

So you know, obviously, we're not going to approach and go like, hey, by the way, we just -- you know, named you as a member of the committee. But you know, 2012 statement. I get it and I don't think, you know, going into this we intended it, you know, today get everybody in the room who could potentially be a part of this. I

think we want to define who's going to be a part of this. And then we can figure out how we get those folks involved in this. Yes.

DR. YEE: This is Allen. So do we foresee the Office of EMS expanding their roles and responsibilities to include activities within the facilities and posted facilities?

Because if we don't envision that down the road, then I don't think that's palatable for the Department of Health, right?

Why -- I'm not sure we should be increasing our span of our mission to include -- to significantly include them. I think we should mention them.

They're -- they are part of us and part of the care of the patient. But I wouldn't focus on it. I think the office -- the role of the Office of EMS is really 90% role, going toward the out of hospital group. So that's where we should spend our time and effort.

MR. STARK: Yeah. Well, it's -- and the Board is specifically is about the EMS system. It's advising the Office of EMS on the EMS system.

DR. YEE: All right, play devil's advocate yet again. But we're defining EMS as everything. But yet, we're not focused -- so -- but we can't. One, it'd be too unwieldy. This would be an advisory board of like 3000 people.

MR. STARK: Right.

DR. YEE: So I think we're in a conundrum. It's a big word for me.

MR. CRITZER: But I think -- it's Gary. If you look at what a lot of the futurists are saying and what EMS really should look like, we should do what -- what the fire service has done to their stuff to start with, which is through fire prevention, they've about worked themselves out of a job on the fire side. It's that we

ought to be out there looking at our potential future customers and helping with prevention, whether it's injury prevention or it's -- you know, I didn't appreciate it until I got on the Board of Health.

And my predecessor would say in his report about childhood obesity. And everybody's going, really? What's that about? But then when I got involved and started thinking about it, those are our future patients.

Why are we not involved at our open houses in our EMS mission of trying to promote healthy lifestyles. And trying to -- and -- and eliminating our future patients.

So it's from prevention to that guy that gets discharged from the acute care facility to rehab. And he's back on the street in some form of a productive lifestyle and everything in between.

And the eye opener for me was when I had the honor of being able to go to the trauma gala at VCU with Dr. Aboutanos and Gary Brown. And at the end of that

night when they hallmarked that -- that patient and they had this line of people -- from everybody from receptionists to social workers to acute care nurses to anybody that touched that patient, that was the system of care.

That's what got him from A to B. And is that where we need to be as an EMS system. If you look at this language in the Code, it says a comprehensive system of care.

It says nothing about just EMT's and paramedics on ambulances. It says a comprehensive system of care. Now how we get to that, I'm like you. We have a -- we'd have 10 of these tables with people encircling the room.

But is there a way we can accomplish that with people that share lots of varied aspects of the system, I don't know. I don't know how we reach that. But I think that -- that the intent of the Code and the intent of EMS 2050 is that picture.

MR. STARK: And other folks bring

up an important point. They are doing it in other systems. So you know, we can look into those models and see how they're effectively overcoming some of these challenges about trying to get everybody's word, trying to get everybody in the same room, you know. And then effective ways to --

MR. CRITZER: That might come through committees.

MR. STARK: What's that?

MR. CRITZER: That might come through committees versus seats on this Board.

MR. STARK: Perhaps.

DR. BARTLE: Sam Bartle again. Allen, are you worried that we're creating a system that's going to get too involved or get too picky in certain aspects like hospitals or --

DR. YEE: I -- I'm worried about the span of control. So the bigger the span, the more unwieldy we become. And we'll get nothing done. Right?

That's my fear. Ultimately, this Board does a great job in supporting traditional out of hospital EMS, right? Now if we start getting into -- and I'm not really worried -- I'm not worried about trauma, you know.

I'm worried about the next five or 10 down the road. You know what, congenital adrenal hyperplasia, okay? Those -- that -- that advocacy group.

When they come in and try to federally legislate hydrocortap [sp] on every single ambulance was -- that's what I'm afraid of.

MS. ADAMS: That's now. It's coming.

DR. YEE: Again?

BOARD MEMBER: I think if you have

a system that's -- I'm not saying this -- massive, but at least have some ability to advise for or against or held to modify it.

If you don't have the broad, you know, authority -- for lack of a better term -- to be able to say it, you're going to be stuck with that.

But if we were giving us enough room -- and of course, if we give enough rope, you're either going to hang yourself or make a ladder.

You know, you have to have it to be able to make that ladder to keep -- keep climbing. So it's the people's who's going to be -- side of this. It's going to a ladder or a noose.

So you have to have that more broad authority and you have to have the -- the okay to go, yes, let's go and look at it at the hospital system -- close hospital system and say, this is not a good idea. I mean, we're looking at the global picture.

MR. STARK: And what integration looks like at the beginning can be minimal,

maybe just the sharing of information up front. And then what integration looks like as the system evolves can change, you know.

I'm just -- if we pigeonhole ourselves now, we're setting ourselves up, you know, to be behind in five or 10 years. Yes. Just one more comment and then we'll take 10 minutes.

MS. CHANDLER: Just one more thing. We're an advisory board. We're not a regulatory -- so we can, you know, take all this information we get in here all the time and we can advise them on their decisions, but we can't make it for them.

So if we remember then when -- when we're doing this, we're not actually doing any kind of regulation to hospitals or nursing homes or anything like that. We have -- we can advise them.

MR. STARK: Yeah, your job is advice. And to -- you know, in the code of conduct, you know, to advocate for -- for what you believe is effective for patients

and individuals who are involved in the system. So we're well -- we're well do for a break. Let's take 10 minutes right now. We'll kick back off at 2:40.

(The EMS Advisory Board took a recess at 2:28 p.m., and resumed at 2:41 p.m. The Board's agenda resumed as follows:)

MR. STARK: We all come to this from different viewpoints. You know, our -- our job and -- and kind of what we're getting at here is trying to distill down a few points.

And you know, put together a work-able vision for the future for this organization. We can walk out of here and, you know, everything would remain the same. And I think, like I said before, that would be a disservice to the folks of your state.

You know, for us to remain, well, this is the way we've always done it. You know, this is our defined mission. Folks, missions can be redefined, okay? The -- the hurdles, the legislative hurdles, the

regulatory stuff, I understand it can be a behemoth at times. But it's not completely inflexible and it can be changed. So if you have ideas, bring them to the forefront.

Don't be afraid to, you know, approach the powers that be and redefine what we do. So -- and ultimately, you know, as we said before, you're not a regulatory body. You're an advisory body.

So OEMS gets to take this all under advisement. But you know, I -- I appreciate the responsive comments and, you know, everybody's opinions today thus far.

Let's get back into one of our, you know, responsibilities -- core responsibilities and roles that we had defined, you know, sort of based loosely on EMS 2050 and talk about advocacy.

And you know, we said the over-arching portion of that is, obviously, it has to be patient-centered -- or people-centered, rather. And we talked about, you know, who we're going to include advocacy. Individuals, families, community and providers which is all going to be included

in that realm. What else do we think about when it comes to advocacy in the role of the Board? Or we can even name, you know, other groups that -- that are going to be involved in this process. What else?

BOARD MEMBER: Standards of care. Advocate for the best proven standards of care.

MR. STARK: Okay. Best proven standards of care. What else falls into this? Who are key stakeholders in the -- in the advocacy component? Pick somebody.

BOARD MEMBER: Say, you've got, not just the patient but you've got the clinicians, you've got the people that care for those. So our families as well.

Because if you think about the truly horrific days that we have, who's going to be there to advocate for us, care for us? Because if you look at the document, it actually spells it out.

MR. STARK: Yeah, it talks about -- about debriefing after incidents. You know, being evaluated for stress, for fatigue, things of that nature. It's a lot of things that some agencies are actually currently implementing. Anything else under the advocacy arm?

DR. ABOUTANOS: Mike Aboutanos. So any public health crisis -- emergent public health crisis that -- that comes up, you have to be -- we have to be -- we have to be the body that advocates for -- for that, whether it's opioid or if it's gun violence, whatever.

Whatever the need that comes up, this is -- it's -- anything that has to do with EMS system, the acute aspect of it. You know, we have to be the advocate. So not only what we came for, what are we advocating?

MR. STARK: Other thoughts?

DR. BARTLE: I think we lost -- Sam

Bartle. I think you also have to advocate for the system itself at -- you know, we're working people who rely on it.

MR. STARK: I'm sorry, what --

DR. BARTLE: Advocate for the system itself in that it will work and you can get something out of it.

DR. ABOUTANOS: Mike Aboutanos again. I think we need to advocate for the -- what are our -- the goals and objectives for the -- for the, you know, for our system.

So if -- if -- if our goal, for example, is mortality -- let's put it that way -- secondary to an acute event, you know, that we're seeing all the time. It's not the top five.

It's -- it's a job put forward to be -- be advocating to reduce, you know, motor vehicle crashes. Something that doesn't have to always be in a public health crisis. It's always advocating for what's

causing the highest morbidity and mortality for our system. And so, once we identify what part of the system is responsible for that, we -- that's part of our -- the role of the -- anything we approach with our list.

MR. STARK: All right. Other thoughts? Okay. All right. Let's move on from advocacy. What do we have here. Best practices, constant -- or consistent improvement of care. Okay, start us off. What do we -- what to we need here?

MS. MARSDEN: Julia Marsden. I just have a question. With best practices, how do we currently develop our best practices within each one of the disciplines, as well as then disseminate that information to all of the stakeholders who need to know about it?

MR. STARK: Can anybody speak to that?

DR. YEE: I think -- so this is Allen. I'm speaking purely as a clinician, right? For us -- all the physicians in the room, I think it's relatively easy for -- much easier for us to determine best practices.

Because this is -- this is an area of active research. So we are all up to date on our respective journals and -- and associations.

So we know what the evidence is that -- for EMS. Few and far between, which it makes it even easier, right? But --

MS. MARSDEN: But how do you disseminate -- it's Julia again. How do you disseminate that information? Now I know that the information exists.

But how do you get it to southwest Virginia, to the smaller hospitals down there? How do you get it to the Eastern Shore? How do you get it throughout the Commonwealth if you're -- you know, you're centered in Chesterfield. That's

kind of what my question is.

MR. STARK: Yeah. I mean, how does that manifest itself? Is there actual dissemination of the information or is that evidenced itself in protocols or -- go ahead. I'm going to let doctor --

DR. YEE: So in terms of the evidence-based guidelines, they are propagated through our -- through our -- our own associations as well as the State Medical Direction Committee.

Now, I'm not sure after it goes to Medical Direction Committee and we send it to the regional councils -- I'm not sure how far down it gets to the agency. You know, there -- so there are clearly some opportunities for lines of communication.

MS. DANIELS: It's Valeta. But it has to go to their OMD to be approved, you know, if something that's -- that's difficult, they hadn't done -- they had not done it before. It has to go to their

medical director and he has to approve it. And they have to do a little protocols. So it's a little bit of like a process when that occurs.

They -- they -- the State just can't say, oh, hey, you know, we're going to use PJ's and, you know, every 12-year-old because of this, this and this. And everybody sign off on it.

MS. MARSDEN: This is Julia, again. Right. So do we have a communication pathway for this information? And are these best practices more goals toward the different regions in the Commonwealth?

Or are they -- I mean, what are they going to be? I mean, do we currently have a best practices that we do pass down?

DR. YEE: So -- so this is Allen, again. So we don't really disseminate best practices. We disseminate evidence-based guidelines.

MS. MARSDEN: Okay.

DR. YEE: So they are two separate things. Best practices is consensus-based.

MS. MARSDEN: Mm-hmm.

DR. YEE: We try not to pass that on. But truly, when there's evidence -- when the literature supports it, we do pass that down.

MS. MARSDEN: But I thought best practices could be adapted.

DR. YEE: But not -- it may be scientifically valid.

MS. MARSDEN: I mean, I know in the medical -- yeah, yeah.

DR. YEE: So again, clinician -- it's -- it's a different term.

MS. MARSDEN: Yeah, yeah.

DR. YEE: So -- yeah. I -- I think clearly -- it's easy -- very easy for us to send -- send out evidence-based guidelines. Again, seven or eight of them that exist. So it's very easy. We have those pathways.

But best practices, we -- we generally talk about that at the regional level when the agencies come together and say, hey, this is what we're doing. We don't do that -- I don't think we do that very well as a state.

MR. STARK: Does that fall under advocacy or does it fall under this umbrella? So leave it this umbrella?

DR. ABOUTANOS: Yes.

BOARD MEMBER: Yeah.

MR. STARK: But yeah, this is certainly something that, you know, the better dissemination of knowledge, of that information if that's not occurring currently. What else under this umbrella

here?

DR. BARTLE: Sam Bartle. As EMS-C, they have a national network that they try to use. But sometimes it's hard to get it involved on a local level, down to a regional level, because part of this advocacy -- some of it is kind of independent of everybody. So it's something prepared, but we're not really using it.

MR. STARK: Okay. What else do we consistently improve quality of care in our role, you know, as the Board? What's our role here?

BOARD MEMBER: We can push for funds -- more funding or initiatives, whether it's the -- when we did the defib funding or we focus on the radio systems. Or we make sure that things are interoperable and focus it at some of the greatest needs. And some of it was lap tops or tablets, things like that. We can try to approach -- whether it's, you know, EMS for

Children, we're responding for some device aesthetic --

BOARD MEMBER: The strength devices, which we -- we saw -- we saw a need and Dr. Bartle said that practices say that we need to have them restrained like we do in -- in vehicles. And nationally, that -- that came out as scary standards.

MR. STARK: Yes.

MR. SCHWALENBERG: So I think a lot of this is -- at least this is tied back to, I guess, number four that's on your board. But is that -- obviously, if we're going to push best practices and improvement of care, we've got to know what we're measuring.

So we've got to be able to look at the data that's out there. What are we doing, where are shortfalls? And then how do we overcome those shortfalls.

MR. STARK: What else?

MS. ADAMS: Could you read the list?

MR. STARK: Sure. How do we do it -- better -- good dissemination of knowledge. Talked about how it goes to the Medical Direction Committee, then to the regional.

Getting better about implementation of those best practices. Funding for initiatives. And then measurements -- measurements of data. Yeah.

MS. QUICK: This is Valerie Quick. I would say training is a part of that.

MR. STARK: Absolutely.

DR. O'SHEA: This is Jake O'Shea. And forgive me for not knowing this, but do we do any measurement of quality data now? So for instance, patients with chest pain given aspirin. Is that a data point that we're measuring currently?

MR. SAMUELS: Gary Samuels. In the PEMS region, I sit on the Performance Improvement Committee. And we look at from first patient contact to [unintelligible] those times.

And make sure that we're within -- we set a goal and then we make sure that we're within that goal. We're also starting to look at patients taken to non-trauma facilities that have -- that meet trauma criteria.

So we're starting to -- we're looking at different things within our region. And I'm sure all the regions have some performance improvement aspect that they're -- that they're -- that they're driving with evidence-based pre-hospital care based on national standards and things like that.

Race score rated five. And some regions they use Ban. But -- but those patients go to a comprehensive center versus a primary source of service. So I think they're looking at it -- I think most regions should probably looking at some

things like that.

MS. QUICK: Well, this is where the inequities with why --

MR. STARK: Yeah, when you made that statement, she was like --

MS. QUICK: Yeah. So -- so really, who's responsibility is that? Technically, it's the agency's responsibility to be looking at that.

And hopefully agencies are individually doing that. Now whether or not the regions are doing that, I think it greatly depending on the changes you're looking at.

I think, even looking at that from a broader perspective, the Office of EMS does come back with some statistics based on what we enter into VPHIB, which is still questionable at best. You know, good data is new data out. We're not really quite there with the good data. But I do think that that shows that we do have a

discrepancy within the system of how do we get the data -- who's really looking at that data, who's responsible for making sure that that gets communicated up and -- and down.

Like do we have such variances in certain areas like -- everyone should get aspirin, let's say, for -- you know, chest pain type of patient. Is that more likely to happen in this region or this agency versus that?

That -- those are some of the things that I don't know that we're necessarily looking at. At least, we're not looking at it in a -- a regimented way that is equitable from region to region.

MR. HARRELL: So from the Office perspective, it's most important. We have a newly formed epidemiology unit within the trauma division.

Epidemiologists that have started looking at this and -- and so you know, we take this from each granular level. They're looking at it from the State as a whole. And then they're also taking it down

into the regional-based approach. It's taking into account what the regions are already doing.

As you said, varying from region to region, but also applying standardization to that to see based upon epidemiological survey processes. From the other aspects, yes, we are trying to look at improved data quality.

That is a big issue. Those of you that are in agency leadership, if you are on the no-no side of our list, we will soon interacting with your program reps from that perspective.

And that's -- that's a moving target that, you know, strategically we are trying to address and -- and looking at. Some of that, we will start to change as of the Image Trend contract, as that goes back out for bid in the next few years.

That's something that strategically, yes, it needs to be good data in, good data out. But those are all initiatives that are at various stages based upon region. And also it's at an infancy

with the Office.

MR. STARK: These higher states on Image Trend?

MR. HARRELL: The State product is Image Trend. Agencies have the ability to utilize the State's product or purchase their own third party, which could also be Image Trend.

MR. STARK: Okay.

DR. O'SHEA: And it's Jake O'Shea again. I guess just to follow up on that. Is that an area where the Advisory Board could have some impact to help work with OEMS to say we think it would be reasonable to measure door to EKG time across the State.

And either we look at it by region or by agency to -- to help put up even two or three measure points to say, we think this is -- this is a good place to start looking?

MR. HARRELL: Absolutely. I mean, stakeholders need involvement in helping to determine what areas of focus need to exist. I mean, the Office by itself has over 10 pages of areas of research they want to focus in.

But ultimately, it needs to be stakeholder driven as well. So learning from the Advisory Board and -- and the subsequent committees what their focus is and what they would like to get out of data, whether it's data we currently have or data we need to collect. Those are all areas for -- for input, absolutely.

DR. YEE: I -- I think, you know, I think the efforts of the -- the OEMS has done so far to give data is fantastic. I think there's still some clear opportunities, right?

Because what happens, the Office sends out their report and it goes to like everybody, sort of. Right? But I really want to know -- because ultimately, the region's not accountable for what I do

as an agency. It should come down to the agency. I should get a report card, kind of. A -- a more robust card than what we already have with predetermined measures that we know ahead of time. Right?

You know, and in terms of like the data metrics, I mean, we could use aspirin all day long, you know. But -- I mean, I can probably count -- I can probably find 10 articles for you in a matter of five minutes saying like, aspirin probably doesn't matter whether it's the first 10 minutes or the first hour.

We don't really know how long -- as long as it's given, we know it's good. But what's the optimum time frame? Or EKG to -- do an EKG in 10 minutes. That's very arbitrary. Does that mean at 10 minutes and one second that patient does worse?

Don't know. So some true evidence-based measures. Or we could use something like the compass or whatever they call it. NEMSQA -- is that the new -- yeah, NEMSQA, right? NEMSQA, take their core -- I hate to use that term -- core measures, but

I'm going to use it, core measures and let's just measure that. You know, at least that's something better. But give it to us as a report card. So there are some clear opportunities, I think.

MR. STARK: Other comments? Okay. So we have dissemination of knowledge. Better implementation, funding for certain initiatives.

Measurements including measurements across the State. Training, better data collection, and then more individualized assessments. Yes.

MS. ADAMS: This is Beth. It's not -- it's not just about data collection, it's about data sharing.

MR. STARK: Sure.

MS. ADAMS: Because most of the time when we get -- have issues related to delinquency in -- in the VPHIB, the Virginia Pre-Hospital Information database/system,

it's -- it's because -- it's because of things that are important, but not critical to patient care there.

I mean, we got caught in a -- in a technology snafu that had to do with some back-end thing from the software that was not mapped properly. Had been mapped, got lost in some transitional upgrade.

And so suddenly -- the fact that I'm missing two data points that, one which is a zip code, frankly doesn't matter to me when I'm thinking about patient outcomes.

Unless there's a whole zip code population that's not being cared for appropriately. But the fact that it's not there doesn't make -- make or break my day. So it's -- it's not just collection and sharing.

MR. STARK: Okay. Fair point.

DR. YEE: We also -- as EMS, we tend to measure things that are, quite honestly, meaningless, right? And --

because we can, right?

MS. ADAMS: Well, it's a convenience sample.

DR. YEE: It's a convenience sample. What we really need to do is integrate with the medical records so we can truly look at outcomes. Right? I mean, I -- the last 10 years, we worked on outcomes, outcomes, outcomes.

It is a royal pain to get the outcomes. Right? It is a manual pulling of records. You know, and when you're dealing, you know, 40,000 calls, that's tough.

MS. ADAMS: And to that end -- Beth again -- with -- with regard to the outcomes. Even though everybody that's an accredited some kind of center has outcome and feedback and training as part of their accreditation process or certification process. Sometimes it -- credit to the trauma folks. They are very good at giving me -- giving -- most of them are pretty good

with giving me trauma outcomes. But other entities, it's -- it's a nightmare. And -- and many places don't say our -- our relationship to the patients stops when we got them to their door. And then we get all kinds of --

MR. STARK: They throw up the HIPAA flag and --

MS. ADAMS: They throw the HIPAA flag, they --

MR. STARK: Yeah.

MS. ADAMS: They -- they -- yeah. It -- it gets lost in -- in the risk management crowd. And I understand that, but we can't do better service to our patients if we don't know where we bollixed it this time.

MR. STARK: Yeah, I agree. By the way, if you -- the regulation that says they can share the information from you is 45 CFR

164.506. And they're talking about amending that regulation in the future to require data sharing among providers that share a common treatment relationship with the patient.

MS. ADAMS: Great. But then they show the 42 CFR part two thing when I bring in people who are intoxicated or otherwise chemically impaired on enhanced. And then it gets really silly. So --

MR. STARK: Yeah, that's ridiculous. Information sharing. They're making express certain exceptions under HIPAA probably in a couple of years.

They're just requesting information at this point. But we're looking to see express exceptions for sharing with outreach organizations, you know, rehab centers, you know.

Post-hospitalization care and other organizations. So clearly, you can share that information. They're just mistaken about that. So that's about

education, that's about -- you know, some of it's interoperability, too, with the states that are going to Health Information Exchange. Go to a centralized record, man.

That's -- that's awesome. Get the patient and just give -- give their say-so to put everything in centralized record. That solves at lot of -- a lot of issues.

Other comments about best practices, improvement of care. Okay. Put that aside. What's number four up there? I can't -- I can't read the red.

BOARD MEMBER: Data driven.

DR. YEE: Data driven.

MR. STARK: Data driven, yeah, you got me. I can't read crap any more. Data driven. What do we need? What's that?

BOARD MEMBER: I see the following path of three.

MR. STARK: Yeah.

MS. ADAMS: Three and four -- Beth again. Three and four go hand in hand. We need -- we -- we need to look at data, not only in terms of patterns and treatment modalities as -- as well as link to outcomes.

But we also know -- need to look at data in terms of, do we have our units placed correctly so that people don't wait inordinate amounts of time that can impact their care.

So just because there's always been a fire station at the corner of walk and don't walk doesn't mean it should -- that that's where the ambulance or the transport unit should live.

MR. STARK: Yeah, and that's simple data to mine, by the way.

BOARD MEMBER: Yeah.

MR. STARK: There are solutions for

that. Is anybody using a FirstWatch in their data solution? They can do that stuff for you. They can do a, you know, a little pinpoint map, you know, for dynamic deployment or whatever.

MS. ADAMS: But -- but even those agencies that don't have the luxury of funding to be able to afford FirstWatch --

MR. STARK: Yep.

MS. ADAMS: -- which is a lovely solution. In the absence of that, there are free apps that you can pinpoint locations and get distances and look at transfer times and -- and flow times. Not that the world ends and begins on response times.

MR. STARK: No. And response times --

MS. ADAMS: And in fact, they really don't matter. But --

MR. STARK: In most cases.

MS. ADAMS: -- to the citizen who's holding the other end of that phone, it matters enormously. Because even if it's a four-minute response time, it's 47 to the person holding the phone.

MR. STARK: Yep. Yes, sir.

DR. YEE: You know, what I would love to have my hands on easily is population health data.

MS. ADAMS: Mm-hmm.

DR. YEE: Right? I don't know what the prevalence of illness is and obesity is in certain -- certain finite areas of the county.

I know overall what it is in our planning district, whatever the health department district is. But I don't know by -- by smaller community. So I can't target interventions.

MS. ADAMS: For your -- your community information piece.

DR. YEE: For my -- for my -- yeah, prevention.

MS. ADAMS: Your prevention, your public screening --

DR. YEE: Public health. Yeah, all of that.

MS. ADAMS: -- open house, let's do blood pressure checks.

DR. YEE: Yeah.

MS. ADAMS: Let's check A1C's. Let's -- yeah.

MR. STARK: But would that be the Department of Health who collects those sort of metrics. But you know, what do we want them -- we can drive what we want them to collect, too, you know. What else when we

talk about the data driven component? Yes.

DR. YEE: Cost data. I have no idea what it costs at the hospital. Well, that's a lie. A small fib. I don't know what the overall cost is at certain, you know, centers. Right?

You know, what does it cost to do a trauma alert at one facility on one side of the state versus another? Is there a disparity, you know.

When -- when -- you know, and some -- ET3's going to help with some of this, you know. You know, whether urgent care or non -- you know, an emergency department.

I -- I just don't -- we -- I don't think anyone here in this room really has a good feel for what the overall health care costs are, and reimbursements. Because most of us are not on the payor side.

MS. ADAMS: I'm -- Beth again. I would also be interested in -- maybe this is just this moment in time. But since the

implementation of the -- we have to tell them how much the air medical transport's going to cost if I'm conscious enough to get that -- receive that information. How that has impacted the use of HEMS across Virginia.

DR. YEE: That only -- you only have to release that information if it's an emergency. Because it's an ER to ER transfer, it's an emergency by EMTALA regs.

MS. ADAMS: Right. But -- but most of our -- our air carriers in Northern Virginia is not inter-facility.

DR. ABOUTANOS: Mike Aboutanos. Sorry to stop this, but I'm a little confused now with that. We're way down a different path, I think, than what this time for this.

So I think just the agreement that we need that to then ask as far as what they are, where they are. Because I think -- I wish we would just stop, honestly.

That's my opinion as -- we can scale back a little bit. We agree on the big functions and move on. I'm not sure whether the data-driven -- whether it's cost, whether it is this.

Is -- is that really what we're supposed to be doing these two days? I know one of it is the mission. And we're defining our core responsibility.

I think our core responsibility, data-drive -- very important data. How to move -- how -- you know, the bigger agenda for it. But to keep on going on at this part, I --

MR. STARK: Well, we're getting into, I think, some of the core responsibilities here. Also, the composition of the Board's going to be driven by some of this in going down the rabbit hole. Point's well taken and we'll finish up with the last two measures here. Yes.

BOARD MEMBER: One thing from data

we need overall is in what the purpose is. And what -- what do we want to see from data. We heard Mr. Brown deciding what it is or someone who can help with, you know, the needs out there.

MR. STARK: Okay. Other comments? Okay. All right, what's number five up there?

MS. ADAMS: Insuring sustainability.

MR. STARK: Okay.

MS. ADAMS: No. Not insurance. Insuring.

MR. STARK: Oh, insuring. There we go.

MS. ADAMS: I'm sure State Farm wants to insure their sustainability as well, but --

MR. STARK: I -- when we put that up there, I was -- all right.

MS. ADAMS: I kept looking at it going -- huh.

MR. STARK: All right, insuring sustainability.

MS. DANIELS: I don't see where -- this is Valeta. I don't see where there's an issue. Population's going up. EMS calls increase every year. I -- I think we're pretty well sustainable.

DR. YEE: No.

MS. ADAMS: The need is sustainable. The need for services is sustainable. But do we have the resources?

BOARD MEMBER: Yes.

MS. ADAMS: Do we have the trained providers? Do we have the beds to put the

patients in when we get them there?

MR. CRITZER: Do we have the funds?

MS. ADAMS: Do we have the vehicles, do we have the mechanisms? It's like Julia was talking about at break with telemedicine, maybe we don't need to put -- give everybody a ride. Maybe we just need a good WiFi signal. So maybe we need broadband across the Commonwealth.

MR. HENSCHEL: One of the biggest -- Jon Henschel. One of the biggest issues is providers. And that's not just EMS providers. We see the decline there, but nursing and across the board. System-wide. It's across the board. So that makes us have to look at other options, such as technology-driven options. And, you know, how do we -- how do we bring folks on board? What's going to drive that?

MR. STARK: So recruitment and retention.

MR. HENSCHEL: That's a part of it.

MR. STARK: Okay. Yes.

MR. CRITZER: Can this Board -- and actually, should this Board -- I think they should -- be involved in advising the Board of Health on reimbursement matters.

I -- we're not getting enough money to make the wheels go around. Let's get that word up-line to other folks that -- ET3's a good example, how to have sustainable funding.

Local governments are always challenged with where's the money going to come from to hire these providers and be competitive and insure we got people on the street.

And now we're talking about them and mobile integrated health care. Who's going to pay for that? Some -- some places say it pays for itself. But sustainable funding as far as this -- should this Board have input into that? I think it should. Have up -- if it's up-line to the

Board of Health to say, hey, we need to say to the legislators, we need to say to the feds we need more money. This is part of what this Board can do.

MS. QUICK: Valerie Quick. Yeah, I would --- I would say it's about having that workforce there, training that workforce. Do we have the right equipment for that workforce, too?

Whether that equipment be computers, like ambulances -- just all sorts of different things that -- that we need in order to -- to actually provide the service.

DR. ABOUTANOS: I was going to say, also, the sustainability of pre-hospital, but also the -- the bed level -- the trauma fund goes away. I'll just give you one system.

One out of an entire injury prevention program now suddenly goes away. And so that's part of the system involved and we need to look at whole system, not only be focused on part of it. The

prevention part is a -- is a huge part of trauma funds. Education also goes there, so that's another point. And -- I don't know from the post-acute, whatever they -- what's sustainability they would need.

MR. CRITZER: Cuts EMS funding overall, whether it's --

MR. STARK: Yeah. This gets -- this gets back to, you know, I noticed the lack of, you know, the addressing of the reimbursement aspect of this.

And it's really what it boils down to is sustainability of operations. Because there are folks in rural parts of America right now that, you know, their practice go out of business.

And then, you know, it becomes a fire-based entity that has to fill the delta. And -- and the only way to sustain that model are taxpayer dollars, you know. So you know, we need to think about other opportunities. Right now, you know, GAO says our -- our margins on Medicare for EMS

services are below cost. So you know, we make it up, obviously, on the other stuff. So yeah, I think that that should be part of -- of the role of the Board.

BOARD MEMBER: We need to also think about sustainable -- this group itself might need -- are doing things that have purpose, that have true meaning instead of just being a bunch of people getting together to gripe. So -- and keep sustainable by being purpose-driven and of substance.

MR. STARK: Yep. Other thoughts about insuring sustainability. Okay. All right. Let's move on to --

DR. O'SHEA: Fiscal responsibility.

MR. STARK: Fiscal responsibility. All right. What are the responsibilities of the Board with regard to this?

DR. ABOUTANOS: Mike Aboutanos. I

do think this committee is -- one of its main function is to have -- this advising with regard to the advocacy -- is -- is having fiscal responsibility toward what is it -- what's our top priority where it costs our system the most.

Where the money should be instead of the -- if we don't give that priority, people are going to allocate funding to the -- to areas that are not as impactful.

And this is really advice we should be giving to the Board of Health. This -- this is really our top thing. If you're going to put money, this is where the money should go into, and the reason why. And -- but this Board should -- that's one of our -- one our core function.

MR. STARK: Okay.

MR. PARKER: Ryan, I also think -- this is Chris. I also think we have the fiscal responsibility for funds that we utilize. So if we look at how much it costs

for the Board meetings and committee meetings. And do we have a meeting just to have a meeting to have a meeting to plan a meeting.

I think we have to look at that as well. Because that ties into what we have that's available.

MS. ADAMS: To -- Beth again. To that end, maybe we think -- should think about alternatives. While there is benefit in face to face meetings, there are a lot of -- of good technology solutions that would save people a lot of time and the State some money if we weren't all driving to one location.

MR. STARK: Yep.

MS. ADAMS: That we could phone in and video-conference.

MR. STARK: We -- we talked a little bit about that this morning. I noticed that in your bylaws -- I don't know

if you guys want to speak to that now. But --

MR. HARRELL: I mean, it's not disallowed now. The problem that comes into it is, of course, the bulk of you -- you know, a great percent of them would have to be at a single location.

And then anybody who's remotely viewing and/or participating in Advisory Board meetings, they -- that -- that location -- that physical location then has to be posted as -- as a public meeting place for anybody else who would like to participate at that site.

So if it's your home or your office, that then, you know, has to be posted publicly and open to people to come sit in your home or your office and participate with you.

BOARD MEMBER: All right. Scratch that.

MR. HARRELL: So it's -- it's

something that is allowed and it's being looked at as to how it could be accomplished. But you know, again, we talked about do we still have to have a -- what is it here, 50 -- greater than 50% in a central location.

DR. ABOUTANOS: Okay. So Mike -- Mike Aboutanos. This goes back to what we were saying before about technology and all of this. I think we understand the rules. That we're not -- it's like, okay, that's the rule.

That's the Code that we live by. And we all -- we all know how ineffective -- cost ineffective, you know, it is really not a great system. Especially now that you could be virtually anywhere and be in the same place.

We could use technology. Technology's advancing and our EMS system -- the ability for the Office's support what we're doing is still archaic. And I think by us just sitting around saying, this -- this is how it has to be, it's -- it's not

really -- talk about advocacy. This is where the advocacy should be. We should step up and just say, we are holding efficient all the stuff -- we could've moved all these meetings -- three years to establish trauma system plan is ridiculous.

It could've been done so much faster and not cost people any money. Not have providers, physicians, you name it leave what they're doing -- leave patient care to travel all the way down.

I mean, there is a -- a reasonable -- a reasonable way of demonstrating that this doesn't make sense. And the fear of you have to be public, you have to be open.

Absolutely, technology allows for that. And so I think this should be one -- one thing. And this won't be us alone. It will be every other agency that's doing it.

It's just like every -- every spear needs an arrow at the beginning. So we may be the arrow for this. But I just -- I just think that should be one -- one part

of our fiscal responsibility. It goes back to back to what you were saying, Chris.

MS. DANIELS: Valeta. So I know VAVRS has done a -- a good job on handling that. We have -- instead of meeting in person, we meet a lot over the phone.

I think that's what we're planning on? What is it, every six months or every three, four months? So we've cut our costs effectively.

However, so I have a question for you, Adam. So if 50% of the people showed up here, does the other 50% have to advertise for that other location.

MR. HARRELL: Yes.

MS. DANIELS: Okay. So that's -- that's not realistic, I mean, unless you want me to come over to your house and I -- well, we can do it together.

MR. HARRELL: So one -- one of the things that we're looking at with this as a

possibility is it's not necessarily being in your home, but you know, in the health districts throughout the state.

We have, you know, other facilities that it could be held at to where it's not as cumbersome a drive for somebody to drive two and a half hours from, you know, Northern Virginia through traffic to get here.

Whereas, you could go to a local health district or something like that. But again, it's -- you know, we -- we've got a lot of speed bumps through that because of all the requirements and regulations associated.

So it's something that we're trying to look at to help facilitate that. But you know, it's -- it's a cumbersome process that's not ours to control.

MS. DANIELS: Right. So it's not an overnight process with a Chair meeting process. All right.

MS. QUICK: It's -- it's great to

look at the -- the actual Board here and the work that it does. But this is really a drop in the bucket when it -- when you're really looking at EMS funding.

If I were to just look at what gets funded from the EMS grants, what -- what is truly needed versus what is a want for an area I really do think needs to be looked at a lot closer.

And how that relates to the rest of the system. We can look at -- and this kind of goes back to the whole council system. What are we spending money for there? Is it useful?

What are spending money for in certain conditions? Is -- is that useful? You know, I -- I think that you really can look at a lot of different areas and not -- not just kind of pigeon it down to what does this community's going to need.

MR. STARK: Okay. Other thoughts on financial and fiscal responsibility?

DR. YEE: I think someone has to --

this is Allen. So somebody has to ask the question is what we do with the Office of EMS -- what they do, is it -- and this is, you know, I -- this is a Chesterfield thing. Is it a core government function? Right? Can someone else do it and -- and do it cheaper?

Are there -- are the redundant services across our Board, across the Office that can be shared with another office or another board? Make us -- make us essentially, a little slimmer and faster.

MR. STARK: Yeah. And that goes back to what we started with this morning, you know. Whether or not current composition of the Board is -- is necessary, you know.

Do we -- if we're going to talk about fiscal responsibility, we really need to get back to that -- that core tenant that's, you know, when we look at composition of that Board, this Advisory Board and the committees as well. So you know, that's a function of fiscal

responsibility. And that will drive that. Other comments? Are we -- these six, you know, core purpose, responsibilities are at least, you know, in principle kind of on board with this is sort of the -- the mission and looking forward.

This encompasses what we should be, you know, aspiring for. Kind of in agreement there, you know. And I think some of the stuff that we're trying to develop here are the core responsibilities of this Board in moving forward. Other comments before we wrap up in that respect? Yeah.

BOARD MEMBER: We don't have it anywhere in our core responsibilities. But somewhere we have to put review the system-wide EMS plan -- Statewide EMS Plan, which is one of our defined responsibilities.

MR. STARK: Yep.

MS. ADAMS: Isn't that our commitment to innovation and excellence?

Number three. There in the middle -- yep. Right there. Isn't that where we demonstrate that by reviewing and evaluating that information? Question mark.

MR. STARK: Yeah. It can fall under a couple.

MS. ADAMS: Well, actually --

MR. STARK: Fiscal responsibility --

MS. ADAMS: -- you could -- you could merge three and four that -- that are evaluation and -- evaluation and innovation of care is linked -- everything is -- that we do, all of the -- all of these responsibilities are data-driven.

But specifically, those related to outcomes and deliverables because five's easier to remember than six.

MR. STARK: Yeah. Fair enough. Okay. So we went over, you know,

composition of the Board. What we're going to look at is based on -- I will distill these down to, you know, the six core principles that we've looked at here. And I'll also distill that into some of the core responsibilities of the Board as well.

So we've kind of checked those two off. And then, that's when we look at the proposed revisions to the bylaws that will be driven based on, you know, our model in moving forward here.

What about, you know, ideas about -- when we talk about the 20 Advisory Board members here, do we think that based on the six parameters that we've established -- these core principles.

Do we think that we could establish Advisory Board members based on those? Do we think these are broad enough that we can, you know, drive the requisite core group that needs to be on that Board? And is that the way it should go, too? Yeah, go ahead.

DR. O'SHEA: Jake. I -- I guess I

would say looking at the current, you know, composition of the Board against these core principles, as opposed to starting de novo would be my suggestion.

MR. STARK: Okay. You got a comment?

MR. R. J. FERGUSON: Jason Ferguson. Just saying that to maybe looking at the -- thinking of the big picture and looking at the mini-structures that -- that build the -- the worker bees that -- so that you don't have the Board getting this big.

MR. STARK: Yep. Other comments?

MS. ADAMS: Question.

MR. STARK: Mm-hmm.

MS. ADAMS: Beth, Northern Virginia. Is there a provision in the committee structure of the Commonwealth that allows to use staff folks as ex-officio

members to -- to fill a need? So for instance, with Adam's epidemiologists that's now part of the Office of EMS staff, can -- could they, in fact, serve that capacity as a resource to this body without being on the Board?

MR. BROWN: The entire Office of EMS, we're all -- we're all a resource. Staff resources to the Board. I mean, that's even in the Code. It says the Office of EMS staff's the State EMS Advisory Board. Quite honestly, it's a matter of priorities.

MS. ADAMS: Mm-hmm.

MR. BROWN: It's a matter of, you know, breadth and scope of -- of what may need to be done. I can sit here and say it would be nice to staff everything that you want, but that may not be physically possible.

MS. ADAMS: No. But if -- if this body could, for instance, identify a report

that would -- could be generated from the VPHIB side of the House --

MR. BROWN: Yes.

MS. ADAMS: -- to be issued to us two weeks prior to an upcoming meeting that looked at -- at a specific topic area that that might fulfill some of the need for information that we're seeking without finding a room big enough to accommodate more chairs.

MR. BROWN: And again, how that would communicate to our Office from -- whether it comes from the committee or the Board or however, it is just one person in one locality seeking something because they've got a coming board meeting themselves next week.

We may have to get -- get to it -- you know, it would have to be kind of more of a systems approach, depending on what you're looking at. Kind of getting back, I think, what Dr. O'Shea was talking

about earlier --

DR. BARTLE: Sam Bartle.

MR. BROWN: -- and that reports.

DR. BARTLE: Sam Bartle. I don't know if this is -- and I'm not seeing how this can make us or help us choose individual positions because they're very broad and very -- it's something that every member of the Board should be doing and looking at in a -- for anything that comes up.

So it would be nice to help whittle down who can be on the Board or should be on the Board. But I think it's going to be -- this is what whoever is on the Board needs to consider.

MR. STARK: Yeah. We're going to have to consider the constituent members, and like I said, what purpose they fulfill. And we'll go from there. All right. Let's -- let's take 10 minutes and then we'll

reconvene for the remainder of the afternoon.

(The EMS Advisory Board Retreat stood in recess at 3:37 p.m., and resumed at 3:48 p.m. The Board's agenda resumed as follows:)

MR. STARK: And after the meeting -- we just had a discussion. He said I don't mean to be that abrupt. I get it. I -- I've been through a lot of these meetings.

And you know, we're -- we're trying to get everybody on board with the process. After this, I'm going to distill the things that we've talked about today into concepts here.

Also going to distill some of those core, you know, responsibilities into that document as well. I'll look through to see, you know, where the bylaws currently could use a little revamp. But that's going to be driven afterwards. So it'll make sense once we put it down and give you guys sort of a road map to work from. But I

appreciate the discussion and appreciate everybody, you know, being open about their concerns and -- and everything else. We're going to move on to the goals and objectives of committees.

And I've asked Chris to lead us off on this one. This was added to the agenda. He had some specific items that he wanted to address with respect to the committees here. So I'll go -- go ahead and let Chris have the floor.

MR. PARKER: So some of the discussion that we've had is in aligning our current committees with the trauma committees, as well as -- and we've brought it up a couple of times already today.

Should mobile integrated health care be a committee? So that's something that has been asked. So I'll let it start with the current structure.

Do we see the current committees as being beneficial considering there are no defined goals and objectives? There is mission statements for each

committee, but there's nothing that's define-able to deliver, I should say.

DR. YEE: Chris, I'll start. This is Allen. So I think that the way trauma set it out was -- was a great idea because they gave them goals.

MR. PARKER: Right.

DR. YEE: But now -- but they were new committees. I think as they start solving some of those problems -- some of those initiatives, they'll be in the same boat as the rest of our committees were or -- or they are.

They're just going to be standing committees because we've been in existence for, I mean, a gazillion years.

DR. ABOUTANOS: This is Mike Aboutanos. I -- I agree with Allen to a certain extent. The -- I think what we're asking is maybe redefining the functions of these committees more. We go through the

system -- if you -- my feedback on the committees and what the -- the pre-hospital -- just as much as you kept saying established something nice.

In all honesty, I'm very impressed by -- by our committees. I'm very impressed with how they're set out, where they're at, what they're doing. I just think they're focused on one part of the system.

If you change that, we may be able not to change much that get -- get to the -- you know, if you are -- example is, you know, does your committee handle everything in entire system, not just pre-hospital.

It just, again, goes back to the identity of who we are. If the -- but the -- the structure, what's being handled, I think that one part of the -- I mean, our pre-hospital system, I think it's -- I mean, everybody's in the trenches, all together, we discuss things. It's a very impressive system, you know. And you have been incredibly open in -- in looking and

allowing trauma to come in now. But it's the goal and objective for each committee to a goal long range.

MR. STARK: Did you want to get specifically into each committee, Chris?

MR. PARKER: What's the bill of the group?

BOARD MEMBER: I think it would be worth talking on each committee.

MR. PARKER: Okay.

BOARD MEMBER: We know what they are. I mean, we know what they are, but it's still important.

DR. YEE: So I'm going to play devil's advocate yet again. So shouldn't the committees create some of their own goals and objectives at this point? Right?

BOARD MEMBER: Say what?

DR. YEE: At this point -- because we are established. These are not new committees, right? We, as a -- I've done a few tours in the GAB. And we have yet to -- I'm not sure we've ever asked the GAB chairs to create an -- an agenda, right? We go through the same agenda every single time.

You know, but -- you know, what are our objectives? What are our goals for -- for the -- for two years, let's say. I don't think we've done that or asked the committees to do that.

DR. ABOUTANOS: No -- Mike Aboutanos. I -- I second this 100%. Our biggest fear when we were trying to do the trauma part is lack of ownership.

And even when it's your oath, it doesn't matter, the minute you -- you tell the committee, this is the overall -- what our mission, our goal is.

Then go ahead and make your objective that will fulfill. As long as they're aligned. If they're not aligned, then that's where maybe they contribute.

And that's what -- what we end up doing, having the goal and objective of each. Some of course, the committee come in, get presented back to the group.

And the group give comment back into whether those are aligned or not. So -- but I agree, we get more ownership -- as long as we give the overall, what the -- the overall objection and mission.

MR. PARKER: I also think that from the aspect of when you put someone in the position as the chair of that committee, do they know what -- we don't have anything in cement, either.

Goals, objectives or some kind of procedure, do they know that they're supposed to review 'x' every two years or they're supposed to do this.

So that's something that's been brought to -- Jon's brought that up to me. Do they know exactly what they're supposed to do.

BOARD MEMBER: Is that really

goals?

DR. ABOUTANOS: That's not goals and objectives. That's processes, if you want the goals.

MR. STARK: Do we -- yeah, do we want to lay out any parameters for goals? So these can be short term, long term and -- you know, should they be separately defined?

I know that we have some defined for trauma right now. Maybe those examples might be illustrative to -- even read through -- yes.

DR. O'SHEA: Jake O'Shea. So I -- I think some organizations have the concept of cascading goals. So you know, you have a big over-arching goal, which would be the goals of the EMS Advisory Board.

The committee goals could be created by the committee, but they would have cascade from the over-arching goal of the Advisory Board. And you don't want to have goals going at cross purposes.

MR. PERKINS: Hey, Chris.

MR. PARKER: Yes.

MR. PERKINS: Ryan. I'm Tim Perkins from the Office, for those who I haven't met before. A few years back, and I can't remember when it was, I know the Medevac Committee did this but I'm not sure if other committees did.

We actually had a planning session where we established the mission and vision and kind of went from there. And like I said, I don't remember if other committees did that. But I know the Medevac Committee did.

MR. STARK: Do all the committees currently have a mission and vision? Do the initial 10 have -- so Rules and Regs, Legislative and Planning, Transportation, Communication, Emergency Management, Training and Certification, Workforce Development, Provider Health and Safety, Medical Direction, Medevac, and EMS for

Children had a mission from the original guiding document.

BOARD MEMBER: Yeah, each one has a mission statement.

MR. SAMUELS: Gary Samuels. And this document hasn't been updated in over two and a half, three years. Because it still has Paul Sharp's name on it.

And it still has others on it that haven't been with EMS for -- so as a -- as a guidance document, this is what we're handing to new members of the Board to look at. So we -- I guess it's crawl, walk, run.

Yes, I think it's probably a really good time that we update this document. But I agree that it should be that each committee sets their goals and objectives, and -- and then we put it together.

And then each committee has people that are resources to that committee that work for the Office or -- or the State Board or whomever to kind of balance that

out and help us with the guidance. People that have historical knowledge that are at the table also can help balance that out. I mean, someone like Gary Critzer who -- you know, he -- he led a lot of initiatives. He was leading the Board.

And -- and Chris has kind of picked up on some of those and -- and you filled in when you could. But I -- I think it's truly time that maybe this document -- it's time to revamp it.

But also take a look at the overall structure of it because some of -- some of these committees could be ad hoc committees to -- to kind of drill it down a little bit.

Do we need a Legis[lation] and Planning and a Rules and Regs when they're looking at a lot of the same things? Do we need Transportation and Communications when they could be part of Systems Oversight or -- or EMS Systems as a whole? Or you know -- I don't -- you can develop a lot of different ideas --

BOARD MEMBER: Can make a case for it all.

BOARD MEMBER: Yeah. Well, that was worthless.

MS. ADAMS: Festive, though.

MR. STARK: What's that?

MS. ADAMS: It's festive.

DR. BARTLE: Sam Bartle.

MR. STARK: It's Virginia.

DR. BARTLE: Coming from EMS-C, we sort of got adopted by this Advisory Board. Because we come with goals and objectives from a national standard that's down to a state standard.

It would be nice to be able to say this is what we're working on also supports what this group is working on. But we need to know what this group's goals and

objectives are to say how to align what we're doing with that. Because otherwise, we sort of -- it keeps us kind of hanging out with you guys with, you know, supporting whatever initiatives going on.

But overall to be productive, it would be good to be able to say we're supporting this part. You know, we're in supporting the -- whatever it is, training or the data collection as part of our overall mission. If we don't, we'll still be working on our own -- own objectives.

MR. STARK: So let's talk about -- oh, go ahead.

MR. R. J. FERGUSON: Just a quick question. It's Jason Ferguson. So maybe we should take our own advice and work with it. And if we go back and look through -- again, things haven't been updated as they should have on the web site.

A lot of the Advisory Board minutes are there, to look at really what's coming out of these committees. Because the

majority of them, they -- they meet, they meet for a short period of time. They have no action items.

And just like Gary said, you know, you've got some that talk about the same thing for 30 minutes when they could've put that together or work -- made that possible with work groups or whatever from those.

So you know, maybe that's something to look at because I -- there's -- each Advisory Board meeting, there's -- it's always brought up what this committee didn't meet, the -- they didn't have a quorum or they didn't have any business and that kind of thing.

And it seems like a lot of times, it's the same ones. Whereas some other committees are very busy and bring action items on a fairly consistent basis.

MR. STARK: So can those duties be subsumed other committees that actively meet on a regular basis? You know, can we make those fall under the umbrella of another

committee? I realize, you know, we're listed the names of committees here. So that's a -- obviously, a limitation. But we're not wedded to the -- even the names of the committees, either.

So that's one of the things that we ought to look at. I think that's a really good starting point is looking to committees that don't have a lot of action items, who can't, you know, get a quorum together.

You know, and -- and determine whether or not it -- you know, if we still believe the function, what they're performing is useful then, you know, can we couch it under another umbrella. Yeah.

MR. D. E. FERGUSON: Eddie Ferguson. To your point, Transportation -- for example. We meet twice a -- twice a year is what it looks like. I just assumed that did last fall.

It looks like we serve a central function to the FARC Committee to the ambulance grants. But we didn't -- we

don't -- we haven't had any other business of this Office. And I'm sure that committee was very robust in the past, but with the state ambulance contract and some other things. But now I know that that's -- I haven't been told and I don't know that that's meeting, okay?

So what I'm thinking is that we could -- could operate as a part of the FARC committee to do the ambulance grants and provide that insight, which I do think is an essential function for them. But Kevin, you brought --

MR. PARKER: Eddie, FARC is not a -- FARC is not a committee.

MR. D. E. FERGUSON: Right, it's not a committee. But we serve that -- we serve that function for them. But Kevin, you served in Transportation. And I don't know if I'm missing something.

MR. DILLARD: No. This is -- this is Kevin Dillard. You're right. Years ago

when they had the State Transportation Ambulance contract, they were very active and -- and robust with helping to select that. But now, that committee served a very valuable tool to FARC --

MR. D. E. FERGUSON: Yes.

MR. DILLARD: -- evaluating the grants. But I'm not aware of anything else that is going on.

MR. D. E. FERGUSON: It could be something in the future regarding specifications on the federal level, I don't know. But right now -- but I fear that we can get by with meeting twice a month -- twice a year.

BOARD MEMBER: Twice a year.

MR. D. E. FERGUSON: I'm sorry, twice a year. No, we can't do that.

BOARD MEMBER: One way we could

kind of look at the committees, if you look at the Virginia Office of EMS for -- to get an operational plan that has all their objectives listed and which committees are accountable for those objectives. So that point kind of brings some together, you might see some others cross that way.

And then take what we decide the objectives for this Board is and see which committees we think would be accountable for -- for many of those objectives.

I think that would kind of narrow down instead of -- see, who does what and where the overlap is. It would be kind of easier, I think, to see it that way.

But every one of them in here has which committees account for that agenda. And it's that strategic plan.

MR. STARK: What other methods of oversight for committees if we are lacking, and/or do we want to set specific parameters concerning action items that come out of committees?

MS. ADAMS: Do we really need 10?

MR. STARK: Yeah, actually there's two, four, 10, 11, 13, 14, 15, 16, 17, 18. It's 18.

MS. ADAMS: Okay. Do we really need 18?

MR. STARK: That's -- yeah. I -- I really -- oh, go ahead.

MR. SAMUELS: Gary Samuels. I'm with you and that's kind of what I was trying to look at. You know, how many -- how many of the committees duplicate functions or have -- have such a narrow focus that truly another committee could -- could be working on that same issue. I don't -- I don't know but that could be a -- a whole 'nother work group.

MR. CRITZER: Which comes back to the fiscal accountability for the Board, because you're not having to pay for another

meeting and travel. And low-hanging fruit because it's all in the bylaws of the Board, which the Board have full control of. There's no regulatory action, there's no -- anything that has to happen. This Board controls that committee structure.

MR. PARKER: And this is -- this is Chris. I'll be very transparent in this. This has been the push of why I really wanted us to come and meet today was committee structure.

Sitting through the last three Advisory Board meetings and listening to the committees. Prime example, I'll throw it out there -- pre-hospital care.

There are five goals and four of which are covered in other committees. And I'm sitting there and I'm going, what's the function?

Then you have emergency management and emergency preparedness and response. Their mission and their goals pretty much mirror. So why are we kind of duplicating this?

MS. ADAMS: Chris, some of the names you just mentioned aren't on the list in this packet we got --

MR. PARKER: Correct. They were added since that package was updated.

MS. ADAMS: Okay.

DR. O'SHEA: So to clarify, you're talking about the trauma Pre-Hospital Committee and the trauma Emergency Preparedness and Response Committee.

MR. PARKER: Yes, sir. The pre-hospital committee -- if you look at their goals and they're fine -- defined. So goal one is to develop and implement a minimum set of statewide trauma treatment protocols for adult, pediatric and geriatric.

So in my mindset, Medical Direction does that and EMS-C does that. Correct? Or could do that. So if that's the case, then why do we have that as an

objective? Number two -- two is a tough one that's a little bit different. Establish minimum statewide designation guideline standards for each step of the state trauma triage criteria, both adult and pediatric.

That's not one that I see anywhere. But number three is develop resources for ground critical care transport. If the committee is pre-hospital care, how are they defining critical care transport?

Should that not be Rules and Regs, Medical Direction or Medevac? I mean, that's something that we want to look at.

DR. YEE: I think -- this is Allen. So I think that's what we've done coordinating with the committees is Medical Direction has taken the lead on that.

MR. PARKER: Right.

DR. YEE: And just reports out at pre-hospital care. That's -- that's -- and what -- the genesis behind that was -- that

was an ACS recommendation gone through the trauma system. So that that objective stayed in place knowing that Medical Direction was probably going to take it. Yes, we're redundant.

BOARD MEMBER: But why?

MR. R. J. FERGUSON: Yeah. And why can't we can't we change -- Jason. Why can't we change that? Why do -- why do we -- why do we have to say, well, we -- we knew we were going to keep repeating ourselves, but eventually, it'll get to this point.

But we don't know that unless we make that plan. And -- and I set in that pre -- not the last one, but before pre-hospital. And everything they came up with, someone from the audience says, what -- what is your purpose?

Because everything that you've said, they keep saying goes to this committee, this committee or this committee. And as much as we want involvement, do we

get to the point where we do say we can merge these two? I know -- I don't know, Valerie, how you feel. But I think like Provider Health and Safety could easily fall under the goals of Workforce. There's a lot of duplication in those meetings that we set through.

MS. QUICK: Yeah, absolutely.

MR. R. J. FERGUSON: Because that -- the -- they're smaller and that would make that get more input. So I don't know, just those reports.

DR. YEE: So this is Allen. So work -- you know, that's one example. Emergency -- emergency preparedness and -- and the other one -- emergency management should be probably combined.

Pre-Hospital Care should like -- I would suggest that we morph that into an ops chief committee. Right? We don't have a committee where we got boots on the ground ops chiefs, right? So maybe you

create a committee of 10, you know. Three urban, three suburban, three rural and that's it. You know, and this way you get more of this -- how Valeta put it, the provider input into the system.

BOARD MEMBER: But why do you have to have it specific to trauma?

DR. YEE: No, you wouldn't be trauma. It would be a committee. And maybe we move it out of trauma.

BOARD MEMBER: Gotcha.

DR. YEE: And I think that's -- but again, like I spoke earlier, this is just some of the maturation process of where we had to start.

BOARD MEMBER: Right.

MR. D. E. FERGUSON: It's Eddie Ferguson. Some of that Pre-Hospital Committee composition we worked on as part

of the statewide trauma plan may already address some of the different players that we need.

I know some trauma coordinators named specifically. But it covers everything from your larger institutions to the community hospitals, includes an ops chief, a ground EMS provider, a helicopter representative.

So that -- that composition, the average Virginian, when they look at that and they find out that it may actually work for that operational -- that committee that he's referring to.

MR. STARK: Sounds like we need a global evaluation of the various committees here. And you either got to do that internally and task the folks with it.

And I don't recommend that you, you know, do the old Office Space -- hey, what is it that you actually do around here, sort of approach. I think that, you know, we pointed to a couple of parameters already that we can look into to determine

whether or not we can house some of these functions under the other committees. Or the committee, quite frankly, we don't see a justification for it any longer, there's no reason why we can't just eliminate those functions, you know, and start with this document.

So that's something I -- you know, I'd be interested to hear your folks suggestions on. Would you want somebody on the outside to look at those specific parameters and, you know, make recommendations?

Or can -- can we do this in-house and who's going to -- who's going to take responsibility for that? That make sense?

MS. ADAMS: It's -- it's -- this is Beth. It seems to me that if trauma has been integrated to the EMS Advisory Board and it's EMS -- EMS Advisory and trauma, then we shouldn't double up on committees. That if -- if they've got -- if they've got something that is working and is more

functional, I just pulled up one and they haven't met since February, if the web site's to be believed.

And if the web site's not to be believed, then I'm casting aspersions when it might not be their fault. They may have had 14 meetings, but they're -- nothing posted since February.

MR. STARK: Sure.

MS. ADAMS: Which leads me to say there's an inefficiency somewhere.

MR. STARK: Sure. And you know, part of that is not just making like you said, casting aspersions based on assumptions on available information.

There might be legitimate reasons behind, you know, lack of meetings, lack of objectives. There might -- might actually be that there are duplicative efforts ongoing. So --

MS. ADAMS: Yeah.

MR. STARK: But we need to investigate that. We won't -- yes.

MR. R. J. FERGUSON: It's -- Jason Ferguson. Just to point out, too, that the other -- if we determine the committees we need, then there can be seats added to represent these other areas.

So that away, we don't have so many committees, but maybe everyone has a voice within the -- the committees we determine that should exist.

And then Chris had brought up earlier maybe -- or he gave the example of like a mobile integrated health type of -- maybe a committee needs something there.

We can add other committees that kind of meet that -- needs that are growing and more -- and the risks, too.

MR. STARK: Yeah.

MR. CRITZER: This is Gary. I agree with you. I think the thing to keep in mind -- I know extra committees got

added. It was through the trauma review -- site review system and the task force that we did. Those committees came out of that. This Board approved them.

And it was trauma's feeling that there was a lot of under-representation by those different committee members. So if you could insure that those committee members with added seats were just added, if they combine I think you'd address that concern. They don't have to have a separate committee.

MS. ADAMS: So is there a data source that can tell us whether meetings were, in fact, held? Or do we need -- or do we need to do some kind of heavy duty find every time 'x' got mentioned and search all the minutes for --

MR. CRITZER: If there was a meeting, it should've been an official meeting with a roster and a role and minutes. And --

MS. ADAMS: And is there --

MR. CRITZER: And it should be available through --

MS. ADAMS: Is there a rule about how long --

MR. STARK: Hold on.

MS. QUICK: I can tell you right looking at the meetings -- the two that I go to regularly, the Workforce and the Provider Safety, it is not updated on the web site. So we have met several times in between and it's just not there for whatever reason.

MR. HARRELL: Workforce still has Jose Salazar --

MS. QUICK: Right.

MR. HARRELL: -- as the Chair. And nothing's been posted since 2017.

MS. QUICK: Nothing -- nothing is updated, which is -- you're right.

MS. ADAMS: Since 2017.

MR. HARRELL: Right.

MS. QUICK: Yes. So it's an inefficiency, you're absolutely right. I can tell you being on both those committees, just to second Jason, that they are very much the same information that is being given in each of those. So that is certainly kind of a[n] easy one to --

MR. STARK: Who -- who's in charge of that? After conduct a meeting, who's in charge of posting minutes?

MS. HAMILTON: The secretary --

MR. STARK: It's not him.

MR. HARRELL: An OEMS staffer.

MS. QUICK: It's an OEMS staffer.

MR. PERKINS: I can say that we are working to get the minutes updated --

MR. STARK: Okay.

MR. PERKINS: -- and agendas updated. Staff, especially the division managers, have told us that we're a little bit behind them.

MR. STARK: Okay.

MR. PERKINS: And I notate four or five, but the update -- the responsibility for keeping them updated ends with us. But we do recognize that we need to update those parts of the web site.

MR. STARK: Fair enough. Yeah. And -- and there's a technological solution to that, too, where these folks can, you know, be proficient somewhere they can upload. That's -- that's a discussion for

another day, but yeah -- yeah, that's a good point.

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

MR. STARK: Yes.

DR. O'SHEA: Does it make sense to throw out buckets of committee work that we would conceptually think need to exist? And I think we've talked about, well, this committee and this committee go together. And this one and this one.

But I like the concept -- I think it was -- it was Gary that said sort of an operations committee or an operation chief, or looking at it from buckets of topic as opposed to saying can we merge these two and merge these two.

And -- and I bring that up somewhat selfishly because I -- what I don't see in -- in those committees is -- is sort of a continuous improvement in quality committee under EMS Advisory Board. I don't know which of those committees that we

currently have would be the one that would be focused on that overall.

BOARD MEMBER: Under the trauma system coordinator, there is System Improvement. But again --

DR. O'SHEA: Right.

BOARD MEMBER: -- that's really just a trauma.

DR. O'SHEA: Beyond -- yeah. Beyond trauma, there's no global committee.

BOARD MEMBER: Right.

DR. O'SHEA: And I think we said that that would be an area of focus for us as a -- as a Board.

MS. ADAMS: It seems like in the -- in the absence -- this is Beth again. In the absence of concrete information about how often these groups are meeting, I mean

-- I mean, at quick glance it seems like some of these pair nicely. And they all have -- say that there's a representative on there from -- on behalf -- I mean, it says there's an Advisory Board member on everything, practically all these committees -- and plus or minus being the chairman?

So I know I got told, as I was leaving my first meeting, oh, you need to be on a committee. And I was like, well, how do I pick?

What do I know? And they said, well, committee -- the guy that you replaced has already been replaced. So I was like, okay. Well, do I pick what I like? Do I pick the ones that meets least often because I don't like to drive?

MR. STARK: Yeah. I think clearly one of the other parts of this is obviously updating this guidance document as well. Or we need to get to defining, you know, whether it be buckets or whether it be particularly -- particular committees where you guys want to go with that, and holding a

discussion about that.

MS. ADAMS: The other question, if you're -- so if I'm not an advisory -- because I know some people who are really passionate about some of these topics. And would probably be delighted to have the opportunity to serve.

However, does being on the committee require the same application consideration by the Governor's Office or is this a --

BOARD MEMBER: No, no, no.

MS. ADAMS: -- hey, what are you doing Thursday? We got a meeting in Chesterfield. How does that work?

MR. STARK: Chris, you want to --

MR. PARKER: The committee composition is gone through on the Executive Committee and approved.

MS. ADAMS: Mm-hmm.

MR. PARKER: Between the chair and the Executive Committee. It says to be reviewed annually. Although TCC has set their own to have rotating terms on the term limits.

So again, that's something that -- to consider. Of the committees that we have, all but the trauma committees are chaired by an Advisory Board member.

MR. PERKINS: Has to be.

MR. PARKER: What was that?

MR. PERKINS: Has to be. Per the bylaws --

MR. PARKER: Correct.

MR. PERKINS: -- it has to be chaired by a member of the Board.

MS. QUICK: But not from the

trauma?

MR. PERKINS: That I don't know. That I don't have any insight?

MR. STARK: What's the -- and you know, that begs the question, too, is that a requirement that we want to retain in the bylaws? Do we think there's a --

MR. PARKER: In one place --

MR. STARK: -- policy?

MR. PARKER: -- in the bylaws it says that, you know, you have to serve on the committee. And then in another place on committee structure, it says that you have to -- it has to be chaired by.

MS. ADAMS: Is the size of the Executive Committee specified in statute or the bylaws?

MR. PARKER: Bylaws.

BOARD MEMBER: Is there where the decision on the committees merging and all should be made?

MR. PARKER: That's out of my purview. Well, should the Executive Committee be the ones that make the decision on the merging of --

MR. CRITZER: You can certainly make a draft recommendation. But the Board's got to vote on it because it's going to require a bylaw change, so -- I mean, it's certainly better.

You could appoint a committee to work on it, but you could -- you know -- either way. Still the committee --

MR. PARKER: Did you say you wanted to chair subcommittee? Is that what you just said?

MS. ADAMS: Yeah, I'm jealous and I'm going to chair four of them.

BOARD MEMBER: I was going to suggest that each committee chair at their next meetings, that that be a part -- that be their agenda.

To look at their make-up, what do they do, set goals. Because they already have a mission. And then bring that back to the Executive Committee. Because we have the five Board members that are over all the committees.

MR. PARKER: I think that might have to be something that happens between now and then. Because not all of them will meet in November.

BOARD MEMBER: Yeah, that's true.

MS. ADAMS: Well, most of the committee meetings are scheduled for October.

MR. PARKER: That's what I hear.

MS. ADAMS: Like in two weeks.

MR. STARK: Is that something we can send out an edict that the committees come up with several objectives in 'x' period of time? I think that'd be a reasonable goal.

That would be one of the parameters by which we can, you know, evaluate these committees. Dr. O'Shea.

DR. O'SHEA: I mean, I guess I would just throw out a counter proposal for consideration is this group could come up with some recommendations to consider. Not implement but consider.

Circulate them for discussion amongst the committees. And then, you know, at least give them a framework for the concept of merging, you know, Workforce Development with Provider Health and Safety.

And say, we think this might be a good idea. Why don't you discuss this at your next committee meeting? And that way, there's a framework for them to work from, as opposed to them trying to merge five times 18 -- 90 different objectives,

which could be challenging.

BOARD MEMBER: And we said have the Executive Committee take all the information as the coordinators and bring the -- you know, come up with suggestions and bring that back to the Board as, you know, we're presenting this suggestion.

MS. ADAMS: Well, what role does that coordinator have besides wearing that hat and overseeing one to four committees.

MR. PARKER: It's seven if you think about the trauma --

MS. ADAMS: Or seven. Yeah, okay. But what -- what role? I mean --

MR. PARKER: The coordinator, initially, was supposed to be there to help make sure that it -- the information dissemination happened. So if something was talked about in Medical Direction that needed Legislative and Planning to make sure

that it made its way back.

MS. ADAMS: Okay. So you say --

BOARD MEMBER: If you had a -- but can you request it like a change in the membership, things like that, for them to bring it back to the Executive Committee?

MR. PARKER: Yes.

MS. ADAMS: And how effective is that -- how effectively did that work? Coordinators? Allen?

DR. YEE: Not as effective as we could be.

MS. ADAMS: Okay.

MR. CRITZER: At most Advisory Board meetings the report from the coordinator was, no report.

BOARD MEMBER: Yeah, I think that

it was --

MR. CRITZER: Yeah, there was very little work that they ended up doing. Only if there was a -- some kind of a like -- Medical Direction was working on something that they needed to collaborate with trauma or the others.

MS. ADAMS: So was the premise that -- say my committee, Performance Improvement, was going to then go through my coordinator to report back to the -- to the Board? Or --

MR. SCHWALENBERG: The chair.

MR. CRITZER: The chair reported back.

MS. ADAMS: The chair reported back.

MR. CRITZER: The whole purpose behind that, the coordinators -- when they

were added, oh Gary, that was what? 10 years ago --

MR. SAMUELS: Yeah.

MR. CRITZER: -- 11 years ago was because you -- we were at the same impasse we're at right now. We had committees that weren't achieving work.

And the coordinator's goal was to keep them moving, make sure they stayed on task, make sure that they were focused. And some did real well with that and others did not.

Some didn't need the guidance because they were already focused, like Medical Direction or Rules and Regs. So I don't know -- this is an opportunity to look at that.

Do you really need those coordinator positions? Especially if you streamline the committees.

BOARD MEMBER: And then I'll just say from -- from being a new coordinator, I

mean, I -- the one thing I've tried to do is attend all of the meetings, not just the ones I oversee, but other meetings as well. Because there's so much overlap to come back and say, well you know, that's a great idea.

But such and such committee's talking about this as well and trying to -- how to mention and merge some of those things and streamline it that way. So...

MS. DANIELS: So we get a -- Valeta. So we get an email out, hey, look at your committee, see how they integrate. Are we going to send out an email that says, same thing, however, we've reviewed these committees.

We think these two would match up and these two would pair up, these two would pair up.

MR. STARK: So the --

MS. ADAMS: Well in the absence of information about what they've been doing and -- and maybe it's just because

everybody's exhausted and Vitamin D deprived. But I'm not hearing a lot of real energy about my committee's doing great stuff.

I know sitting at the EMS Councils meetings, I hear most about training and certification and health and safety.

The whole how are we taking care of our folks, both from infectious disease and providing them support for their mental health issues. Those are the ones that I hear most reported back at -- at my council.

MR. STARK: So it depends on the feedback you're going to get back. You know, if we send out the communication that, hey, by the way, we're thinking about axing some of the committees.

You know, justify what you've been doing it. And by the way, if you'd like to merge with another committee, we have to think about how that's going to be -- obviously -- received on that end. And

whether or not we're going to have willing folks that are -- are willing to combine or, you know, otherwise scale back.

MS. ADAMS: It seems tacky to send any kind of email unless -- unless we know whether meetings have been held. And --

MR. STARK: Yeah.

MS. ADAMS: -- whether there's -- there's work product. I mean, if there's stuff to show, I know how I personally would react.

I wouldn't get Miss Congeniality if I had -- was on a committee that had been working hard, had been meeting.

But my work wasn't reflected because whoever was supposed to do it couldn't because they lost, you know, the caddy -- their computer or whatever. That -- so I think we need more information. On paper, it certainly seems like there could be some clumping and streamlining.

MR. STARK: Mm-hmm.

MS. ADAMS: But without information, it's just speculation.

MR. SCHWALENBERG: And I think this goes back to the whole -- I'm sorry, this is Tom. Goes back to the whole communication piece. Now I'll go back to Gary's comment which is, as a new committee chair, I was given not much guidance whatsoever.

So when it comes to report to the Advisory Board, unless I think it's really important, I don't bring it up because I don't want to tie down the Advisory Board with the minutiae.

So it doesn't mean that work's not occurring. And for the committee chair to say, you know, I have no action items doesn't mean the work's not occurring.

MR. CRITZER: Right.

MR. SCHWALENBERG: It's just I have nothing to bring to the Advisory Board at

this level that requires action.

MR. PARKER: Right.

MR. SCHWALENBERG: So I -- I just -- I just want to be careful of what we say in the minutes that -- you know, no action items doesn't mean the work's not occurring.

MR. PARKER: Right.

BOARD MEMBER: It just means that there's -- there's nothing that needs to be --

MR. SCHWALENBERG: That needs focus. Exactly.

MS. ADAMS: But then, how will we know what work is being done if it's not reported in that fashion.

BOARD MEMBER: Because our minutes are posted on the OEMS web site.

MR. SCHWALENBERG: There's minutes they record.

MS. ADAMS: Are your?

BOARD MEMBER: No, I -- I'm joking. That was a joke.

MS. ADAMS: And if they are, swell. But --

BOARD MEMBER: I don't -- they're not up to date.

MR. STARK: Here's the other thing. Does the -- you know, does the Advisory Board want to receive more information? Do you guys want a quick hit on, you know, some of the -- a little bit of the day to day stuff.

Don't just make assumptions that, you know, there are no action items. Okay, what are you guys doing, nothing? Because that's easier than reading through a bunch of Board minutes, too. That makes

your job easier. You don't want to -- you don't want to read through a bunch of --

BOARD MEMBER: We received the quarterly report, but how many people actually read the entire 90-page document?

MR. STARK: Right.

BOARD MEMBER: I mean --

MS. ADAMS: Well, could that could be -- that could be streamlined, too.

MR. STARK: But a more -- maybe more expeditious --

MS. ADAMS: Give me a link and I'll go follow it electronically. Because I'm not printing out 90 pages. So --

MR. STARK: Right.

MS. ADAMS: -- give me a hyperlink, I'll follow it through -- read the pictures

I want.

MR. STARK: But I think the Board needs to consider whether or not they want to communicate, hey, these are sort of the types of things we'd like to be kept abreast of.

You know, just give us a quick hit. We don't need a dissertation on it. But just so we know what activities are occurring at the committee level, you know, that was discussed. You know -- yes.

DR. O'SHEA: Jake again. I'm going to throw out another proposal here. Somebody mentioned the concept of a committee to review this.

The more I think about it, the more I believe that this work will not get accomplished without a small group of individuals looking down and coming to a consensus that they can present to the larger group. Otherwise, we could conceivably throw things back and forth for -- for hours.

MR. STARK: Yeah, we need --

BOARD MEMBER: I agree.

MR. STARK: That's exactly right. We need to task, you know, from inside or outside a small group who has a deadline -- you know, working deadline.

And we need to outline what we need. What they need to review, you know. And then we open it up for discussion after getting --

BOARD MEMBER: And I suggest again, why set up another committee when that's kind of the responsibility of the Executive Committee? We already have one. Why set up a whole separate one for?

MR. STARK: Okay. Yeah.

MR. TANNER: It's Gary. I'll just say -- I think Executive Committee should be the proper method. And then they'll come back with their recommendations and report

back to this group, whether it's merged, bucketed or whatever. I know my committee I'm on, Communications is real active. We haven't had anything to report for a while because we were working on getting up the emergency medical dispatch statewide. And it's taken a lot of work.

BOARD MEMBER: Well, plus it -- I'm the core member of that. It's just been within the last six meetings that you all started doing that work.

MR. TANNER: Yeah.

BOARD MEMBER: Before I was in and out of there, 20 minutes. Now you --

MR. TANNER: Right.

BOARD MEMBER: -- y'all can meet for two hours.

MR. TANNER: Yeah, we're going long now.

BOARD MEMBER: Yeah.

MR. STARK: Yeah. So something -- this is -- you've heard the term voluntold, right?

MR. PARKER: I think it's a great job for the vice-chair.

BOARD MEMBER: Oh, man.

MR. PARKER: Other duties as appointed.

MR. STARK: Let's -- yeah. And let's come up with -- Tim has made the concession that you all endeavor to get the meetings up as soon as possible. So that was gracious of Tim.

MR. PERKINS: I know about the ones that fall under my duties.

MR. STARK: And then let's -- you know, what's a reasonable time line for

that? If we don't set one -- we don't have to set one today. But if we don't, it'll just get tabled. Yeah.

DR. YEE: Why are we talking about this? This is such a tactical level discussion.

MR. STARK: Okay.

DR. YEE: Right? I mean, I -- I have the utmost confidence that Mr. Perkins will re-adjust the -- the posting of the minutes.

MR. STARK: Yep.

DR. YEE: I mean, and leave it at that.

MR. STARK: Yeah. No, we don't -- point taken. We don't need to belabor that any further. This is your -- these are your marching orders. Here's a -- you know, reviewing current activities. Additional

discussion on the matter? Okay. Yeah.

BOARD MEMBER: So a lot of discussion here with regard to these committees has been somewhat reactive to the current state of the committees.

But I think one of the things that will be important -- whether it's a task that's undertaken by us as the Advisory Board or by the Executive Committee -- is to be also visionary forward thinking about what -- what are new areas that we need to -- need to address. You know, we talked about the EMS system and what encompasses that.

And who needs to come in -- into that table. But do we need to make sure that that moving forward, we -- as an Advisory Board and the subcommittees who report up to us -- touch the entire EMS system from prevention to rehab.

And engage the partners that -- that, you know, are part of the entire EMS system to -- to collaborate with them and -- and report back. I think that, you

know, we've -- we've -- I get the sense that we feel like this is -- this -- this Advisory Board is primarily to serve the pre-hospital part of that large, you know, EMS system.

But it's also our responsibility to engage all the partners in the EMS system so that we can, you know, be part of that -- that bigger picture.

DR. YEE: And to echo his comments, I'll give you some examples. We probably should have an informatics committee that deals with an integrated HIE. That's their goal.

I mean, I'm not saying that I'm making a goal for them. They would make the goal for themselves. But something like that, as well as a finance committee to look at sustainability for the payors.

Because we've never, to my knowledge, have engaged the payors into our GAB structure.

MR. STARK: Chris, other concerns?

MR. PARKER: I think you hit it.

MR. STARK: Okay.

MS. ADAMS: Did we come to a conclusion?

MR. STARK: What's that?

MS. ADAMS: Have we come to a conclusion other than Tim graciously saying he'd look for the --

MR. STARK: I believe we have regarding that matter.

MS. ADAMS: Okay.

MR. STARK: So before we get into developing goals and objectives of these committees, we're going to take a look at, you know, the actual structure of the committees and what -- what committees need to exist. And what can be divined of their inefficiencies. We realize -- fair enough.

BOARD MEMBER: I thought we already just established that. And we were turning it over to Eddie and he was going to follow up with the committees. So what -- what do we need to discuss now?

MR. STARK: No, we're moving on from the goals and objectives of -- of the committee.

BOARD MEMBER: Okay. I missed it.

BOARD MEMBER: How does that impact what we're doing here for these two days? I mean, it's -- the decision to mark on from the list. It's like a work -- I would say it all fits. We have very much to accomplish if it can work.

MR. STARK: Yeah.

DR. O'SHEA: And -- and -- Jake O'Shea. Maybe this is how I under -- say it. And someone else can say if they see it differently. One of the questions at hand

is are we going to add six different members to the Advisory Board or recommend the addition because of those additional chairs of trauma committees. I think -- hopefully, if we take this discussion, that guides that discussion, right?

MR. STARK: Sure.

BOARD MEMBER: I guess -- I guess what I'm wondering is, I mean, it's -- it -- what's our goal one? Are we trying to -- is this going to be ironed out? Are we going to know where we're going?

Or is this a continuation? Should we pull something together early in the morning before we start -- we meet at 9:00, right?

MR. STARK: Yeah, we meet at 9:00.

BOARD MEMBER: Should a smaller group try to meet, you know, a little bit earlier than that? Or should, you know, how -- how does this fit into it?

MR. STARK: Yeah. Tomorrow was supposed to be a continuation of today. But you know, I think we've fairly well covered a lot of the bases, you know, throughout the course of today.

We can -- I can go back to distill some of the stuff that we talked about when we talk about, you know, vision tomorrow. You know, more broadly. But I think we hit on a lot of that today.

So this is driven by you folks and what you need. So you know, the agenda was set by the Board. So what -- whatever you guys need. Yes, sir.

MR. LAWLER: Matt Lawler. If there's really not a lot of agenda items left for tomorrow, why don't we just do the work ourselves tomorrow, rather than moving it to the Executive Committee.

MR. STARK: What do you guys think?

BOARD MEMBER: Well, I think that probably the person that wants the six Board

members wants space time to -- to discuss that.

MR. STARK: Okay.

BOARD MEMBER: Which I don't know where he is, but I can tell you. Hospital quality and -- if they're not a provisional, then apparently, they're doing this to -- if they're provisional, they've done something wrong to make it time to approve on.

BOARD MEMBER: Well, that would be totally out. I don't think they need six positions. I don't think they need one. Like I said, that -- somebody else ends up representing STEMI. That opens up stroke.

MS. ADAMS: This is Beth. Hey, Tim. Are you aware that there is any plan for a statewide look -- I know there is a state stroke system. I know that there's a stroke -- a statewide STEMI -- the VHAC cult -- the whole VHAC thing, Virginia Heart Attack Coalition. Is there any -- I mean,

part of what blossomed forth all the trauma, the parallel -- but you need the trauma stuff -- was because of the statewide trauma assessment that AC -- that we brought -- the Commonwealth brought ACS in to do.

So I haven't -- I've been to the -- to the VHAC and the -- and the stroke meetings. But I'm not aware that there's a parallel move afoot to do that.

MR. PERKINS: I'm not aware of one, either.

MS. ADAMS: So to that end, we don't have to -- I think it's safe, knock on wood, to say that we don't anticipate -- in the near or immediate future -- that there will be, you know, here comes the neurovascular group.

Here's the cardiovascular group, etcetera. So maybe the -- the way to look at it is to, okay, if they've got a committee that's doing similar, if not identical, work and they're doing it better than our current committee, maybe we should

let them have that one. And we'll take this one and figure out -- and sort it out that way.

BOARD MEMBER: Then that comes back to, do they need six places on the Board or do they need a position on the Board at all. That, to me, will call it --

DR. YEE: So -- so -- but for your -- for the group's education, I think that the neurovascular and the intensivist -- the interventionalist did try to make a -- some impact on us last year with some -- for some legislation and some white papers, as well as the American Heart Association with the STEMI care --

BOARD MEMBER: Mm-hmm.

DR. YEE: -- pathways.

BOARD MEMBER: But they haven't -- but they haven't requested -- I know they had -- tried -- had some impact on care.

DR. YEE: Yeah.

BOARD MEMBER: But I -- I don't -- haven't felt like they've said, okay, I need a -- we need a parallel structure set up to -- to match what's been put in place for trauma --

DR. YEE: Not to my knowledge.

BOARD MEMBER: -- at this point in time.

DR. YEE: Not to my knowledge.

BOARD MEMBER: Yeah, okay. Yeah, that's what I was wondering about.

MR. STARK: Yes.

MR. R. J. FERGUSON: Jason Ferguson. Dr. Yee, you -- you have said -- like we talked about earlier, I really do think a lot of those trauma committees -- the concept is great. So -- like acute

care, could that include STEMI, stroke and not just specific to trauma. Could prevention be tied in with prevention and public health? And add that as a --

DR. YEE: Yeah.

MR. R. J. FERGUSON: -- goal.

DR. YEE: This is Allen. I think that what Dr. Aboutanos created is our foundation. We just changed that acute care from trauma acute care to all of acute care. And then they could have two, three reps -- they can figure out their own reps, you know.

Two, three trauma, two, three STEMI, two, three stroke. And then we'd truly have the integration that we need at the committee level.

BOARD MEMBER: Right.

DR. YEE: And at the GAB level, I mean, we still have that focus on who -- who

we really are, right? Yet we have the input, the interfaces with our other stakeholders.

BOARD MEMBER: Right.

MS. ADAMS: And that gets back to --

MR. STARK: Yeah.

MS. QUICK: Valerie Quick. Yeah, I mean, we don't have to wait for the neuro-interventionalists or anyone else that comes to the table.

I think that our responsibility to -- to the people that we serve is looking at all of the different entities that make up our system.

And should be coordinated and that we should take it into account how we can integrate them and how we can really uphold some of the -- the issues that are going around with all patient care. I mean, if -- trauma has been very much interactive

in all of that, but that's still a -- a very small portion of our calls. So we need to make sure that we are also looking at the rest of the system, the medical part of the system.

The preventative part of the system. So taking into account what he has there is sort of broadening it out to incorporate and bring in some of those other entities, I think, is fine.

But that doesn't need to be at this level. That needs to be at the committee levels.

BOARD MEMBER: Agreed.

MR. STARK: Other comments, concerns? Okay. I know, you know, we've gotten through a lot of the agenda today. And you know, sort of tee'd up where we want to be.

I think at least most of you are on board with the concept of, you know, transitioning to more of that patient-centered model. And we talked about, you

know, our six objectives. And we're going to outline some of that for you folks to take a look at, and balance with the core objective as -- as well so the committees have work to do.

Tomorrow what we'd like to do -- we're going to do -- we have dinner tonight, obviously. And then tomorrow, I want you all to think about, you know, a vision of the Board and -- and the trauma care system. You know, we talked -- we hit on some of that today.

But I want everybody to come in tomorrow, you know, with their vision of where we need to be, you know, and any suggestions regarding committees that you currently sit on.

Let's tackle the high level stuff at the end here and like I said, if there's anything else remaining -- I mean, we -- we're all in one place right now. So this was meant as an exercise for you folks. So you know, if there's anything else, any other items that we need to touch on while we're all here -- because I know some of you

traveled distance to be here -- then we need to knock those out, you know, tomorrow. If it's a committee thing, obviously, we can leave it to the committee. But if it's things that we need to address as a Board, you know, let's do that.

You know, if there are items today that you're thinking about, you know, and have further -- you want to have further discussion on it, perfectly fine. But let's come in with that broad level objective tomorrow. All right? And it's been a long day, huh?

Other comments, questions? You know, and just -- in my own observation of your EMS system, I will say you guys are at the forefront of a lot of these initiatives, you know.

The State of Virginia is probably -- if I had to rank it, it'd be like the 80th percentile versus, you know, a lot of other state systems in terms of being innovative. But you know, there's some duplication ongoing right now. I will say -- and I said this earlier -- that there are

other states who have implemented, you know, the model that we talked about this morning based on the EMS vison for 2050.

And it's not that difficult to engage those industry partners. And again, right now we are making it -- this is an advisory board.

You know, we're making suggestions to OEMS and -- and moving forward. And I just want to make sure, you know, there are no sacred cows and, you know, all of our opinions -- everybody got a chance to be heard today.

Ultimately whether or not some of those ideas see the light of day, you know, it's going to depend on what's feasible from that model. So anybody else have questions or -- okay. All right.

Meeting stands adjourned. We're going to have dinner in here, so we have a little bit of time before dinner. But like I said, tomorrow is going to be broad level. I want everyone to think about the vision and any other remaining items that we need to wrap up. So, thanks.

(The State EMS Advisory Board Retreat, Day One, concluded at 4:47 p.m.)

CERTIFICATE OF THE COURT REPORTER

I, Debroah Carter, hereby certify that I was the Court Reporter at the STATE EMS ADVISORY BOARD RETREAT, DAY ONE, held in Glen Allen, Virginia, on September 16th, 2019, at the time of the State EMS Advisory Board Retreat herein.

I further certify that the foregoing transcript is a true and accurate record of the testimony and other incidents of the State EMS Advisory Board Retreat herein.

Given under my hand this 13th of October, 2019.

Debroah Carter, CMRS, CCR
Virginia Certified
Court Reporter

My certification expires June 30, 2020.