WESTERN VIRGINIA EMERGENCY MEDICAL SERVICES COUNCIL
BOARD OF DIRECTORS

DRAFT MEETING MINUTES

DATE: June 16, 2011

LOCATION: Salem Civic Center – Community Room

Directors Present
Steve Allen
Billy Altman
John Beach
Jim Cady, Sr.
Tim Duffer
Steve Eanes
Colt Hagmaier
Kevin Hamm
Carey Harveycutter
Mike Jefferson
Rob Logan
Steve Simon
Joe Trigg
Ford Wirt

Staff Present
Debbie Akers
Charles Berger
Mary Christian
Gene Dalton
Mike Garnett
Sandi Short

Guests Present
Tim Perkins, OEMS

TO ORDER:
President Ford Wirt called this regular meeting of the Board of Directors to order at 5:30 PM. Ford thanked the Salem Civic Center for providing the meeting space for our meeting

SECRETARY'S REPORT:
Ford presented minutes of the last meeting as distributed. He called for any corrections or additions.

Motion was made and duly seconded to approve. **Motion CARRIED.**

TREASURER'S REPORT:
Treasurer Carey Harveycutter presented the unaudited treasurer's report for FY 11 year to-date, (ending June 30). He noted that all accounts were within expectations.

The Executive Director explained the new page on the report relating to the Medical Reserve Corps.

Motion was made and duly seconded to accept the report,. **Motion CARRIED.**

EXECUTIVE COMMITTEE:
Steve Eanes inquired to follow up on the inability of the regional councils to obtain summary data from the statewide "VPHIB" electronic data collection system. Rob Logan reported that there had been some discussion at the state level, but no action had been taken. Billy Altman

reported that OEMS continues to sanction agencies that are not compliant in data submission, even though they are taking positive steps to become compliant.

A motion was made and seconded directing the president to write a letter to Health and Human Resources Secretary Dr. Bill Hazel requesting that regions be given access to de-identified, summary data, in light of the fact that the councils are required by contract to, and rightfully should, conduct research in order to improve performance in the provision of EMS, with copies to the Office of the Attorney General, Commissioner of Health Dr. Karen Remley, and OEMS Director Gary Brown expressing our dissatisfaction with this issue. The motion was duly seconded and **CARRIED.**

The Executive Committee met prior to this meeting to review and discuss the agenda items and also a personnel issue relating to compensation for staff members..

None Mike Garnett explained the process, and the agency survey that was used in developing the Surge Annex to the MCI Plan. Steve Eanes questioned the use of the term "Emergency Services" and asked that references be changed to "Emergency management." The Executive Committee recommends and moves adoption of the Surge Annex to the MCI plan. The MCI plan in its entirety will be reviewed and revised in the 2012 fiscal year.

Upon motion of the committee, the Surge Plan Annex was **ADOPTED.**

An updated Ambulance Diversion Policy was presented. Rob explained the revisions, which were to update some hospital names, and some contact information. This policy covers the NSPA region, which encompasses the Western and Blue Ridge EMS Council areas. The Executive Committee recommends and moves adoption of the updated plan. Upon motion of the committee, the Ambulance Diversion Plan was **ADOPTED.**

Tim Perkins from the Virginia Office of EMS arrived and was introduced by President Wirt.

MEDICAL DIRECTION COMMITTEE:
Debbie Akers reported on progress toward roll-out of the new Operational Guidelines. Much work toward converting the guidelines to the flowchart format has been completed. Debbie and Dr. Lane will be finalizing this document in the coming three months.

Debbie Akers reported on the development of the regional stroke plan. The final pre-adoption stroke committee meeting was held earlier on this date, and several minor revisions were made. A final draft was presented to the Board. Much discussion was held relating to several provisions in the plan. It was moved and duly seconded to defer adoption, and to refer the plan to the executive committee, and to give the executive committee the authority to adopt after further consideration and revision to clarify matters primarily relating to transport modality, by July 15. Motion **CARRIED**. *(Note added after the meeting: The Executive Committee met on Tuesday, June 21 and recommended to the Stroke Committee several revisions to the Stroke Plan. Dr. Lane then circulated a revised draft including those changes to the Stroke Committee. With the committee's concurrence, the draft went back to the executive committee. Two other revisions were recommended by members of the executive committee that were in keeping with earlier discussions by the EC and Stroke Committee. A newly-revised draft was circulated to the EC. On June 30, all members of the executive committee met by consensus emails and adopted the plan.)*

In Dr. Lane's absence, no report was given for the state medical direction committee.

Rob Logan offered the current EMS Operational Protocols to be reaffirmed. Motion was made and duly seconded to reaffirm the current protocols. Motion **CARRIED.**

PERFORMANCE IMPROVEMENT COMMITTEES:
Charles Berger reported for the General and Trauma Performance Improvement Committees. Both met today. Several matters were discussed, including a number of new PI projects involving both trauma and general performance improvement. The need to obtain data was discussed, along with the difficulty of obtaining compliance from the agencies and the refusal of OEMS to provide summary data collected from the VPHIB program.

A motion was made and seconded to write a letter to Health and Human Resources Secretary Dr. Bill Hazel, copied to the Attorney General, requesting that regions be given access to de-identified, summary data, in light of the fact that the councils are required by contract to, and rightfully should, conduct research in order to improve performance in the provision of EMS. After much discussion, the motion was tabled to be considered again at the next regular meeting.

NSPA:
Rob Logan reported for the Near Southwest Preparedness Alliance. Morris Reece is presently attending the NSPA Regional Collaboration workshop at Mariner's Landing. Funding for the coming year will be slightly reduced from the current year, but all programs will continue.

Rob also reported on progress in the Medical Reserve Corps program. Our coordinator, Tanya Ferraro is on the job and had been actively recruiting MRC volunteers across the two health districts covered in our program.

EMS ADVISORY BOARD:
Dale Wagoner provided a written report for the Advisory Board. The next meeting is set for August 12, 2011 in Richmond.

EMS FINANCIAL ASSISTANCE:
A report with current cycle award recommendations was distributed.

NEW BUSINESS:
The president appointed Carey Harveycutter, Steve Eanes and Steve Simon to meet with staff to develop an updated investment strategy for the council.

PRESIDENT'S REPORT: Ford thanked the directors for their continued participation. It was noted that the City of Salem reappointed John Beach for another three-year term.

EXECUTIVE DIRECTOR'S REPORT:
Rob called the Board's attention to the quarterly report provided to the Virginia Office of EMS. He also discussed the upcoming contract modification for FY 2012 funding.

STAFF REPORTS:
Debbie Akers – None
Mike Garnett – None
Charles Berger - None
Gene Dalton - None

Mary Christian - None

OTHER BUSINESS:
None

HEARING OF THE PUBLIC:
None

Being no further business, the meeting was adjourned at 6:25 PM.

/s Robert Logan, Executive Director

WESTERN VA EMS COUNCIL
UNAUDITED TREASURER'S REPORT
AS OF MAY 31, 2011

REVENUES	BUDGET	TOTAL	% YTD
STATE GOVERNMENT (OEMS CONTRACT)	406,190	364,166	89.65%
LOCAL GOVERNMENT	90,000	132,652	147.39%
UNITED WAYS	3,000	3,737	124.58%
CONTRIBUTIONS	2,000		0.00%
SPECIAL GRANTS / HOSPITAL FOUNDATIONS	122,000	124,959	102.43%
DIRECT PROGRAM INCOME (Tuitions, grants, VDH/OEMS)	235,000		0.00%
DIRECT MRC INCOME	-		
NSPA OFFSET REVENUE (Contract for services)	7,000	11,515	164.50%
AEMER SALARY OFFSET	9,360		0.00%
RENT INCOME (NSPA)	18,000	16,500	91.67%
INTEREST / INVESTMENT	6,000	6,789	113.15%
MISCELLANEOUS/SPECIAL FUNDS	-		
TOTAL REVENUES	898,550	660,318	73.49%
EXPENDITURES	**BUDGET**	**TOTAL**	**% YTD**
SALARIES / WAGES (WVEMS)	337,100	321,276	95.31%
SALARIES / WAGES (NSPA)	101,000	106,212	105.16%
PAYROLL TAXES (FICA)	33,515	31,497	93.98%
VEC	300	466	155.34%
SEP / RETIREMENT	26,000	22,658	87.15%
HOSPITAL / MEDICAL INSURANCE	46,000	40,172	87.33%
LIFE INSURANCE/DISABILITY	7,400	9,121	123.25%
DENTAL INSURANCE	3,400	2,426	71.36%
PROFESSIONAL SERVICES/FEES	11,000	13,335	121.23%
MEDICAL DIRECTION ASSISTANCE	1,500		0.00%
MAINTENANCE / REPAIRS / SERVICE CONTRACTS	2,500	1,848	73.92%
OCCUPANCY (Utilities, repairs, NRV rent etc.)	16,000	19,619	122.62%
POSTAL / SHIPPING	3,800	2,961	77.93%
TELECOMMUNICATIONS	10,500	10,298	98.07%
SUPPLIES (ADMIN)	7,035	4,651	66.11%
EQUIPMENT	6,100	5,000	81.97%
INSURANCE	7,500	7,373	98.31%
DIRECT PROGRAM EXPENSES	220,000		0.00%
DIRECT MRC EXPENSES	-		
PRINTING / PUBLICATIONS	4,000	2,828	70.71%
TRAVEL / LODGING	8,000	5,823	72.79%
FUEL/VEHICLE MAINTENANCE	12,000	9,533	79.44%
MEETING SUPPORT	2,800	558	19.93%
DUES / MEMBERSHIP FEES	1,500	1,509	100.63%
STAFF DEVELOPMENT	10,000	6,427	64.27%
CISM PROGRAM COSTS	2,000	1,928	96.39%
COMMUNICATION SITE RENTAL	8,100	7,625	94.14%
COMMUNICATIONS WIRELINES	4,200	6,580	156.67%
COMMUNICATIONS MAINTENANCE	1,500		0.00%
COMMUNICATIONS UTILITIES	800	452	56.52%
COMMUNICATIONS INSURANCE	3,000	3,000	100.00%
COMMUNICATIONS EQUIPMENT			
TOTAL EXPENDITURES	898,550	645,177	71.80%

REVENUE (PROGRAM ACCOUNTS)	TOTAL
OEMS FUNDS - INTERMEDIATE (4055-01)	9,958
OEMS FUNDS - ENHANCED (4055-02)	2,365
OEMS FUNDS - ADJUNCT (4055-03)	10,240
OEMS FUNDS - CARDIAC (4055-04)	
OEMS FUNDS - CT TRANSITION (4055-05) (A/R OEMS)	
OEMS FUNDS - SHOCK TRANSITION (4055-06) (A/R OEMS)	
OEMS FUNDS - ALS CE (4055-07) (A/R OEMS)	
PROGRAM SERVICE FEES (4060)	14,925
PROTOCOL, ETC. SALES (4070, 4070-01)	366
TEXTBOOK SALES (4090)	1,254
CONSOLIDATED TESTING (4120)	41,733
DRUG BOX ENTRANCE FEES (4130)	1,280
GRANTS & SPECIAL PROJECTS (4150)	4,695
SALES - CONSUMER GOODS (4240)	
WEB DATABASE (4260)	
PROCESSING FEES (4270)	
PROGRAM TUITION - INTERMEDIATE (4310-01)	8,600
PROGRAM TUITION - ENHANCED (4310-02)	
PROGRAM TUITION - ADJUNCT (4310-03)	8,205
PROGRAM TUITION - CARDIC (4310-04)	
PROGRAM TUITION - OTHER (4310-05)	
ID CARD SALES (4320)	219
TUITION CREDIT REIMBURSEMENT (4335)	
OMD PROJECT (4345)	
COMMUNITY COLLEGE COURSE REVENUE (4370)	3,161
TRAVEL/TOWING CONTRACT REVENUE (4390)	
TOTALS	107,001

EXPENSES (PROGRAM ACCOUNTS)	TOTAL
CONTRACTS FOR SERVICES (5105-01, 5106-01) (INTERMEDIATE)	8,330
CONTRACTS FOR SERVICES (5105-02, 5106-02) (ENHANCED)	3,775
CONTRACTS FOR SERVICES (5105-03, 5106-03) (ADJUNCT)	10,063
CONTRACTS FOR SERVICES (5105-04, 5106-04) (CARDIAC)	
CONTRACTS FOR SERVICES (5105-05, 5106-05) (SPEC. PROJ.)	135
CONTRACTS FOR SERVICES (5105-06, 5106-06) (ALS TEST)	878
CONTRACTS FOR SERVICES (5105-07, 5106-07) (CTS)	24,197
CONTRACTS FOR SERVICES (5105-08, 5106-08) (CE WEEKENDS)	
CONTRACTS FOR SERVICES (5105-09) (DRUG TESTING)	2,600
PAYROLL TAXES (FICA) (5030)	3,213
VEC (5040)	244
SUPPLIES (5160-02) (Programs)	2,798
SUPPLIES (5160-03) (CTS)	1,284
SUPPLIES (5160-05) (ALS TESTING)	
SUPPLIES (5160-06) (EDUCATION)	2,351
TEXTBOOKS (5170-02) (ALS)	9,796
TEXTBOOKS (5170-03) (BLS)	
EQUIPMENT (5180-03) (BLS)	
EQUIPMENT (5180-04) (BLS TESTING)	10
EQUIPMENT (5180-05) (ALS TESTING)	
EQUIPMENT (5180-06) (EDUCATION)	2,415
INSURANCE (5200-02)	1,378
GRANTS & SPECIAL PROJECTS (5510) (INCLUDES TICP PROJECT)	4,632
DRUG BOX EXCHANGE (5520)	964
CREDIT CARD DISCOUNT (5540) minus 4160	2,663
MERCHANDISE FOR RESALE (5560)	
ID CARD PROGRAM (5640)	
RETENTION PROJECT (5660)	
COMMUNITY COLLEGE FEES (5690)	3,161
TUITION REIMBURSEMENT - ENHANCED (5695-01)	
TUITION REIMBURSEMENT - INTERMEDIATE (5695-02)	
TRAVEL/TOWING CONTRACT EXPENSE (5720)	
OMD PROJECT (5750)	
SWVEMS CONTRACT (5760)	
TOTALS	84,887

REVENUE (MRC ACCOUNTS)		TOTAL
PROGRAM MANAGEMENT - MRC	4295-10, 4295-11	16,000
COST REIMBURSEMENT - MRC	4296-10, 4296-11	10,692
TOTALS		26,692
EXPENSES (MRC ACCOUNTS)		TOTAL
SALARIES AND WAGES - MRC	5010-10, 5010-11	6,779
FICA EXPENSE - MRC	5030-10, 5030-11	519
HOSPITAL MEDICAL - MRC	5060-10, 5060-11	802
DENTAL INSURANCE - MRC	5090-10, 5090-11	87
TELECOMMUNICATIONS - MRC	5150-10, 5150-11	262
SUPPLIES - MRC	5160-10, 5160-11	528
PROMOTIONAL - MRC	5165-99	4,864
TRAINING SUPPLIES - MRC	5170-10, 5170-11	1,049
EQUIP-MRC	5180-10, 5180-11	3,875
MILEAGE-MRC	5230-10, 5230-11	114
TOTALS		18,878

WESTERN VIRGINIA EMS COUNCIL, INC.
Balance Sheet
May 31, 2011

ASSETS

Current Assets			
PETTY CASH	$ 66.27		
FSA CASH	2,329.25		
MUTUAL ENDOWMENT ACCOUNT	5,581.54		
SUNTRUST CHECKING	243,237.00		
SUNTRUST PAYROLL	200.00		
VALLEY BANK MONEY MARKET	188,617.51		
ACCOUNTS RECEIVABLE	8,422.71		
Total Current Assets			448,454.28
Property and Equipment			
Total Property and Equipment			0.00
Other Assets			
COMMUNICATIONS EQUIPMENT	151,377.13		
MISCELLANEOUS EQUIPMENT	191,509.50		
OFFICE EQUIPMENT	50,881.41		
BUILDING	175,223.00		
LAND	201,600.00		
BLDG. IMPROVEMENTS	64,232.94		
GENERATOR BUILDING & EQUIPME	11,402.25		
ACCUMULATED DEPRECIATION	(382,434.42)		
Total Other Assets			463,791.81
Total Assets		$	912,246.09

LIABILITIES AND CAPITAL

Current Liabilities			
ACCOUNTS PAYABLE	$ 3,523.35		
CLEARING ACCT (UNCASHED CHE	290.00		
ACCRUED SALARIES	24,864.21		
FLEX SPENDING ACCOUNT	(186.44)		
Total Current Liabilities			28,491.12
Long-Term Liabilities			
Total Long-Term Liabilities			0.00
Total Liabilities			28,491.12
Capital			
FUND BAL. UNRESTRICTED	650,161.00		
FUND BAL. UNRESTRICTED DES.	50,978.00		
RETAINED EARNINGS	65,371.07		
FUND BALANCE TEMP. RESTR.	81,433.00		
Net Income	35,811.90		
Total Capital			883,754.97
Total Liabilities & Capital		$	912,246.09

Western Virginia EMS Council
Report from the Governor's EMS Advisory Board

The most recent meeting was held May 13, 2011 in Glen Allen, Virginia.

The **2010 Appropriations Act** established the Line of Duty Fund (LODF) with the Virginia Retirement System (VRS) as the investment manager. Localities, via item 258 of the Enrolled 2011-2012 Budget, now have an additional year to choose to 'opt out' of the LODF. Localities now have until June 30, 2012 to 'opt out' of the VRS fund and begin self funding their locality's claims. Each locality should have received their proposed payment rates from the Virginia Retirement System (VRS) to assist them in making this important decision. NO ONE CAN "OPT OUT" OF THE LINE OF DUTY ACT (LODA). All claims will still be processed through the Department of Accounts with the final decision made by the Comptroller.

Funding the Benefit

1. Option One: Participate in the LODF invested by VRS. This requires no action on the part of the locality since each locality is automatically covered.

2. Option Two: Opt out of the LODF. This requires the governing body to pass an opt-out resolution. The locality may choose to:

- Pay-as-you-go, where the locality pays the benefits as they occur; or
- Pre-fund the benefit, where the locality sets aside money or invests money to fund any future claims.

The deadline for an irrevocable election to opt out of the LODF: June 30, 2012. If localities do not take action, they will be enrolled automatically in the Fund.

If you have questions regarding the change to the state's LODA program, you can contact Connie Jones at the Department of Accounts – (804) 786.1856 or Trish Bishop with the Virginia Retirement System - 1-888-827-3847 or visit **www.valoda.org**.

OEMS Division of Educational Development is proposing the use of the National Registry of EMT's certification examinations for all initial EMS certification levels recognized in Virginia. This includes EMR, EMT, AEMT, Intermediate, and Paramedic. There are pros and cons to this change. The following are topic points that will dictate some of the discussion as this topic moves forward: 1) *written test sites* – the current number of test sites are limited. 2) *Costs of Exam* – It currently costs $70 to take the exam, but OEMS is proposing to pay this fee if logistics can be worked out with National Registry. 3) *Automation of Reciprocity for Virginia Programs* – currently this is not automated and someone taking National Registry has to apply to OEMS for reciprocity.

The Durable Do Not Resuscitate (DDNR) Regulations is still awaiting review and approval by the Governor's Office.

The final draft of the Virginia Emergency Medical Service Regulations 12VAC5-31 resides with the Secretary of Health and Humans Services awaiting review and approval. If that is ever done, they will still have to go to the Governor for approval.

Future RSAF grants for recruitment and retention will require the recipient to provide statistical data of the efforts to Office of EMS.

A new website has been created to assists healthcare providers meet the needs of Virginia's changing demographics. It focus is to help providers with delivery of culturally and linguistically appropriate health care services. The site is: www.ClasActVirginia.org

Thank you for your confidence in me to represent the Council on the Advisory Board. Should you have any questions, comments or concerns, please do not hesitate to contact me.

Respectfully submitted,
Dale Wagoner

WVEMS EMS Surge Capacity Annex Plan

I. Introduction:

a. Background& Purpose:

A MCI Surge is a sudden and or unexpected event whether man-made or natural that can overwhelm a local healthcare system. The objective of this plan is to be an annex to the already existing Regional MCI plan. It will focus on maximizing the resource capacity to evaluate, triage, stabilize, and transport victims of a Multi-Casualty Incident (MCI) or other public health emergency when the capacity of the localities' EMS system has been compromised or exceeded.

b. Scope:

The Surge Plan addresses only the mutual aid response of the regional emergency medical services (EMS) system to a Mass Casualty Incident that overwhelms local Prehospital resources.

The mechanism of action for triage, initial stabilization and transport from the incident scene would still follow the parameters of the Regional MCI plan using START triage and the ICS structure. The only added factor would be additional EMS agencies under mutual aid aspects to assist in the uploaded patient count.

II. Command and Control for Surge Incidents:

Following along with the Commonwealth of Virginia MCIM guidelines, surge incidents should follow the ICS Command Structure as far as who makes requests for additional resources and the use of them.

III. Concept of Operations for Surge Incidents:

a. When and how the plan would be activated:

When at any given point of time, a local system's ability to manage a sudden or rapidly growing influx of patients with the available resources is compromised/severely strained. The plan could be activated by the following:

1a. The Incident Command at the scene of an MCI according to the existing local protocol, usually through the local ECC.

2a. The local Emergency Services Coordinator, or that person's representative, of a political subdivision who has authority for the management of the incident.

3a. The Chief Executive Officer, or that person's representative, of a health care facility that is required to evacuate or move patients.

4a. Due to communication ability with the Incident Command, MCI Medical Control and local prehospital resources, it would be advantageous that the local Emergency Operations Center activate the regional surge plan.

b. Use of resources/progression:

As stated in the regional MCI plan vehicle resources are tracked by sources in the staging and transport sector. During a MCI surge, more than likely multiple transport vehicle resources will be needed, both Pre-hospital and civilian sources.

Using the enclosed resource sheets, it is the goal of the WVEMS region to create and distribute a region wide listing of the following resources:

1. Licensed EMS transport vehicles
2. Other local civil sources (School systems, municipal transport systems)
3. Various interoperable communication resources. (radio caches and comm.. trailers)
4. Personnel

A. *Licensed EMS transport vehicles:* WVEMS will compile and have available listing of all EMS agencies and a listing of Licensed EMS vehicles they have and those available through MOUs. The listing will also include licensed transport vehicles for "private" ambulance services that operate within the WVEMS region.

B. *Non-EMS Licensed transport resources:* WVEMS will construct a listing of civil and private transport resources that are available if needed for a patient surge. The listing will include local school transportation depts., municipal bus services and non- profit social transport services. A listing will be made available to respective jurisdictions.

C. *Communication resources:* WVEMS will keep a listing of available communication resources that could be available if needed for a MCI surge. Resource listing will include various communication trailers and radio caches owned by various public safety agencies.

D. *Personnel:* Due to the unique mixture of EMS agencies within the WVEMS boundary, WVEMS will work with agencies on a plan for staffing call-up/recall procedures.

E. *Supplies/Equipment:* WVEMS will work with NSPA and other agencies on regional sites for potential EMS supply caches.

It is reminded that transport unit availability should not hinder the agency's ability to provide services for their own locality.

c. Coordination with other Surge resources and planning:

i. Hospitals- WVEMS will offer to participate in local hospital surge capacity planning, as the EMS component is very important as far as transport and destination modalities.

ii. Local Health Departments- WVEMS will offer to work with local VDH emergency planners on the Prehospital component of a surge plan.

iii. Local government – WVEMS will work with locality LEPC or other municipal committees on the EMS component of MCI Surge management.

IV. **Information Management**

i. Communications Systems for use during Surge Incidents:

Radio communication will remain the primary method of communication for all sectors during a MCI Surge,. The NSPA mobile communications command trailer or other communication resources (VDEM Comm. Bus or VTRS radio cache) may be requested to provide on (or near) site interoperable communications.

V. **Demobilization and Recovery :**

1.. The Medical Incident Manager will be responsible for notifying the EOC and MCI Medical Control that all patients have been assigned to transport units and that all on-scene patient care activities have been completed and ended at the MCI or Evacuation site or sites.

2. The on-scene Medical Incident Manager should confer with the appropriate official(e.g. Incident Command, Emergency Services Coordinator, healthcare facility CEO) to determine any additional patient care need for EMS prior to contacting the MCI Medical Control.

3. MCI Medical Control will deactivate the MCI Plan among activated hospitals when the designated MCI Medical Control hospital is notified by the on-scene Medical Incident Manager that EMS activities are completed at the MCI or Evacuation site or sites, and when it determined that all other patient care issues have been taken care of.

4. Once patient care activities are ended, the EOC and IC will start allowing resources to stand down. Rehabilitation of units will include restocking and cleaning to be functional to return to service within their locality. Rehabilitation of personnel will include incident debriefing and CISM if needed.

VI. **Testing and Exercise:**

As many agencies and localities only due training on "localized" incidents, many are unfamiliar with what EMS surge capacity is. WVEMS can assist in training and education into Mass Casualty Incident Management and surge capacity. It is vital that education and training be done, as the prehospital component is an important aspect of any multi-agency incident.

Surge Capacity Survey
Results Overview

zoomerang

Date: 6/7/2011 1:41 PM PST
Responses: Completes
Filter: No filter applied

2. Does your agency have a MCI plan in place?

Yes		31	66%
No		16	34%
	Total	47	100%

3. Does your agency conduct training in Mass Casualty Incidents?

Yes		27	57%
No		20	43%
	Total	47	100%

4. If training is conducted, what types of incidents are rehearsed?

Terrorism		15	32%
Natural Disasters		22	47%
Epidemic		6	13%
Not Applicable		18	38%
Other, please specify		17	36%

5. Are those in supervisory positions within your agency experienced in ICS training and responsibilities?

Yes		42	89%
No		5	11%
	Total	47	100%

6. Are you as an agency familiar with what EMS Surge Capacity Planning is?

Yes		19	40%
No		28	60%
	Total	47	100%

7. Is your agency familiar with what the Regional Hospital Coordination Center is?

Yes	21		45%
No	26		55%
Total	47		100%

8. What is the number of Critically Injured or ILL patients in a given situation that would overwhelm your agency's capacity to handle?

1 - 5	19		40%
6 - 10	21		45%
11 - 15	4		9%
16 and over	3		6%
Total	47		100%

11. In the event of an MCI, how do you get additional staff or duty crews notified to report, so that additional ambulances can be put in service and respond?

Phone Trees	14		30%
Paging system	28		60%
Smart Phones	11		23%
Radio/Pager ALL CALL	31		66%
Other, please specify	15		32%

12. In regards to question #11, what would be the time frame to get additional ambulances out?

1/2 hour - 1 hour	40		85%
1 hour - 3 hours	6		13%
greater than 3 hours	1		2%
Total	47		100%

13. In the event of a sustained (multiple days) MCI event would you be able to staff ALL ambulances continuously in 12 - 24 hour shifts ?

Yes	21		46%
No	25		54%
Total	46		100%

Trauma Listing / Agency Vehicles	Vehicles	FR	EMTB	ST	EN	CT	I	P	Calls/yr
Planning District 4	79	2	470	0	41	0	60	40	24,190
FLOYD	11	0	44	0	2	0	7	5	1,702
FLOYD COUNTY EMS INC	2	0	0	0	0	0	4	3	771
FLOYD COUNTY LIFE SAVING AND FIRST AID SQUAD INC	9	0	44	0	2	0	3	2	931
GILES	10	0	74	0	5	0	4	8	1,783
CELANESE CORPORATION	1	0	9	0	1	0	0	3	34
GILES LIFESAVING AND RESCUE SQUAD INC	7	0	44	0	3	0	1	4	1,546
NEWPORT VOLUNTEER RESCUE SQUAD	2	0	21	0	1	0	3	1	203
MONTGOMERY	43	2	288	0	28	0	31	16	14,182
BLACKSBURG RESCUE SQUAD	11	0	70	0	13	0	15	8	2,426
CHRISTIANSBURG RESCUE SQUAD	11	1	67	0	6	0	4	5	3,400
ELLISTON FIRE DEPARTMENT	3	1	13	0	0	0	0	0	115
LIFELINE AMBULANCE SERVICE	2	0	15	0	0	0	0	2	6,466
LONG SHOP-MCCOY VOLUNTEER FIRE	3	0	18	0	3	0	0	0	110
RINER VOLUNTEER RESCUE SQUAD INC.	1	0	6	0	0	0	0	0	0
SHAWSVILLE VOLUNTEER RESCUE SQUAD	6	0	29	0	1	0	2	0	695
VIRGINIA TECH RESCUE SQUAD	6	0	70	0	5	0	10	1	970
PULASKI	11	0	54	0	6	0	16	10	5,157
RADFORD ARMY AMMUNITION FIRE/RESCUE	0	0	28	0	1	0	0	0	65
REGIONAL EMS, INC.	10	0	23	0	5	0	16	10	5,024
TWIN COMMUNITY VOLUNTEER FIRE DEPARTMENT	1	0	3	0	0	0	0	0	68
RADFORD	4	0	10	0	0	0	2	1	1,366
RADFORD EMERGENCY MEDICAL SERVICES	3	0	0	0	0	0	2	0	1,208
RADFORD UNIVERSITY EMS	1	0	10	0	0	0	0	1	158
Planning District 5	198	17	867	0	68	0	199	216	58,689
ALLEGHANY	16	8	98	0	23	0	10	3	2,610
BOILING SPRINGS VOLUNTEER FIRE DEPARTMENT AND	3	0	9	0	5	0	2	0	175
CLIFTON FORGE RESCUE SQUAD	3	1	31	0	5	0	3	1	1,297
DUNLAP FIRE AND RESCUE	3	4	19	0	4	0	3	0	350
FALLING SPRING RESCUE SQUAD INC	2	0	14	0	3	0	2	1	232
IRON GATE VOLUNTEER FIRE DEPARTMENT	2	0	8	0	1	0	0	0	206
SHARON VOLUNTEER FIRE DEPARTMENT, INC.	3	3	17	0	5	0	0	1	350
BOTETOURT	30	6	110	0	6	0	18	9	5,755
BLUE RIDGE VOLUNTEER FIRE DEPARTMENT & RESCUE	2	2	16	0	0	0	2	0	673
BOTETOURT COUNTY EMERGENCY SERVICES	14	0	29	0	2	0	11	6	3,178
EAGLE ROCK VOLUNTEER FIRE DEPARTMENT/RESCUE	4	3	13	0	2	0	2	1	374
EVENT MEDICAL STANDBY	0	0	1	0	0	0	0	0	10
FINCASTLE RESCUE SQUAD	3	1	20	0	2	0	2	0	478
TROUTVILLE RESCUE SQUAD	7	0	31	0	0	0	1	2	1,042
COVINGTON	7	0	36	0	18	0	3	0	1,343
COVINGTON RESCUE SQUAD	4	0	17	0	12	0	2	0	1,183
WESTVACO RESCUE SQUAD	3	0	19	0	6	0	1	0	160
CRAIG	8	0	31	0	2	0	4	2	653
CRAIG COUNTY EMERGENCY SERVICES	1	0	0	0	0	0	0	1	0
CRAIG COUNTY RESCUE SQUAD - EMS INC	5	0	22	0	2	0	4	1	610
PAINT BANK FIRE & RESCUE	2	0	9	0	0	0	0	0	43
ROANOKE	79	0	230	0	3	0	78	116	29,922
CARILION CLINIC PATIENT TRANSPORTATION	37	0	45	0	1	0	14	49	7,645
JEFFERSON COLLEGE OF HEALTH SCIENCE	0	0	4	0	1	0	1	7	0
ROANOKE EMERGENCY MEDICAL SERVICES INC	3	0	30	0	0	0	6	3	867
ROANOKE FIRE - EMS DEPARTMENT	35	0	142	0	0	0	55	57	21,410
UNITED AMBULANCE SERVICE	4	0	9	0	1	0	2	0	0
ROANOKE COUNTY	41	1	268	0	14	0	62	61	14,616
BENT MOUNTAIN FIRST AID & RESCUE SQUAD INC	1	0	8	0	0	0	2	1	97
CATAWBA-MASON'S COVE RESCUE SQUAD INC	0	0	19	0	0	0	1	1	60
CAVE SPRING FIRST AID & RESCUE SQUAD	3	0	79	0	4	0	7	5	1,222
FORT LEWIS VOLUNTEER FIRE DEPARTMENT INC	1	0	4	0	0	0	0	0	85
READ MOUNTAIN FIRE/RESCUE	6	0	19	0	3	0	2	2	818
ROANOKE COUNTY FIRE & RESCUE	25	1	81	0	1	0	43	46	9,476
ROANOKE FIRE DEPARTMENT/RESCUE SQUAD - #5	0	0	23	0	1	0	1	0	445
VINTON FIRE AND EMS	2	0	4	0	1	0	4	2	1,536
VINTON FIRST AID CREW, INC	3	0	31	0	4	0	2	4	877
SALEM	17	2	94	0	2	0	24	25	3,790
GENERAL ELECTRIC RESCUE SQUAD	0	1	6	0	0	0	0	0	6

Trauma Listing	Agency Vehicles	Vehicles	FR	EMTB	ST	EN	CT	I	P	Calls/yr
SALEM FIRE - EMS DEPARTMENT		11	0	33	0	0	0	15	22	3,026
SALEM RESCUE SQUAD		6	0	40	0	2	0	9	3	652
YOKOHAMA INDUSTRIAL RESCUE SQUAD		0	1	15	0	0	0	0	0	106
Planning District 12		173	59	1054	0	104	0	116	95	53,592
DANVILLE		32	1	265	0	34	0	25	24	23,468
DANVILLE FIRE DEPARTMENT		12	1	111	0	0	0	1	0	5,957
DANVILLE LIFE SAVING & FIRST AID CREW INC		11	0	89	0	14	0	13	11	5,216
GOODYEAR TIRE AND RUBBER COMPANY		0	0	52	0	0	0	0	0	49
REGIONAL ONE EMS		9	0	13	0	20	0	11	13	12,246
FRANKLIN COUNTY		31	1	176	0	8	0	13	29	6,222
CALLAWAY VOLUNTEER RESCUE SQUAD		3	0	14	0	1	0	1	0	97
FORK MOUNTAIN VOLUNTEER FIRE DEPARTMENT AND		1	0	9	0	0	0	0	0	301
FRANKLIN COUNTY PUBLIC SAFETY		22	1	82	0	5	0	7	26	3,407
FRANKLIN COUNTY RESCUE SQUAD		0	0	25	0	0	0	0	3	1,684
RED VALLEY RESCUE SQUAD, INC.		1	0	7	0	1	0	0	0	368
SCRUGGS FIRE DEPARTMENT AND RESCUE SQUAD, INC.		1	0	20	0	1	0	2	0	210
SNOW CREEK RESCUE SQUAD		3	0	19	0	0	0	3	0	155
HENRY		27	10	182	0	13	0	23	18	5,980
BASSETT RESCUE SQUAD INC		5	5	42	0	2	0	6	1	2,042
FIELDALE-COLLINSVILLE RESCUE SQUAD		5	0	35	0	4	0	3	5	1,800
HENRY COUNTY DEPARTMENT OF PUBLIC SAFETY		13	5	90	0	5	0	10	11	1,211
RIDGEWAY DISTRICT RESCUE SQUAD, INC.		4	0	15	0	2	0	4	1	927
MARTINSVILLE		14	8	27	0	10	0	20	12	8,806
MARTINSVILLE FIRE & EMS		4	8	18	0	5	0	14	10	2,220
PROVIDENCE EMS TRANSPORT LLC		3	0	4	0	1	0	0	0	120
STONE AMBULANCE SERVICE, INC.		7	0	5	0	4	0	6	2	6,466
PATRICK		21	26	119	0	18	0	9	6	2,618
ARARAT RESCUE SQUAD		2	0	14	0	0	0	0	0	230
BLUE RIDGE VOLUNTEER RESCUE SQUAD		2	0	12	0	2	0	1	2	110
CCDF VOLUNTEER FIRE DEPARTMENT & RESCUE SQUAD		2	1	10	0	0	0	1	0	245
FAIRYSTONE VOLUNTEER FIRE DEPARTMENT, INC		1	4	0	0	0	0	0	0	0
JEB STUART RESCUE SQUAD		3	4	32	0	3	0	1	1	1,243
MOOREFIELD STORE FIRE DEPARTMENT		2	5	9	0	0	0	0	0	131
PATRICK COUNTY EMERGENCY SERVICES		1	1	0	0	0	0	0	0	0
SMITH RIVER RESCUE SQUAD		4	1	31	0	10	0	4	2	346
STUART VOLUNTEER FIRE DEPARTMENT		2	9	1	0	3	0	0	0	180
VESTA RESCUE SQUAD		2	1	10	0	0	0	2	1	133
PITTSYLVANIA		48	13	285	0	21	0	26	6	6,498
640 COMMUNITY RESCUE		2	0	12	0	2	0	2	0	169
BACHELORS HALL VOLUNTEER FIRE DEPARTMENT		2	0	6	0	0	0	0	0	161
BLAIRS VOLUNTEER FIRE & RESCUE INC		3	1	20	0	1	0	0	0	590
BROSVILLE COMMUNITY VOLUNTEER FIRE DEPARTMENT		3	0	16	0	1	0	3	1	664
CALLANDS VOLUNTEER FIRE AND RESCUE INC		3	0	13	0	1	0	1	0	319
CASCADE VOLUNTEER FIRE DEPARTMENT		2	0	4	0	0	0	2	0	130
CHATHAM RESCUE SQUAD		5	0	25	0	2	0	6	1	892
CLIMAX VOLUNTEER FIRE COMPANY INC		2	0	8	0	0	0	0	0	102
COOL BRANCH RESCUE SQUAD		3	0	22	0	0	0	0	0	185
DRY FORK VOLUNTEER FIRE DEPARTMENT INC		2	3	7	0	0	0	0	0	90
GRETNA RESCUE SQUAD		3	0	14	0	1	0	5	0	671
KEELING VOLUNTEER FIRE DEPARTMENT		2	4	4	0	0	0	0	0	121
KENTUCK VOLUNTEER FIRE DEPARTMENT, INC.		3	5	11	0	0	0	2	0	0
LAUREL GROVE VOLUNTEER FIRE & RESCUE INC		2	0	19	0	2	0	1	0	324
MOUNT CROSS VOLUNTEER FIRE & RESCUE, INC		2	0	17	0	0	0	2	0	341
MOUNT HERMON VOLUNTEER FIRE DEPARTMENT		2	0	13	0	2	0	0	2	547
RINGGOLD VOLUNTEER FIRE DEPARTMENT		3	0	31	0	4	0	0	0	702
RIVERBEND VOLUNTEER FIRE DEPARTMENT		1	0	2	0	0	0	0	0	60
TUNSTALL VOLUNTEER FIRE DEPARTMENT		3	0	41	0	5	0	2	2	430

Vehicle	Unit	GA	AA	NA	NT
Planning District 4		52	0	0	27
FLOYD		8	0	0	3
	FLOYD COUNTY EMS INC	0	0	0	2
	FLOYD COUNTY LIFE SAVING AND FIRST AID SQUAD	8	0	0	1
GILES		7	0	0	3
	CELANESE CORPORATION	1	0	0	0
	GILES LIFESAVING AND RESCUE SQUAD INC	4	0	0	3
	NEWPORT VOLUNTEER RESCUE SQUAD	2	0	0	0
MONTGOMERY		25	0	0	18
	BLACKSBURG RESCUE SQUAD	6	0	0	5
	CHRISTIANSBURG RESCUE SQUAD	6	0	0	5
	ELLISTON FIRE DEPARTMENT	0	0	0	3
	LIFELINE AMBULANCE SERVICE	2	0	0	0
	LONG SHOP-MCCOY VOLUNTEER FIRE	2	0	0	1
	RINER VOLUNTEER RESCUE SQUAD INC.	1	0	0	0
	SHAWSVILLE VOLUNTEER RESCUE SQUAD	4	0	0	2
	VIRGINIA TECH RESCUE SQUAD	4	0	0	2
PULASKI		10	0	0	1
	REGIONAL EMS, INC.	10	0	0	0
	TWIN COMMUNITY VOLUNTEER FIRE DEPARTMENT	0	0	0	1
RADFORD		2	0	0	2
	RADFORD EMERGENCY MEDICAL SERVICES	2	0	0	1
	RADFORD UNIVERSITY EMS	0	0	0	1
Planning District 5		123	3	0	72
ALLEGHANY		12	0	0	4
	BOILING SPRINGS VOLUNTEER FIRE DEPARTMENT	3	0	0	0
	CLIFTON FORGE RESCUE SQUAD	3	0	0	0
	DUNLAP FIRE AND RESCUE	3	0	0	0
	FALLING SPRING RESCUE SQUAD INC	2	0	0	0
	IRON GATE VOLUNTEER FIRE DEPARTMENT	1	0	0	1
	SHARON VOLUNTEER FIRE DEPARTMENT, INC.	0	0	0	3
BOTETOURT		14	0	0	16
	BLUE RIDGE VOLUNTEER FIRE DEPARTMENT &	1	0	0	1
	BOTETOURT COUNTY EMERGENCY SERVICES	7	0	0	7
	EAGLE ROCK VOLUNTEER FIRE	2	0	0	2
	FINCASTLE RESCUE SQUAD	2	0	0	1
	TROUTVILLE RESCUE SQUAD	2	0	0	5
COVINGTON		6	0	0	1
	COVINGTON RESCUE SQUAD	3	0	0	1
	WESTVACO RESCUE SQUAD	3	0	0	0
CRAIG		6	0	0	2
	CRAIG COUNTY EMERGENCY SERVICES	0	0	0	1
	CRAIG COUNTY RESCUE SQUAD - EMS INC	4	0	0	1
	PAINT BANK FIRE & RESCUE	2	0	0	0
ROANOKE		54	3	0	22
	CARILION CLINIC PATIENT TRANSPORTATION	34	3	0	0
	ROANOKE EMERGENCY MEDICAL SERVICES INC	3	0	0	0
	ROANOKE FIRE - EMS DEPARTMENT	13	0	0	22
	UNITED AMBULANCE SERVICE	4	0	0	0
ROANOKE COUNTY		23	0	0	18
	BENT MOUNTAIN FIRST AID & RESCUE SQUAD INC	1	0	0	0
	CAVE SPRING FIRST AID & RESCUE SQUAD	2	0	0	1
	FORT LEWIS VOLUNTEER FIRE DEPARTMENT INC	0	0	0	1
	READ MOUNTAIN FIRE/RESCUE	2	0	0	4
	ROANOKE COUNTY FIRE & RESCUE	15	0	0	10
	VINTON FIRE AND EMS	1	0	0	1
	VINTON FIRST AID CREW, INC	2	0	0	1
SALEM		8	0	0	9
	SALEM FIRE - EMS DEPARTMENT	4	0	0	7
	SALEM RESCUE SQUAD	4	0	0	2
Planning District 12		109	0	0	64
DANVILLE		14	0	0	18
	DANVILLE FIRE DEPARTMENT	0	0	0	12
	DANVILLE LIFE SAVING & FIRST AID CREW INC	6	0	0	5

Vehicle	Unit	GA	AA	NA	NT
REGIONAL ONE EMS		8	0	0	1
FRANKLIN COUNTY		21	0	0	10
CALLAWAY VOLUNTEER RESCUE SQUAD		2	0	0	1
FORK MOUNTAIN VOLUNTEER FIRE DEPARTMENT		1	0	0	0
FRANKLIN COUNTY PUBLIC SAFETY		14	0	0	8
RED VALLEY RESCUE SQUAD, INC.		1	0	0	0
SCRUGGS FIRE DEPARTMENT AND RESCUE SQUAD,		1	0	0	0
SNOW CREEK RESCUE SQUAD		2	0	0	1
HENRY		19	0	0	8
BASSETT RESCUE SQUAD INC		5	0	0	0
FIELDALE-COLLINSVILLE RESCUE SQUAD		4	0	0	1
HENRY COUNTY DEPARTMENT OF PUBLIC SAFETY		7	0	0	6
RIDGEWAY DISTRICT RESCUE SQUAD, INC.		3	0	0	1
MARTINSVILLE		13	0	0	1
MARTINSVILLE FIRE & EMS		3	0	0	1
PROVIDENCE EMS TRANSPORT LLC		3	0	0	0
STONE AMBULANCE SERVICE, INC.		7	0	0	0
PATRICK		15	0	0	6
ARARAT RESCUE SQUAD		2	0	0	0
BLUE RIDGE VOLUNTEER RESCUE SQUAD		2	0	0	0
CCDF VOLUNTEER FIRE DEPARTMENT & RESCUE		2	0	0	0
FAIRYSTONE VOLUNTEER FIRE DEPARTMENT, INC		0	0	0	1
JEB STUART RESCUE SQUAD		3	0	0	0
MOOREFIELD STORE FIRE DEPARTMENT		0	0	0	2
PATRICK COUNTY EMERGENCY SERVICES		0	0	0	1
SMITH RIVER RESCUE SQUAD		4	0	0	0
STUART VOLUNTEER FIRE DEPARTMENT		0	0	0	2
VESTA RESCUE SQUAD		2	0	0	0
PITTSYLVANIA		27	0	0	21
640 COMMUNITY RESCUE		2	0	0	0
BACHELORS HALL VOLUNTEER FIRE DEPARTMENT		0	0	0	2
BLAIRS VOLUNTEER FIRE & RESCUE INC		2	0	0	1
BROSVILLE COMMUNITY VOLUNTEER FIRE		2	0	0	1
CALLANDS VOLUNTEER FIRE AND RESCUE INC		2	0	0	1
CASCADE VOLUNTEER FIRE DEPARTMENT		0	0	0	2
CHATHAM RESCUE SQUAD		3	0	0	2
CLIMAX VOLUNTEER FIRE COMPANY INC		0	0	0	2
COOL BRANCH RESCUE SQUAD		2	0	0	1
DRY FORK VOLUNTEER FIRE DEPARTMENT INC		0	0	0	2
GRETNA RESCUE SQUAD		3	0	0	0
KEELING VOLUNTEER FIRE DEPARTMENT		0	0	0	2
KENTUCK VOLUNTEER FIRE DEPARTMENT, INC.		0	0	0	3
LAUREL GROVE VOLUNTEER FIRE & RESCUE INC		2	0	0	0
MOUNT CROSS VOLUNTEER FIRE & RESCUE, INC		2	0	0	0
MOUNT HERMON VOLUNTEER FIRE DEPARTMENT		2	0	0	0
RINGGOLD VOLUNTEER FIRE DEPARTMENT		3	0	0	0
RIVERBEND VOLUNTEER FIRE DEPARTMENT		0	0	0	1
TUNSTALL VOLUNTEER FIRE DEPARTMENT		2	0	0	1

www.wvems.org

Western Virginia Emergency Medical Services Council, Inc.

Regional Stroke Triage Plan

Developed by the WVEMS Stroke Committee, Charles J. Lane, MD, Chair
In conjunction with the Virginia Department of Health, Office of EMS
and the Virginia Stroke Systems, a statewide collaborative for improving stroke care.
Adopted by the WVEMS Board of Directors - June 30, 2011

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Index

Executive Summary

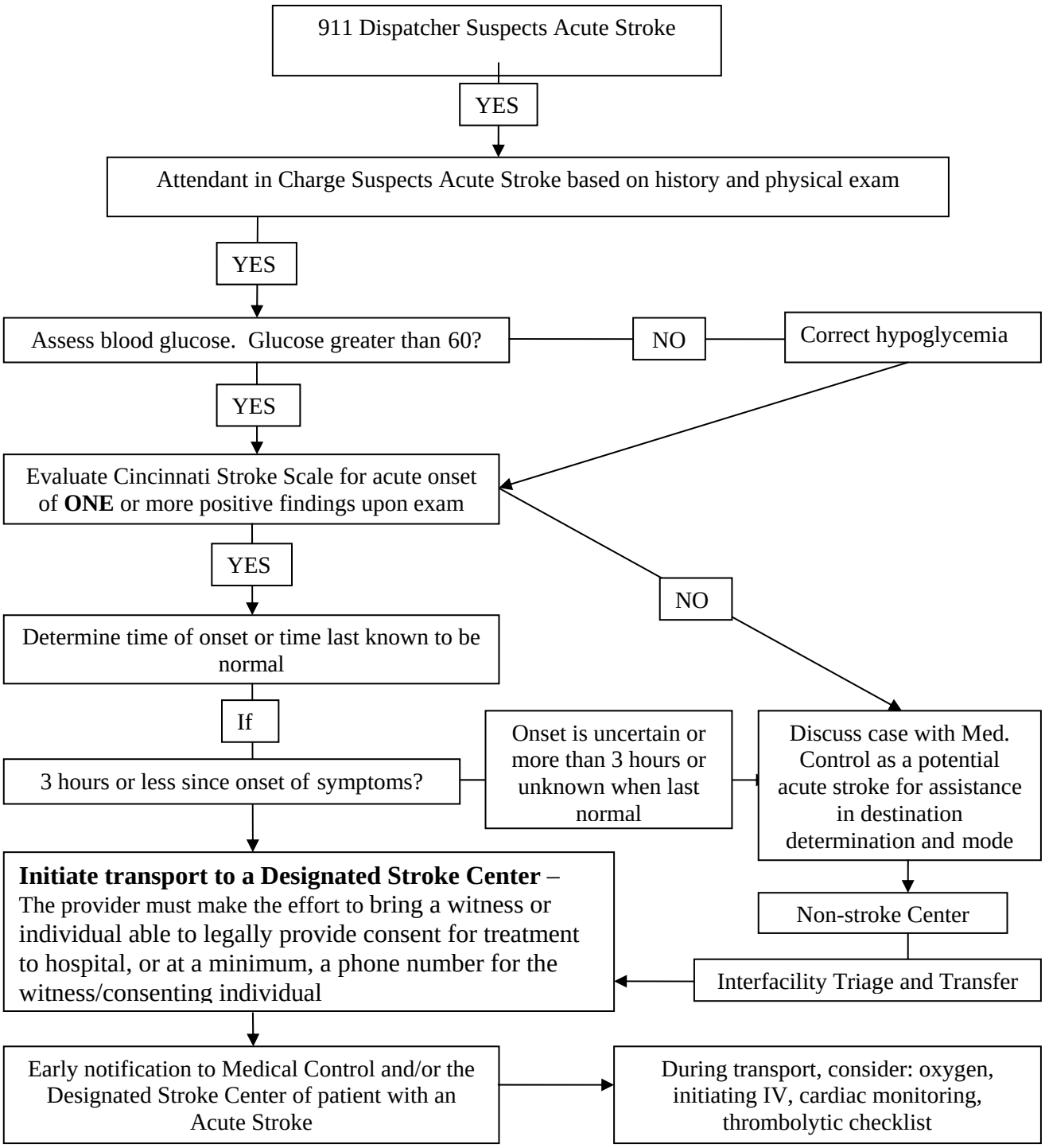
Under the *Code of Virginia* **§** *32.1-111.3*, The Office of Emergency Medical Services acting on behalf of the Virginia Department of Health has been charged with the responsibility of maintaining a Statewide Stroke Triage Plan. The Western VA EMS region which includes the counties of Alleghany, Botetourt, Craig, Floyd, Franklin, Giles, Henry, Montgomery, Roanoke, Patrick, Pittsylvania and Pulaski; and the cities of Covington, Danville, Martinsville, Radford, Roanoke and Salem is responsible for establishing a strategy through a formal region wide Stroke Triage Plan that will incorporate the region's geographic variations, variances within out-of-hospital provider capabilities and acute stroke care capabilities and resources including hospital capabilities and the capacity to transfer patients between hospitals and tertiary care centers, such as Joint Commission "certified" Stroke Centers or comparable process of care consistent with the recommendations of the Brain Attack Coalition.

The purpose of the Western VA EMS Council Regional Stroke Triage Plan is to establish a uniform set of criteria for the prehospital care, treatment and transport of the acute stroke patient. The plan will identify a formalized stroke plan that will augment the state stroke triage plan to recognize and address variations within our region in both prehospital and hospital resources. This Regional Stroke Triage Plan addresses patients experiencing an "acute stroke" defined as any patient suspected of having an acute cerebral ischemic event or stroke with the onset of any one symptom within a three hour period although acknowledgement of an extension to four and one-half hours may be appropriate in situations where advanced medical consult is available. The primary focus of this plan is to provide guidelines to facilitate the early recognition of the patient suffering from acute stroke symptoms and to expedite their transport to a center able to provide definitive care within the three-hour time window.

The primary goal of the WVEMS Regional Stroke Plan is to develop a Stroke Emergency Care Plan that, when implemented, will result in decreased stroke mortality and morbidity in the WVEMS region. In order to accomplish this, a number of specific processes are essential. These are:

1. The ability to rapidly and accurately identify patients suffering from stroke-like symptoms.
2. Patients who have sustained an acute stroke event must receive care in a hospital that has a stroke treatment program in place, capable of providing immediate and comprehensive assessment, resuscitation, intervention, and definitive care.
3. The Western VA EMS Council must provide continuous and effective region-wide coordination of prehospital and hospital care resources so stroke patients will be most expeditiously transported to the closest available interventional center capable of performing stroke interventions, so patient care can be provided in a manner both appropriate and timely, while establishing and maintaining continuity. To accomplish this process there must be a method of tracking the care capability for stroke patients and reviewing the quality of the process itself.
4. The regional plan must provide all hospitals in the region the opportunity to participate in the system (an inclusive system), and to receive stroke patients if they are willing to meet the system and operations criteria, as established by this plan.
5. Provide quality EMS service and patient care to the EMS system citizens.
6. Continuously evaluate the EMS system based on established EMS performance measures for stroke.

Field Stroke Triage Decision Scheme



(*) See Appendix A for guidance regarding dispatch protocols

(**) If time from symptom onset is more than 3 hours, discuss case with Medical Control as a potential acute stroke for destination determination. Patients with specific acute stroke types may benefit from intervention up to 24 hours, although the sooner an acute stroke is treated, the better the potential outcome. Based on patient time of onset and discussion with Medical Control, consider whether use of HEMS will offer potential benefit to the patient, either in time to Designated Stroke Center, or for critical care management expertise. EMS does not determine whether a patient is excluded from any or all therapeutic options. Final decisions regarding patient eligibility for any given intervention will be determined by the receiving physician(s).

Guidance Documents

Cincinnati Prehospital Stroke Scale (CPSS)/FAST

All patients suspected of having an acute stroke should undergo a formal screening algorithm such as the CPSS/FAST. Use of stroke algorithms has been shown to improve identification of acute strokes by EMS providers up to as much as 30 percent. The results of the CPSS/FAST should be noted on the prehospital medical record. ANY abnormal (positive) finding which is suspected or known to be acute in onset is considered an indicator of potential acute stroke.

F-(face)	FACIAL DROOP: Have patient smile or show teeth. (Look for asymmetry) **Normal:** Both sides of the face move equally or not at all. **Abnormal:** One side of the patient's face droops.
A-(arm)	MOTOR WEAKNESS: Arm drift (close eyes, extend arms, palms up for 10 seconds; in only one leg is involved, have patient hold leg off floor for 5 seconds) **Normal:** Remain extended equally, drifts equally, or does not move at all. **Abnormal:** One arm drifts down when compared with the other.
S- (speech)	Have the patient repeat, "You can't teach an old dog new tricks" **Normal:** Phrase is repeated clearly and correctly. **Abnormal:** Words are slurred (dysarthria) or abnormal (dysphasia) or none (aphasia).
T-Time	Time of SYMPTOM ONSET:_____ If patient awakened with symptoms, when were they last known to be normal?

* Results of the CPSS/FAST should be included on the patient's prehospital medical record.

Acute Stroke Patient Transport Considerations

MODE OF TRANSPORTATION: Because of the diverse geography of the Western VA EMS Council region, EMS systems face unique challenges in the transport of their patients to a designated stroke center. Consideration should be given to hospitals available to the region and the resources they have available to acute stroke patients.

Consideration should also be given to prehospital resources including, the level of care available by the ground EMS crews, the closest HEMS (Helicopter EMS) service available at the time of the incident, and other conditions such as transport time and weather conditions. Use of HEMS services can assist with the stroke patient reaching definitive medical care in a timely fashion.

Field transports by helicopter of stroke patients as defined in this plan shall:

1. Significantly lessen the time from scene to a designated Stroke Center compared to ground transport.
2. Bypassing a non-stroke designated hospital to transport directly to a designated stroke center should not be greater than 30 minutes.
3. Stroke patients transported by air must meet the clinical triage criteria for transport and be transported to the closest Designated Stroke Center.
4. HEMS transport should be considered to meet the goal of having acute stroke patients expeditiously transported to a Designated Stroke Center, within three hours of symptom onset; unless consultation with on-line medical control has occurred.
5. Patient required a level of care greater than can be expected by the local ground provider if the HEMS unit can be on scene in a time shorter than the ground unit can transport to the closest hospital.

NOTE: Any patient with a compromised airway or impending circulatory collapse must be transported to the closest hospital emergency department for stabilization and treatment.

RAPID TRANSPORTATION: Because stroke is a time-critical illness, time is of the essence, and EMS should initiate ***rapid transport*** once an acute stroke is suspected. Consideration should also be given to prehospital resources including use of helicopter EMS (HEMS) available at the time of the incident, and other conditions such as transport time and weather conditions. Use of HEMS can facilitate acute stroke patients reaching Designated Stroke Centers in a timeframe that allows for acute treatment interventions.

The likelihood of benefit of acute stroke therapy decreases with time, but there are several therapy options which offer definite benefit outside the standard 3 hour window; and therefore, consultation with on-line Medical Control is STRONGLY encouraged in the situation of a patient being unable to arrive at a designated Stroke Center within the three-hour window from symptoms onset.

NOTE: The use of the term "rapid transport" does not relieve the operator of the vehicle from exercising "due regard, and should not be interpreted as requiring the use of red-lights and siren." Rather it is a reminder to reduce time on scene to minimize out of hospital time.

Designated Stroke Centers

The Commonwealth of Virginia defines a Designated Stroke Center as a hospital that has achieved Primary Stroke Center Certification by the Joint Commission. The process of Stroke Designation/Certification is entirely voluntary on the part of the hospitals and identifies hospitals that have established and maintain an acute stroke program that provides a specific level of medical, technical, and procedural expertise for acute stroke patients. Designation ensures that the hospital is prepared to provide definitive acute stroke care at all times and has an organized approach to providing clinical care, performance improvement, education etc. As of April 1, 2011, the list of Designated Stroke Centers accessible to the Western VA EMS Council region includes:

Carilion Roanoke Memorial Hospital	Roanoke	**Centra Lynchburg General**	Lynchburg
Augusta Health Center	Fisherville	**Martha Jefferson Hospital**	Charlottesville
University of Virginia Medical Center	Charlottesville		
Duke University	Durham, NC	**Forsyth Medical Center**	Winston-Salem, NC
North Carolina Baptist Hospital	Winston-Salem, NC	**The Moses H Cone Memorial Hospital**	Greensboro, NC

The list of hospitals becoming designated as stroke centers is increasing. A current list of The Joint Commission Primary Stroke Centers that meet the definition of Virginia Designated Stroke Centers is available at http://virginiastrokesystems.org/ or by entering the state of interest at http://www.qualitycheck.org/consumer/searchQCR.aspx

Interhospital Triage Criteria

Various hospitals meet many of the components of a Designated Stroke Center based on national survey results and would be the next logical choice. The closest hospital may not be the most appropriate hospital. Resource information via **self-reported data** on the level of acute stroke care provided by hospitals which are not Designated Stroke Centers is available at http://virginiastrokesystems.org/.

Non-stroke center hospitals within the Western VA EMS Council region must develop transfer guidelines and agreements that would allow for the expeditious and appropriate management of acute strokes when the care required exceeds their capabilities. This is especially critical for transfer of patients following thrombolysis since specific protocols must be followed to diminish the risk of cerebral or systemic hemorrhagic complications. The Western VA EMS Council does not presume to direct hospitals with regard to interfacility transfer of patients.

Stroke Triage Quality Monitoring

The Western VA EMS Council, Inc., will report aggregate acute stroke triage findings on an intermittent basis, but no less than annually, to assist EMS systems and the Virginia Stroke Systems Task Force to improve the local, regional, and Statewide Stroke Triage Plans. A de-identified version of the report will be available to the public and will include, minimally, as defined in the statewide plan, the frequency of

(i) over and under triage to Designated Stroke Centers in comparison to the total number of acute stroke patients delivered to hospitals and
(ii) Helicopter EMS utilization.
(iii) EMS Benchmarks

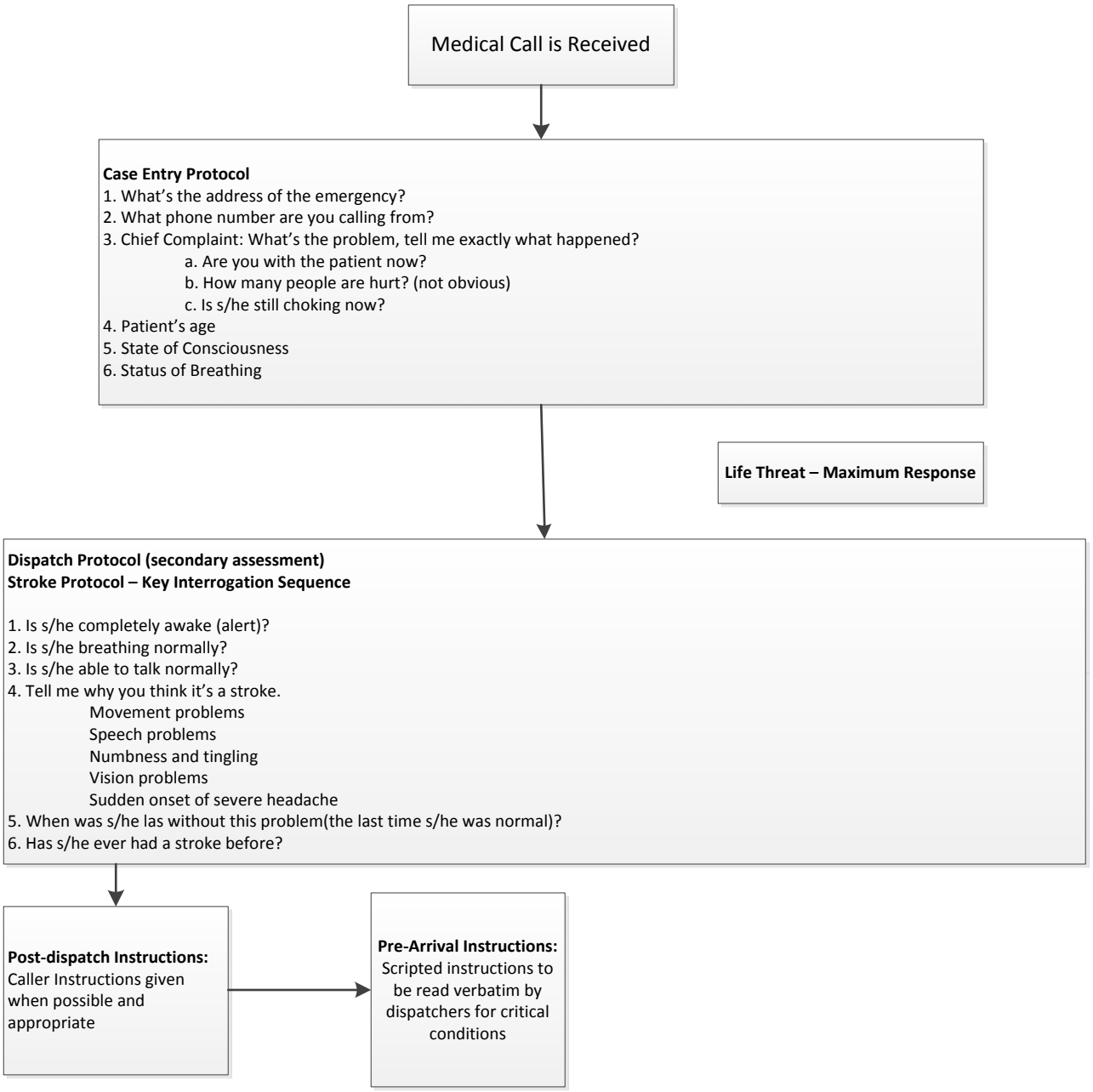
The Western VA EMS Council Performance Improvement Committee will produce a report which will be used as a guide and resource that will establish the EMS Benchmarks to be measured. This report will have three primary evaluation areas: timeliness of care, treatment provided, and outcomes of care. The fields identified are critical to analyses for the following reasons: they allow linking of EMS data and hospital stroke data, they allow for "real time" collection of data focused upon process improvement, and they allow for retrospective systemic analyses. The ultimate goal of collecting this data is to provide actionable information, to the WVEMS Stroke Committee and the WVEMS Medical Direction Committee, relative to the care processes and outcomes associated with their treatment of acute stroke patients as it relates to EMS.

Stroke Related Resources

Virginia Stroke System Web page: http://virginiastrokesystems.org/
Virginia Office of EMS Stroke Web page: http://www.vdh.virginia.gov/OEMS/Trauma/Stroke.htm
Joint Commission http://www.jointcommission.org/certification/primary_stroke_centers.aspx

Appendix A: Dispatch Resources

The following information is offered as a guideline for use by dispatch centers within the Western Virginia EMS Council region that do not have established procedures. The questions to be asked of the caller have been established by the Medical Priority Dispatch System and are contained on Card 28.



Appendix B: Thrombolytic Checklist

NOTE: Exclusions on this checklist are not absolute. Final decisions regarding patient eligibility for any given intervention will be determined by the receiving physician(s).

Date:_____ Time:_____EMS Agency/Unit: _____
Patient Name:_____ Age:_____ Estimated .weight:_____lbs/kg

PROVIDE THIS FORM TO THE ED NURSE, PHYSICIAN OR NEUROLOGIST AT BEDSIDE

1. Did patient awaken with symptoms? Yes / No
2. Time last known to be normal: _____
3. Time of symptom onset: _____
4. Onset witnessed or reported by: _____
5. Witness/Family or other individual able to legally provide consent for treatment coming to Emergency Department? _____ [ENCOURAGE TO DO SO]. If not, phone # where such individuals will be immediately available for calls from hospital staff to assist in giving additional patient history and consent.

( ) - OR ( ) -

Cincinnati Stroke Scale Score:

Symptoms from **Cincinnati Stroke Scale** (circle abnormal findings)

ANY ONE FINDING = POSSIBLE STROKE=MINIMIZE ON SCENE TIME

FACIAL DROOP: R L
ARM DRIFT: R L
SPEECH: slurred wrong words mute /unable to speak

1 2 3

Indicate status for each

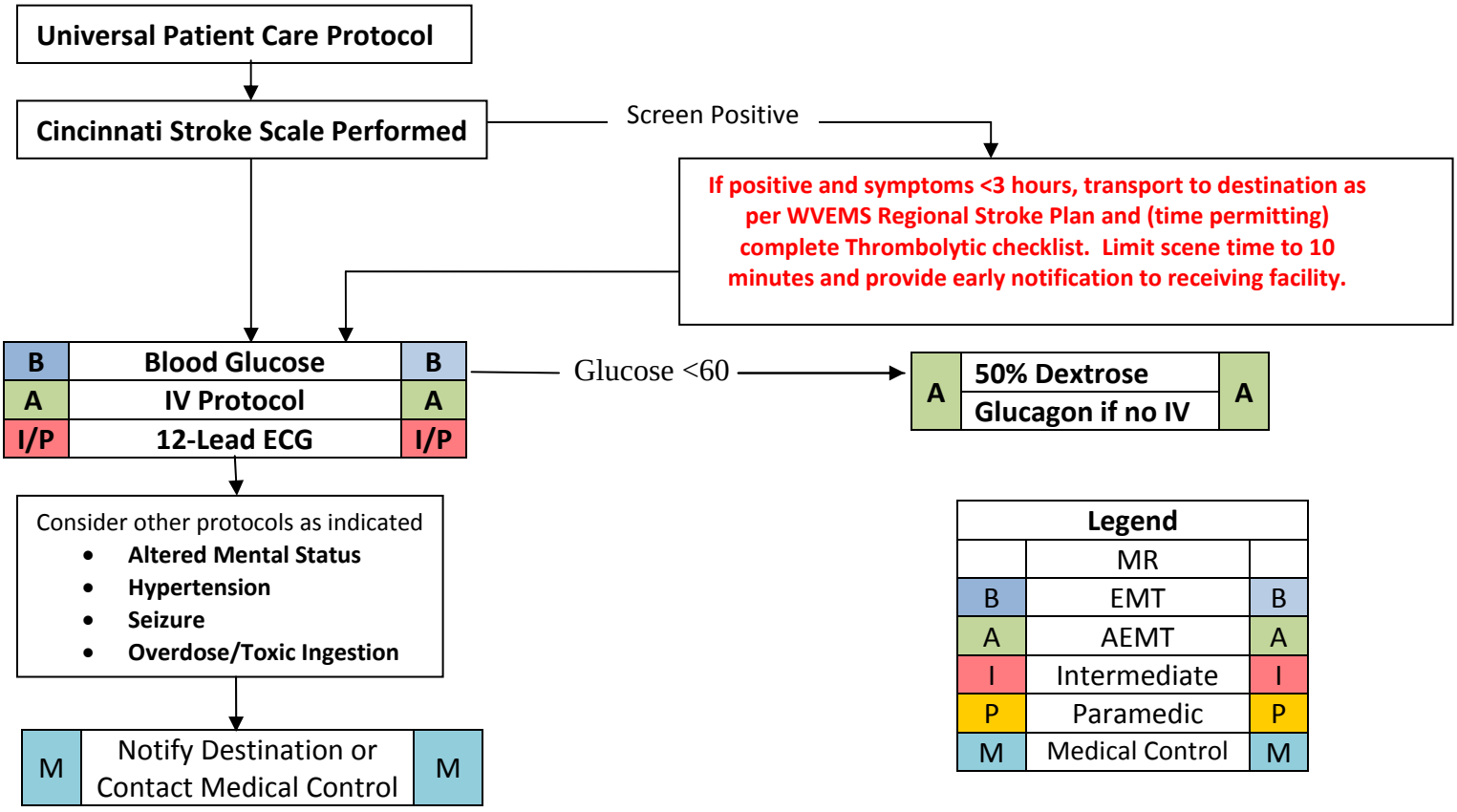
Current use of anticoagulants (e.g., Warfarin/Coumadin, Plavix)	Yes	No	Unknown
Has blood pressure consistently over 185/110 mm Hg	Yes	No	Unknown
Witnessed seizure at symptom onset	Yes	No	Unknown
intracranial hemorrhage history	Yes	No	Unknown
GI or GU bleeding history within 3 weeks	Yes	No	Unknown
This event within 3 months of prior stroke	Yes	No	Unknown
This event within 3 months of serious head trauma	Yes	No	Unknown
This event within 21 days of acute myocardial infarction	Yes	No	Unknown
This event within 21 days of lumbar puncture (spinal tap)	Yes	No	Unknown
This event within 14 days of major surgery or serious trauma	Yes	No	Unknown
Is pregnant	Yes	No	Unknown
Abnormal blood glucose level (<50) FSBS (if done):	Yes	No	Unknown

Receiving Site/Physician Printed Name: _____Time_____

EMS Provider Name: _____Signature_____

Appendix C: Proposed WVEMS Suspected Stroke Patient Care Protocol

History	Signs and Symptoms	Differential
• Previous CVA, TIA's • Previous cardiac / vascular surgery Associated diseases: diabetes, hypertension, CAD • Atrial fibrillation • Medications (blood thinners) • History of trauma	• Altered mental status • Weakness / Paralysis • Blindness or other sensory loss • Aphasia / Dysarthria • Syncope • Vertigo /Dizziness • Vomiting • Headache • Seizures • Respiratory pattern change • Hypertension / hypotension	• **See Altered Mental Status** • **TIA (Transient ischemic attack)** • **Seizure** • **Hypoglycemia** • **Stroke** **Thrombotic or Embolic (~85%)** **Hemorrhagic (~15%)** • **Tumor** • **Trauma**



Legend		
	MR	
B	EMT	B
A	AEMT	A
I	Intermediate	I
P	Paramedic	P
M	Medical Control	M

Pearls

Recommended Exam: Mental Status, HEENT, Heart, Lungs, Abdomen, Extremities, Neurological
The Thrombolytic Checklist should be completed for any suspected stroke patient if time permits. At a minimum the information contained on top half of checklist should be provided to receiving facility.
Scene times should be limited to 10 minutes, early destination notification/activation should be provided and transport times should be minimized based on the EMS System Stroke Plan.
Onset of symptoms is defined as the last witnessed time the patient was symptom free (i.e. awakening with stroke symptoms would be defined as an onset time of the previous night when patient was symptom free)
The differential listed on the Altered Mental Status Protocol should also be considered.
Elevated blood pressure is commonly present with stroke. Consider treatment if diastolic is > 110 mmHg.
Be alert for airway problems (swallowing difficulty, vomiting/aspiration).
Hypoglycemia can present as a localized neurologic deficit, especially in the elderly.
Document the Stroke Scale results in the PCR.
Document the 12 Lead ECG as a procedure in the PCR.

Code of Virginia References

Code of Virginia

§ 32.1-111.3. Statewide Emergency Medical Care System

A.

1. Establishing a comprehensive emergency medical services patient care data collection and evaluation system pursuant to Article 3.1 (§ 32.1-116.1 et seq.) of this chapter;

2. Collecting data and information and preparing reports for the sole purpose of the designation and verification of trauma centers and other specialty care centers pursuant to this section. All data and information collected shall remain confidential and shall be exempt from the provisions of the Virginia Freedom of Information Act (§ 2.2-3700 et seq.);

B

1. A strategy for implementing the statewide Trauma Triage Plan through formal regional trauma triage plans developed by the Regional Emergency Medical Services Councils which can incorporate each region's geographic variations and trauma care capabilities and resources, including hospitals designated as trauma centers pursuant to subsection A of this section. The regional trauma triage plans shall be implemented by July 1, 1999, upon the approval of the Commissioner.

1. *A uniform set of proposed criteria for prehospital and inter hospital triage and transport of trauma patients, consistent with the trauma protocols of the American College of Surgeons' Committee on Trauma, developed by the Emergency Medical Services Advisory Board, in consultation with the Virginia Chapter of the American College of Surgeons, the Virginia College of Emergency Physicians, the Virginia Hospital and Healthcare Association, and prehospital care providers. The Emergency Medical Services Advisory Board may revise such criteria from time to time to incorporate accepted changes in medical practice or to respond to needs indicated by analyses of data on patient outcomes. Such criteria shall be used as a guide and resource for health care providers and are not intended to establish, in and of themselves, standards of care or to abrogate the requirements of § 8.01-581.20. A decision by a health care provider to deviate from the criteria shall not constitute negligence per se.*

§ **32.1-116.1:1**. Disclosure of medical records.

Any licensed physician, licensed health care provider, or licensed health care facility may disclose to an emergency medical services provider, emergency medical services physician, or their licensed parent agency the medical records of a sick or injured person to whom such emergency medical services provider or emergency medical services physician is providing or has rendered emergency medical care for the purpose of promoting the medical education of the specific person who provided such care or for quality improvement initiatives of their agency or of the EMS system as a whole. Any emergency medical services provider or emergency medical services physician to whom such confidential records are disclosed shall not further disclose such information to any persons not entitled to receive that information in accordance with the provisions of this section.

§ 32.1-116.2. Confidential nature of information supplied; publication; liability protections.

A. The Commissioner and all other persons to whom data is submitted shall keep patient information confidential. Mechanisms for protecting patient data shall be developed and continually evaluated to ascertain their effectiveness. No publication of information, research or medical data shall be made which identifies the patients by names or addresses. However, the Commissioner or his designees may utilize institutional data in order to improve the quality of and appropriate access to emergency medical services.

B. No individual, licensed emergency medical services agency, hospital, Regional Emergency Medical Services Council or organization advising the Commissioner shall be liable for any civil damages resulting from any act or omission preformed as required by this article unless such act or omission was the result of gross negligence or willful misconduct.

§ 8.01-581.19 Civil Immunity for physicians, psychologists, podiatrists, optometrists, veterinarians, nursing home administrators and certified emergency services personnel while members of certain committees.

A *Any physician, chiropractor, psychologist, podiatrist, veterinarian or optometrist licensed to practice in this commonwealth shall be immune from civil liability for any communication, finding, opinion or conclusion made in performance of his duties while serving as a member of any committee, board group, commission or other entity that is responsible for resolving questions concerning the admission of any physician, psychologist, podiatrist, veterinarian or optometrist to, or the taking of disciplinary action against any member of, any medical society, academy or association affiliated with the American Medical Association, the Virginia Academy of Clinical Psychologists, the American Psychological Association, the Virginia Applied Psychology Academy, the Virginia Academy of School Psychologists, the American Podiatric Medical Association, the American Veterinary Medical Association, the International Chiropractic Association, the American Chiropractic Association, the Virginia Chiropractic Association or the American Optometric Association provided that such communication, finding, opinion or conclusion is not made in bad faith or with malicious intent.*

B Any nursing home administrator licensed under the laws of this Commonwealth shall be immune from civil liability for any communication, finding, opinion, decision or conclusion made in performance of his duties while serving as a member of any committee, board, group, commission or other entity that is responsible for resolving questions concerning the admission of any health care facility to, or the taking of disciplinary action against an member of, the Virginia Health Care Association, provided that such communication, finding, opinion, decision or conclusion is not made in bad faith or with malicious intent.

C Any emergency medical services personnel certified under the laws of the Commonwealth shall be immune from civil liability for any communication, finding, opinion, decision or conclusion made in performance of his duties while serving as a member of any regional council, committee, board, group, commission or other entity that is responsible for resolving questions concerning the quality of care, including triage, interfacility transfer and other components of emergency medical services care, unless such communication, finding, opinion, decision or conclusion is made in bad faith or with malicious intent.

EMS Regulation 12 VAC 5-31-390. Destination/trauma triage.
An EMS agency shall participate in the Regional Trauma Triage Plan established in accordance with § 32.1-111.3 of the Code of Virginia.