WVEMS BOARD OF DIRECTORS
Thursday, March 10, 2016
Executive Committee - 1:30 PM
Full Board - 2:00 PM
Salem Civic Center
Parlor C

1. Call to Order
2. Introduction of New Directors and Guests
3. Secretary's Report
    a. Minutes - December 10, 2015 meeting *pdf* Dec 2015 Minutes Complete (7.33 MB)
4. Treasurer's Report
    i. FY 2016 Year-to-Date Financial Report - Unaudited *pdf* TREASURER'S REPORT FEBRUARY 2016 (17 KB)
    ii. Review and Adoption of FY 2017 Budget *pdf* Budget FY17 (7 KB)
    iii. Auditor engagement extension
5. Presentation – Mission Lifeline: John Dugan, AHA Mid Atlantic/VHAC
6. Reports and Action Items
    . Executive Committee
        i. Regional EMS Plan - Final Review and Revision Regional EMS Plan 2015
        ii. Awards Program 2016
    a. Medical Direction
        i. Protocol Revisions - Progress Report (Charles Lane, MD)
        ii. Education Workgroup - JCHS Project Progress Report (Steve Simon)
    b. EMS Operations
        i. Communications Workgroup – NRV repeater project
        ii. MCI Planning Workgroup – Reaffirm MCI Plan
    c. Performance Improvement Committees (meets same day as Board) (Charles Berger)
        i. Revision to Trauma Triage Plan (adopted at Dec, 2015 meeting)
        ii. Revision to Stroke Triage Plan *pdf* Stroke Triage Plan 2015 (316 KB)
    d. Near Southwest Preparedness Alliance (NSPA) - (David Linkous)
7. State EMS Advisory Board Report (Jason Ferguson)
8. EMS Financial Assistance
9. New Business
10. President's Report
11. Staff Reports
12. Public comments
13. Adjourn

WESTERN VIRGINIA EMERGENCY MEDICAL SERVICES COUNCIL
BOARD OF DIRECTORS

DRAFT MEETING MINUTES

DATE: March 10, 2016

LOCATION: Salem Civic Center, Parlor C

Directors Present
Steve Allen
Billy Altman
Joe Coyle
Steve Davis
Tim Duffer
Jason Ferguson
Carey Harveycutter
Daryl Hatcher
Mike Jefferson
David Linkous
Robert Logan
Matt Rickman
Kris Shrader
Steve Simon
Eric Stanley, DO
Dallas Taylor
Joe Trigg
Valerie Tweedie
Dale Wagoner

Staff Present
Cathy Cockrell
Sandi Short
Charles Berger
Mike Garnett
Gene Dalton

Guests Present
Tim Perkins, VOEMS
John Dugan, AHA Mid-Atlantic/VHAC

TO ORDER
In the absence of the president and vice president, Secretary Steve Simon called this regular meeting of the Board of Directors to order at 2:00 PM.

Mr. Simon introduced guests:
Tim Perkins, Virginia Office of EMS
John Dugan, American Heart Association (Virginia Heart Attack Coalition)

He then introduced new board members:
Valerie Tweedie, at-large 4th Planning District at-large
Matt Rickman, City of Salem

Mr. Simon thanked John Beach for his many years of service representing the City of Salem. He and the executive director welcomed Ms. Tweedie and Mr. Rickman to the board.

SECRETARY'S REPORT

Secretary Simon presented minutes of the last meeting as distributed. He called for any corrections or additions.

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

TREASURER'S REPORT
Treasurer Harveycutter presented the year-to-date report for the current fiscal year.

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

Treasurer Harveycutter then presented the draft budget for FY 2017. There are no significant changes. The budget includes finds for a 1.25% cost of living increase, and a 2% merit increase for staff that will be awarded at the discretion of the executive director.

Motion was made and seconded to adopt the budget to include a 1.25% cost of living increase and discretionary merit increase up to 2%. **Motion CARRIED.**

The treasurer presented a request from the business manager to extend the engagement of Brown Edwards & Company for one additional year due to the integration of Virginia EMS Symposium accounting into our books in the current fiscal year. The request is attached to and made a part of these minutes.

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

SPECIAL PRESENTATION
Secretary Simon introduced John Dugan, Director, Clinical Systems, Health Strategies for the American Heart Association Mid-Atlantic Affiliate. Mr. Dugan discussed the "Mission Lifeline" EMS Recognition program that is currently underway. He distributed the attached flyer and encouraged participation by agencies in the WVEMS region.

EXECUTIVE COMMITTEE
The executive committee met prior to the regular meeting.

The executive director presented the WVEMS Regional EMS Plan, and discussed several recommended revisions.

Motion was made and duly seconded to approve the plan as revised. **Motion CARRIED.**

The executive director and regional education director Cathy Cockrell discussed plans for the upcoming regional EMS awards. Staff has been working on ways to increase interest and attendance, and proposes that we develop a larger event, and make the awards presentation a part of that event. A nationally-known speaker is being recruited.

There was much discussion on other alternatives for an event, and the consensus was that an event to bolster attendance was good and should be pursued. Several means for publicity were suggested. There was also discussion on the overall lackluster participation statewide, and the potential to eliminate the program in the future. The executive director explained that such a move would have to come from the state level and would likely not be considered for at least another year.

Motion was made and seconded to approve moving ahead with the search for other alternatives, with any action to be approved by the executive committee. **Motion CARRIED.**

MEDICAL DIRECTION COMMITTEE

Protocol Updates

Dr. Stanley and Cathy Cockrell reported that work is underway for a comprehensive review and update of protocols.

Allied Resources and Pharmacy Workgroups

Changes in Board of Pharmacy regulations have been published. The Pharmacy Workgroup will meet in the next two weeks, and these changes will be rolled out. A new Drug Administration Record will be developed.

Education Workgroup

Development of the joint Jefferson College/WVEMS program is underway. It has been determined that a new employee is not needed at this time.

EMS OPERATIONS

Communications Workgroup

The new repeaters for the NRV have been ordered and work is underway.

MCI Workgroup

The Regional MCI Plan is a fluid document. It is currently being reviewed by NSPA and WVEMS. At present no revisions are recommended.

Motion was made and seconded to reaffirm the existing MCI plan. **Motion CARRIED.**

PERFORMANCE IMPROVEMENT COMMITTEE

Trauma and General Performance Improvement Subcommittees

Charles Berger reported for the General and Trauma Performance Improvement Committees. Both met today.

The Trauma Triage Plan Was reviewed and updated, and approved by the board at its last meeting. Further revisions will be made pending changes to the state trauma triage plan.

The Stroke Triage Plan was reviewed by the stroke workgroup and the general performance improvement committee. Only minor revisions to statistics and technical updates were recommended.

Motion was made and seconded to adopt the Stroke Triage Plan as revised. **Motion CARRIED.**

NSPA

David Linkous, board member representing the Near Southwest Preparedness Alliance, reported for NSPA. He mentioned several upcoming classes and events, including a Behavioral Health Summit on April 6-7, and the NSPA Annual Regional Workshop on April 21-22, and he reported on the ongoing Long Term Care assessments underway across the region.

EMS Advisory Board
Jason Ferguson reported for the EMS Advisory Board. He also provided a written report which was distributed, and is attached to and made a part of these minutes.

EMS Financial Assistance
The deadline for the upcoming cycle is March 15.

NEW BUSINESS
None

PRESIDENT'S REPORT
Mr. Simon reported 70 percent of directors in attendance. He thanked the members, staff and guests for their attendance.

STAFF REPORTS
Rob Logan - None

Cathy Cockrell - None

Charles Berger – OMD workshop at the Greenfield Center on April 20.

Mike Garnett – None

Gene Dalton - None

Sandi Short – None

HEARING OF THE PUBLIC
None

Being no further business, the meeting was adjourned at 3:05 PM.

/s Robert Logan, Executive Director

WESTERN VA EMS COUNCIL
UNAUDITED TREASURER'S REPORT
AS OF FEBRUARY 29, 2016

REVENUES	BUDGET	TOTAL	% YTD
STATE GOVERNMENT (OEMS CONTRACT)	433,450	207,725	47.92%
LOCAL GOVERNMENT	133,000	134,282	100.96%
UNITED WAYS	3,000	1,333	44.45%
CONTRIBUTIONS	1,000		0.00%
NSPA/VHHA PROGRAM REVENUE	425,000	392,274	92.30%
DIRECT PROGRAM INCOME (Tuitions, grants, VDH/OEMS)	294,000	43,598	14.83%
VA EMS SYMPOSIUM		10,604	0.00%
NSPA OFFSET REVENUE (Contract for services)	10,000	22,789	227.89%
RENT INCOME (NSPA)	18,000	12,000	66.67%
OTHER INCOME - SALE OF ASSET	0		0.00%
CREDIT CARD HOSTING FEE		598	
ROLLOVER FROM FY13 SURPLUS (BOARD APPROVED)	0		0.00%
INVESTMENT / GAINS/LOSSES	15,000	(4,220)	-28.13%
TOTAL REVENUES	1,332,450	820,983	61.61%
EXPENDITURES	**BUDGET**	**TOTAL**	**% YTD**
SALARIES / WAGES (WVEMS)	410,000	313,392	76.44%
PAYROLL TAXES (FICA)	31,365	24,226	77.24%
VEC	1,200	574	47.83%
403(b) / RETIREMENT	20,500	11,927	58.18%
HOSPITAL / MEDICAL INSURANCE	55,000	31,320	56.95%
LIFE INSURANCE/DISABILITY	10,000	8,241	82.41%
DENTAL INSURANCE	3,600	1,837	51.03%
PROFESSIONAL SERVICES/FEES	8,500	11,310	133.06%
MEDICAL DIRECTION ASSISTANCE	1,000		0.00%
MAINTENANCE / REPAIRS / SERVICE CONTRACTS	2,000	1,946	97.32%
OCCUPANCY (Utilities, repairs, NRV rent etc.)	20,000	13,461	67.31%
POSTAL / SHIPPING	2,000	1,014	50.70%
TELECOMMUNICATIONS	14,000	11,054	78.96%
SUPPLIES (ADMIN)	9,485	6,255	65.94%
EQUIPMENT	8,000	3,732	46.65%
INSURANCE	8,000	6,197	77.46%
DIRECT PROGRAM EXPENSES	160,000	58,436	36.52%
NSPA/VHHA PROGRAM EXPENSES	499,000	404,235	81.01%
PRINTING / PUBLICATIONS	3,500	1,074	30.67%
TRAVEL / LODGING	7,000	2,614	37.35%
FUEL/VEHICLE MAINTENANCE	16,000	7,283	45.52%
MEETING SUPPORT	1,200	88	7.32%
DUES / MEMBERSHIP FEES	1,200	1,463	121.88%
STAFF DEVELOPMENT	12,500	2,212	17.70%
CISM PROGRAM COSTS	2,000	334	16.68%
COMMUNICATION SITE RENTAL	8,100	5,700	70.37%
COMMUNICATIONS WIRELINES	7,500	5,752	76.69%
COMMUNICATIONS MAINTENANCE	4,000	580	14.49%
COMMUNICATIONS UTILITIES	800	328	41.03%
COMMUNICATIONS INSURANCE	3,000	2,000	66.67%
COMMUNICATIONS EQUIPMENT	2,000		0.00%
TOTAL EXPENDITURES	1,332,450	938,585	70.44%

PROGRAM

REVENUE (PROGRAM ACCOUNTS)	TOTAL
OEMS FUNDS - INTERMEDIATE	3,895
OEMS FUNDS - ENHANCED	
OEMS FUNDS - ADJUNCT	800
OEMS FUNDS - CARDIAC	
OEMS FUNDS - CT TRANSITION	
OEMS FUNDS - SHOCK TRANSITION	
OEMS FUNDS - ALS CE	
OEMS FUNDS - BLS	
OEMS FUNDS - EMT	
PROGRAM SERVICE FEES	5,835
PROTOCOL, ETC. SALES	776
TEXTBOOK SALES	
CONSOLIDATED TESTING	18,055
DRUG BOX ENTRANCE FEES	5,075
GRANTS & SPECIAL PROJECTS	
SALES - CONSUMER GOODS	
WEB DATABASE	
PROCESSING FEES	
PROGRAM FEES - MONROE HEALTH CENTER	
PROGRAM TUITION - INTERMEDIATE	
PROGRAM TUITION - ENHANCED	
PROGRAM TUITION - ADJUNCT	
PROGRAM TUITION - CARDIC	
PROGRAM TUITION - OTHER	
PROGRAM TUITION -	
PROGRAM TUITION - NRVTC	
ID CARD SALES	145
COMMUNITY COLLEGE COURSE REVENUE	9,017
TOTAL REVENUES	43,598

EXPENSES (PROGRAM ACCOUNTS)	TOTAL
CONTRACTS FOR SERVICES (INTERMEDIATE)	7,250
CONTRACTS FOR SERVICES (ENHANCED)	
CONTRACTS FOR SERVICES (ADJUNCT)	60
CONTRACTS FOR SERVICES (CARDIAC)	
CONTRACTS FOR SERVICES (SPEC. PROJ.)	75
CONTRACTS FOR SERVICES (ALS TEST)	5,399
CONTRACTS FOR SERVICES (CTS)	14,630
CONTRACTS FOR SERVICES (CE WEEKENDS)	
CONTRACTS FOR SERVICES (DRUG TESTING)	
CONTRACTS FOR SERVICES (EMT)	
CONTRACT FOR SERVICES (MONROE HEALTH CENTER)	
PAYROLL TAXES (FICA)	1,226
VEC	629
RENT - NRV TRAINING CENTER	742
POSTAGE (NRVTC)	
SUPPLIES (Programs)	1,104
SUPPLIES (CTS)	130
SUPPLIES (ALS TESTING)	446
SUPPLIES (EDUCATION)	
SUPPLIES (NRVTC)	
TEXTBOOKS (EMT-I)	
TEXTBOOKS (ITLS)	681
TEXTBOOKS (AMLS)	624
TEXTBOOKS (NRV)	2,975
EQUIPMENT (ALS TESTING)	
ITLS CERTIFICATES	
EQUIPMENT (EDUCATION)	
EQUIPMENT (NRVTC)	2,887
INSURANCE	2,247
TRAVEL (MONROE HEALTH CENTER)	
PRINTING / PUBLICATIONS (EDUCATION)	
PRINTING / PUBLICATIONS (NRVTC)	
AMLS CERTIFICATES AND CARDS	
GRANTS & SPECIAL PROJECTS	1,408
DRUG BOX EXCHANGE	4,025
CREDIT CARD DISCOUNT	2,428
MERCHANDISE FOR RESALE	452
ID CARD PROGRAM	
COMMUNITY COLLEGE FEES	9,017
TUITION REIMBURSEMENT - ENHANCED	
TUITION REIMBURSEMENT - INTERMEDIATE	
TOTAL EXPENDITURES	58,436

WESTERN VIRGINIA EMS COUNCIL, INC.
Balance Sheet
February 29, 2016

ASSETS

Current Assets			
FSA CASH	$ 1,853.35		
SUNTRUST CHECKING	184,279.53		
SUNTRUST PAYROLL	200.00		
VALLEY BANK MONEY MARKET	65,740.81		
ACCOUNTS RECEIVABLE	5,758.44		
TUITION RECEIVABLE	13,056.72		
Total Current Assets		270,888.85	
Property and Equipment			
Total Property and Equipment		0.00	
Other Assets			
FRANKLIN TEMPLETON-AMERIPRISE	128,841.70		
COMMUNICATIONS EQUIPMENT	121,360.59		
MISCELLANEOUS EQUIPMENT	321,713.64		
OFFICE EQUIPMENT	34,391.84		
BUILDING	175,223.00		
LAND	201,600.00		
BLDG. IMPROVEMENTS	74,792.94		
GENERATOR BUILDING & EQUIPMENT	16,672.25		
ACCUMULATED DEPRECIATION	(342,721.36)		
Total Other Assets		731,874.60	
Total Assets		$ 1,002,763.45	

LIABILITIES AND CAPITAL

Current Liabilities			
ACCRUED SALARIES	$ 30,746.68		
SALES TAX PAYABLE	1.59		
FLEX SPENDING ACCOUNT-MEDICAL	3,957.55		
DEFERRED REVENUE	4,589.14		
Total Current Liabilities		39,294.96	
Long-Term Liabilities			
Total Long-Term Liabilities		0.00	
Total Liabilities		39,294.96	
Capital			
FUND BAL. UNRESTRICTED	707,162.00		
FUND BAL. UNRESTRICTED DES.	55,036.00		
RETAINED EARNINGS	340,470.05		
FUND BALANCE TEMP. RESTR.	20,374.00		
Net Income	(159,573.56)		
Total Capital		963,468.49	
Total Liabilities & Capital		$ 1,002,763.45	

WVEMS ADOPTED BUDGET FY 2016 and PROPOSED 2017		
	Budget 15-16 Adopted	**FY 2017 (proposed)**
REVENUES		
State Government (OEMS Contract)	433450	440000
Local Government	133000	133000
United Ways	3000	3000
Contributions	1000	1000
NSPA/VHHA Program Revenue	425000	440000
MRC	94000	94000
Direct Program Income (tuitions, grants, VDH/OEMS)	200000	215000
NSPA Offset Revenue (Contract for services)	10000	12000
Rent income (NSPA)	18000	18000
Other Income (Sale of Assets - Insurance claim)		
Rollover from FY 13 Surplus (Board Approved)		
Interest/Investment	15000	14000
TOTAL REVENUES	**1,332,450**	**1,370,000**
EXPENSES		
Personnel		
Salaries/Wages (WVEMS)	410000	430000
Payroll Taxes (FICA)	31,365	32,895
VEC	1200	1200
403(b) Thrift	20,500	21,500
Hospital/Medical Insurance	55000	54000
Life/ADD/Disability	10,000	10,000
Dental Insurance	3600	4000
Staff Services Total	**531,665**	**553,595**
Non-Personnel		
Professional Services/Fees	8,500	8,500
Medical Direction Assistance	1,000	1,000
Maintenance/Repairs/Service Contracts	2,000	2,000
Occupancy (Utils, cleaning, maint, etc.)	20,000	22,000
Postal/Shipping	2,000	2,000
Telecommunications	14,000	14,000
Supplies (Admin)	9,085	9,705
Equipment	8,000	9,000
Insurance	8,000	8,000
Direct Program Expenses	160,000	162,000
NSPA/VHHA Program Expenses	410,000	420,000
MRC Expenses	89,000	89,000
Printing/Publications	3,500	3,500
Travel/Lodging	7,000	6,000
Vehicle Fuel/Maintenance	16,000	15,000
Meeting Support	1,200	1,200
Dues/Membership Fees	1,200	1,600
Staff Development	12,500	12,500
CISM Program Costs	2,000	2,000
Radio Systems		
Site Rental	8,100	8,100
Telephone Wirelines	7,500	7,500
Maintenance	4,000	4,000
Utilities	800	800
Insurance	3,000	3,000
Equipment	2,000	4,000
Reserve for Capital (Bldg Maint, Grant match for Communications & Training Equip)		
TOTAL EXPENSES	**1,332,050**	**1,370,000**

BECAUSE TIME MATTERS.

American Heart Association. | MISSION: LIFELINE®

2016 Mission: Lifeline® EMS Recognition Criteria and Measures

Mission: Lifeline® EMS will accept applications from January 1, 2016 – March 31, 2016 based on self-reported quarterly summary data for the 2015 calendar year. The listed achievement measures will be used to determine recognition eligibility. Any issued award will be in effect from May 31, 2016 - May 30, 2017.

Achievement CRITERIA:

- Each measure must achieve at least 75% compliance for the year per award level to be eligible for recognized status.
- The 2016 award period includes patients treated from January 1, 2015 – December 31, 2015.
- Patient volume requirements pertain to achievement measures #2 and/or #3 below*. It is assumed when volume requirements are met for measure #2 and/or #3, volume requirements will also be met for measure #1.
- Data is to be submitted in quarterly intervals as stated below:
  - Quarter 1 – January, February, March
  - Quarter 2 – April, May, June
  - Quarter 3 – July, August, September
  - Quarter 4 – October, November, December

Achievement MEASURES:

1. Percentage of patients with non-traumatic chest pain ≥ 35 years, **treated and transported** by EMS who received a **pre-hospital 12-lead electrocardiogram**
2. Percentage of STEMI patients **treated and transported directly** to a STEMI receiving center, with **pre-hospital first medical contact to device time** ≤ 90 minutes
3. Percentage of lytic eligible STEMI patients **treated and transported** to a STEMI referring hospital for fibrinolytic therapy with a **door-to-needle time** ≤ 30 minutes

- *Agencies that transport to both PCI capable and Non-PCI capable hospitals will report measures #1, 2, and 3.*
- *Agencies that only transport to PCI capable hospitals will report measures #1 and #2.*
- *Agencies that only transport to non-PCI capable hospitals will report measures #1 and #3.*

NEW - Reporting Measures:

- What percentage of your 12 lead ECGs are performed on patients with non-traumatic chest pain ≥ 35 years, within 10 minutes of First Medical Contact (FMC)?
- Within what timeframe are 75% of hospital notifications performed after 1st positive 12 lead ECG? (75% fractile)
  Example: 75% of hospital notifications are performed within **xxx minutes** of 1st positive 12 lead ECG.
- Percentage of under-call and percentage of over-call activations**

Submission of reporting measures data is **OPTIONAL. Submitting reporting measure data is not required to achieve recognition nor will any reporting measure data be considered when determining eligibility for recognition. Because some reporting measures may become required achievement measures in the future program years, agencies may wish to begin developing their collection processes for them sooner than later.*
*** More information on the specific definitions of these measures will be released soon.*

Award LEVELS and VOLUME Requirements:

- **BRONZE:** A minimum of 75% compliance for each required measure.
  - **Volume:** at least 2 STEMI patients per reporting quarter with at least 4 STEMI patients in the 2015 calendar year.
- **SILVER:** Aggregated annual score achieving a minimum of 75% compliance for each required measure.
  - **Volume:** at least 8 STEMI patients in the 2015 calendar year.
- **GOLD:** 2 consecutive calendar years achieving a Silver award
  - **Volume** at least 8 STEMI patients in the 2015 calendar year. + must have achieved Silver award in previous year.

Updated: 6/11/2015

Western Virginia Emergency Medical Services Council, Inc.

Western Virginia EMS Council
Regional Stroke Triage Plan

Western Virginia EMS Council, Inc.
1944 Peters Creek Road NW
Roanoke VA 24017
800.972.4367
www.wvems.org

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.
Originally adopted by the WVEMS Board of Directors - June 30, 2011(Revised March 11, 2015)

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Executive Summary

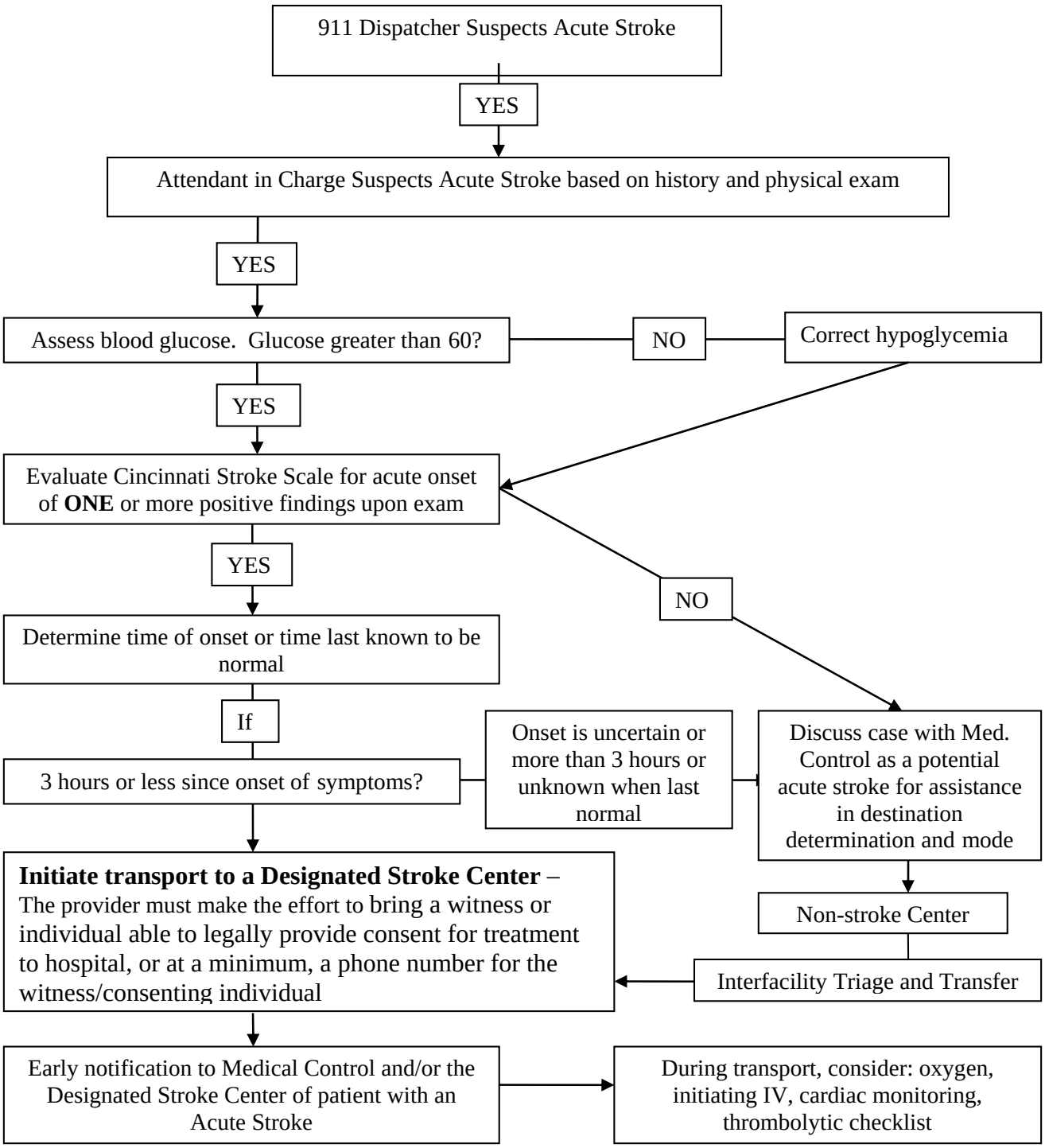
Under the *Code of Virginia* **§** *32.1-111.3*, The Office of Emergency Medical Services acting on behalf of the Virginia Department of Health has been charged with the responsibility of maintaining a Statewide Stroke Triage Plan. The Western VA EMS region which includes the counties of Alleghany, Botetourt, 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, 2015, the list of Designated Stroke Centers accessible to the Western VA EMS Council region includes:

Carilion Roanoke Memorial Hospital	Roanoke	**Centra Lynchburg General**	Lynchburg
LewisGale Medical Center	Salem	**Martha Jefferson Hospital**	Charlottesville
University of Virginia Medical Center	Charlottesville	**Augusta Health Center**	Fisherville
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
Danville Regional Medical Center	Danville		

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

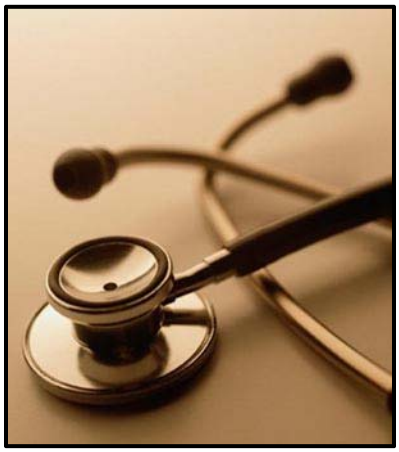
The Western VA EMS Council, Inc., will report aggregate acute stroke triage findings on an intermittent basis, but no less than annually, to assist EMS systems and the Virginia Stroke Systems Task Force to improve the local, regional, and Statewide Stroke Triage Plans. A de-identified version of the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

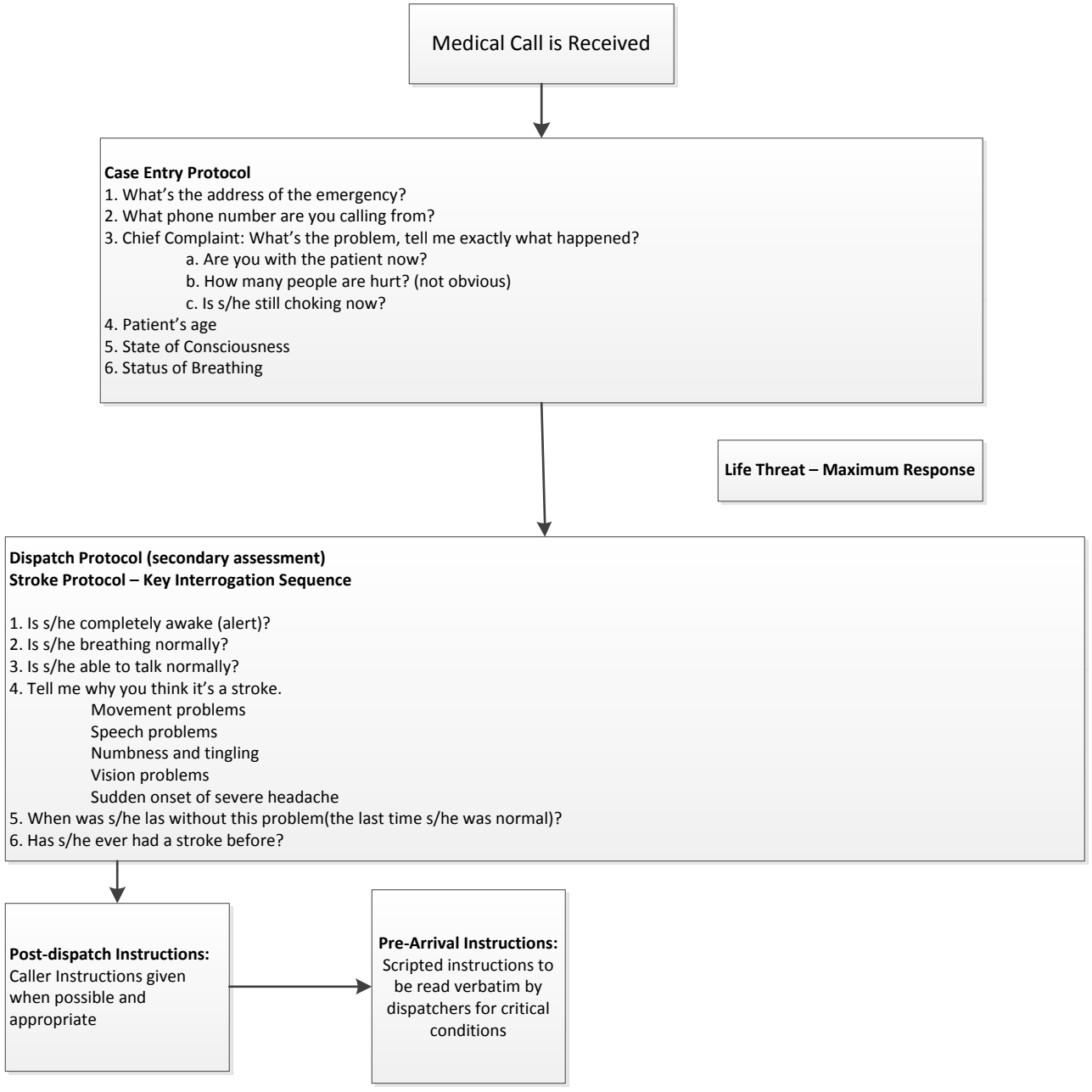
Stroke Related Resources

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: WVEMS Stroke 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**

Universal Patient Care Protocol

Cincinnati Stroke Scale Performed

Screen Positive

If positive and symptoms <3 hours, transport to destination as per WVEMS Regional Stroke Plan and (time permitting) complete Thrombolytic checklist. Limit scene time to 10 minutes and provide early notification to receiving facility.

B	**Blood Glucose**	B
A	**IV Protocol**	A
I/P	**12-Lead ECG**	I/P

Glucose <60 →

A	**50% Dextrose** **Glucagon if no IV**	A

Consider other protocols as indicated
- **Altered Mental Status**
- **Hypertension**
- **Seizure**
- **Overdose/Toxic Ingestion**

M	Notify Destination or Contact Medical Control	M

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

eart, Lungs, Abdomen, Extremities, Neurological
d for any suspected stroke patient if time permits. At a minimum the information contained on top half lity.
rly destination notification/activation should be provided and transport times should be minimized

ssed time the patient was symptom free (i.e. awakening with stroke symptoms would be defined as an was symptom free)
atus Protocol should also be considered.
ith stroke. Consider treatment if diastolic is > 110 mmHg.
lty, vomiting/aspiration).
ogic deficit, especially in the elderly.

e 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.

Virginia EMS Advisory Board
February 5, 2016
Meeting Summary

Deputy Commissioner's Report- Dr. Trump reported that extra efforts associated with Ebola outbreak has ended. The Ebola planning and training has led to an exercise developed in collaboration with VDEM. This "Infectious Disease Exercise in a Box" will be piloted this spring and utilized to plan for other types of outbreaks.

OEMS Report:

- Quarterly Report is posted (Click Here)
- Director Brown reported that Paul Sharpe recently resigned from OEMS and discussed the regrouping of his staff to focus on efforts for continued implementation of NEMSIS V3. He also pointed out that the state deadline for implementation is being realigned with the national deadline of 12/31/16. All data submitted 1/1/17 forward must be V3 compliant. No penalties or formal actions will take place on agencies not meeting previous OEMS deadlines; however data must still be submitted.
- Legislative grid: Updated information that REPLICA is moving forward very well in the process. Delegate Orrock sponsored a bill to "bridge the gap" in case REPLICA did not pass.
- Dr. Lindbeck reported on a Fatigue project that NHTSA and NASEMSO have started, looking at fatigue management in EMS.
- Dr. Lindbeck gave a presentation on Protecting Patient Access to Emergency Medications Act 2016. He explained the 1970 Drug Control Act and interpretations from the DEA that are not concurrent with routine application of drug storage and dispensing in EMS. For additional information go to http://www.naemsp.org

Committee Reports:

- Executive Committee-
  - Continuing to work on reviewing the findings from the ACS site visit
- FARC-
  - December cycle had 116 requests for 9.7 million dollars and 86 agencies were awarded 4.5 million dollars.
  - EMS agencies need to register with eVA to receive grant funds awarded to their agency. New information is available on OEMS website.
- Rules & Regulations-
  - The Medical Direction committee met with them at their meeting concerning an issue in regards to supplemented transport requirements. They will address this issue during their periodic review this year.

- Legislative & Planning-
    - Discussed the legislative process and bills moving forward in the General Assembly.
    - Updated status of regulations.
- Transportation-
    - Will be reviewing all of the RSAF grants for apparatus.
    - They will be bringing forth their recommendations for the next generation ambulance in Virginia before July 1.
- Communications-
    - Took action on two PSAP accreditation applications (Winchester and King and Queen) approved.
    - P25 Compliant Radio Systems- Reaffirmed their position that systems purchased should be P25 compatible in order to be eligible for RSAF grant funding.
- Emergency Management-
    - Update on Model Uniform Coe Criteria (MUCC)- Karen Owens recommended that MUCC be put on hold because there is indecisiveness at the federal level. Current triage tags are still available.
- Medical Directions-
    - Addressed a concern presented by Virginia Ambulance Association that as to whether or not a “Transport” medical director needed to be added to the makeup of the group. The group felt that this was not a necessary change and will not be altering the makeup of the group.
- Medevac-
    - Drone workgroup met and has put together a universal training program and message.
    - Continuing to work on a STEMI review project
- Trauma-
    - Working on addressing recommendations from the ACS review. Will be appointing a multidisciplinary committee to work on a draft trauma plan.
    - VCU, Carilion Clinic, and Norfolk General have all been verified as Level I trauma centers
    - Winchester and Chippenham Medical have been verified as Level II trauma centers
    - Trauma Triage Task Force will be finalizing their recommendations on State Trauma Triage Interfacility Transport Guidelines for presentation to TSOMC.
- EMSC-
    - Working on EMS partnership grant, the Pediatric Readiness Project, and the Pediatric Disaster Preparedness.
- Professional Development-
    - No Report
- Training & Certification-
    - I99 Workgroup held its first meeting, estimate that VA had approximately 200 new Intermediates in 2015.

    - Training Regulations Review Workgroup reported that upon review of survey results from 25 states, the recent updates to EMSTF and regulations that Virginia is in a good position overall.
    - Accreditation Program Internal Psychomotor Testing Workgroup considering allowing accredited EMT programs to conduct in-house psychomotor exams or competency validation through CapStone plans to ramp up their efforts.
- Workforce Development-.
    - Officer I- Back on track, hope to pilot in the Spring
    - Standards of Excellence group continues to work on guidance documents for agencies.
- Provider Health & Safety-
    - Dr. Lindbeck presented information on provider fatigue.
    - Discussed EMS Safety Officer role and establishing guidelines for that.
- EMS Council Director-
    - Recognized Connie Purvis for her longstanding service as she retires in February

Respectfully Submitted,

Jason Ferguson
WVEMS Advisory Board Representative

DIRECTORS:	2015				2016				2017			
	MAR	JUN	SEP	DEC	MAR	JUN	SEP	DEC	MAR	JUN	SEP	DEC
Allen, Steve	X	X	O	X	X							
Altman, Billy	X	X	X	X	X							
Beach, John	O	X	O	O								
Broughman, J. B.					O							
Brown, Bill	O	O	O	O								
Cady Sr., Jim	X	X	X	X	O							
Coyle, Joe	X	O	O	X	X							
Davis, Steve	X	X	X	X	X							
Dick, Tim	O	O	O	O								
Duffer, Tim	X	O	O	X	X							
Eanes, Steven	X	O	O	X	O							
Ferguson, Jason	X	X	X	X	X							
Guests	2	6	1	3	2							
Harveycutter, Carey	X	X	X	O	X							
Hatcher, Daryl	X	O	X	O	X							
Haywood, Rodney			O	O	O							
Hodge, Rickey	O	O	X	O	O							
Jefferson, Mike	X	X	X	O	X							
Lane, Charles	O	O	X	X	O							
Linkous, David	O	O	X	O	X							
Logan, Robert	X	X	X	X	X							
Muterspaugh, Ryan	O	O	X	X	O							
Rickman, Matt					X							
Shrader, Kris	X	O	X	X	X							
Simon, Stephen	X	X	X	X	X							
Stanley D.O., Eric	X	O	X	X	X							
Taylor, Dallas	X	O	X	X	X							
Trigg, Joe	X	X	X	X	X							
Tweedie, Valerie					X							
Wagoner, J. Dale	X	O	X	X	X							
Wirt, Ford	X	X	X	X	O							

STAFF PRESENT:	2015				2016				2017			
	MAR	JUN	SEP	DEC	MAR	JUN	SEP	DEC	MAR	JUN	SEP	DEC
Berger, Charles	X	X	X	X	X							
Christian, Mary	O	O	O	X	O							
Cockrell, Cathy	X	X	X	X	X							
Dalton, Gene	X	X	O	X	X							
Garnett, Mike	X	X	X	X	X							
Short, Sandi	X	X	X	X	X							
Christensen, Chris	O	X	O	O	O							

DID NOT ATTEND = O
NO LONGER INVOLVED

March 2015 Guests: Tim Perkins-OEMS, J.T. Clark-NSPA
June 2015 Guests: Michael Pruitt-NSPA, Jason Gifford, Dr. David Trump-VDH,
June 2015 Guests: Kevin Dillard(Lifecare), Althea McDaniel(Lifecare), Dan(Lifecare)
Sept 2015 Guests: Robert Decarolis
Dec 2015 Guests: Broughman(City of Covington), JT Clark (NSPA), John Hash(Brown Edwards)
March 2016 Guests: Tim Perkins (OEMS), John Dugan (AHA/VHAC)