

Northern Virginia Emergency Medical Services Council, Inc.

Board of Directors Meeting

4081 University Drive, 3rd Floor

Fairfax, VA 22030

Meeting Minutes

Thursday, September 19, 2024



DIRECTORS PRESENT (Listed Alphabetically by First Name)

See the list at the end of the minutes.

GUESTS

Chief Felipe Hernandez, Alexandria Fire Department

Kristin Nickerson, Northern Virginia Emergency Response System

Bruce Roemmelt, Member of the Public

Eric Simenson, MMT Ambulance

Peter Sweetse, George Washington University Emergency Department

Call to Order

Council President Nate Strong welcomed all in attendance and called the meeting to order at 10:07 am.

- No representatives from the public requested to address the Board.

Approval of Minutes

The NVEMSC Board of Directors meeting minutes on June 20th, 2024, were emailed for review.

- Tom Olander made a motion to accept as written, seconded by Beth Adams.
- The minutes were **unanimously approved**.

Treasurer's Report

The financial reports for June through August were sent via email for review.

- Beth Adams made a motion to approve the financials as submitted, seconded by Paul DeHaven.
- The financials were **unanimously approved**.

President's Report

President Nate Strong advised he had no report for today's meeting.

- He is working with NVERS on the merger and will cover some highlights later in the report.

Executive Director's Report

Interim Executive Director Laura Vandegrift submitted the following report:

- **OEMS Funding**
 - All outstanding quarterly contract payments have been received as of August 20th, 2024.
- **Sentara Cares Grant**
 - Estee worked diligently to meet the requirements of the Sentara Cares Grant we received in July 2023.
 - She exceeded the objectives of partnering with five each of Federally Qualified Health Centers, community centers primarily serving Spanish-speaking clientele, and predominantly Spanish-speaking faith-based organizations by reaching 20 Federally

Qualified Health Centers, 12 community centers, and 16 faith-based organizations who have all agreed to share the Stroke Smart videos and materials with their community.

- **Medication Kit Transition Update**
 - We continue to update the dedicated section on our website for the EMS Medication Kit Transition, which contains multiple resource documents, step-by-step guides, policy and procedure guidelines, and financial worksheets, among other things.
 - As resources and guidance documents are updated, those are added to their respective areas.
- **EMS Next Steps Update**
 - There was a Special Meeting of the Governor’s Advisory Board on Wednesday, September 18th, to receive and discuss the results of the VDH Office of Internal Audit’s Final Audit Report and the Fitch Report.
 - The Regional Council Directors’ group has been working on a White Paper over the last few weeks to address the importance of Virginia’s Regional EMS Councils and their role in EMS across the Commonwealth in anticipation of any recommendations or decisions resulting from these reports. A copy is attached.
 - Beth will report further on the special meeting of the GAB from yesterday in her report.
- **Governor’s Award Nominations**
 - The Governor’s EMS Award nominations are being finalized and are due by October 1st.
- **EMS Council Designation**
 - The EMS Council Designation packets have been released and are due December 15th. OEMS has recommended that NVEMSC, NVERS leadership, and OEMS meet to discuss the designation for us with the pending merger with NVERS.
 - I am working on setting up a time for that meeting.

STATE AND REGIONAL COMMITTEE REPORTS

Stroke Smart Update

Estee Warring provided the following update:

- This past summer, she participated in several Stroke Smart events, including training for medical providers and a back-to-school event where she passed out stroke awareness material attached to boxes of crayons and markers.
- She continues to work with food banks to distribute magnets and cards with each bag of groceries.
- She distributed 400 magnets and wallet cards this summer, and 138 people received the Stroke Smart class.
- We completed fulfillment of the Sentara Cares grant that was awarded to the council in 2023. The Spanish Stroke Smart video was shared with 12 community centers, 20 clinics, and 16 churches through that grant.
- Estee has also attended the PI meetings with the other EMS councils to improve how we pull data and get the most accurate numbers possible.

AHA Training Center

Michelle Ludeman provided the following written report:

- The AHA must monitor an ACLS and PALS class to complete the name change with the merger. They need a list of upcoming classes for both. Thank you to those who responded to my request.

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- The invoices for membership dues in the NVEMS Council American Heart Community Training Center were sent out on August 29th.

State EMS Advisory Board

Beth Adams provided the following written report:

- Rules & Regulations met on 8/1/2024
 - Chapter 66 (DDNR) approved by Board of Health on 6/13/2024
 - Chapter 32 (EMS regulations) - AG review still pending
 - 3 variance/exemption requests were discussed
 - Bland County re: allowing use of EVOC/CPR drivers
 - PHI Air Medical re: flight medic -> flight nurse pathway (2 v.3 years as ICU nurse)
 - Loudoun County re: background checks & migration to single DERA (designated emergency response agency)
- Legislative & Planning met 8/2/2024
 - Board of Pharmacy EMS-related regulations (see attached DEA guidance 7.3.2024)
 - 2025 Legislative Bills
 - HB1259/SB594: Medical Society of Virginia, OEMS rep & GAB Chair met on 7/15 re: adding EMS to Safe Haven program (<https://safehavenhealth.org>)
 - HB 1259, SB 594: EMS personnel; career fatigue and wellness program
 - 2024 Legislation: Governor signed HB1309: Requires the GAB in consultation with the Board of Veterinary Medicine, to develop guidelines and guidance for the provision of emergency treatment of fire, police, and search and rescue dogs injured in the line of duty and the transportation of such dogs by EMS emergency medical services vehicle to a veterinary care facility equipped to provide emergency treatment to such dog.
 - Discussion re: 18 GAB members' terms ended 6/30/2024, including all in leadership positions
- Governor's Advisory Board met 8/2/2024
 - EMS awards presented at the Governor's mansion on 5/20
 - Rachel Stradling (acting Director OEMS) report
 - special meeting of GAB to release internal audit & OIG report, prior to release of Fitch Report
 - expect OEMS Director position announcement to be released with 2 weeks
 - working with Governor's office re: GAB appointments
 - "Way forward" – move OEMS to VDH building (Madison Building, 109 Governor St, Richmond); OEMS staff not attending GAB unless invited by committee
 - Interim OEMS Strategic Plan approved by Board of Health on 6/13/2024
 - GAB chair & BOH chair to meet with VDH to discuss GAB reappointment/replacements
 - FARC re: Fall RSAF grant cycle (8/1-9/16) established priority funding for EMS Medication Management System (aka med kit transition) – 1st year DEA/CSR fees, security monitoring, cabinetry (no capital improvements) 1st year medication purchases
- My term on GAB ended 6/30/2024, but I'll continue to represent NVEMSC until my replacement is named.
- Next Steps Workgroup meeting date TBD

- I will continue to serve on the Next Steps Workgroup.
- Governor’s Advisory Board (GAB) Special Called Meeting on September 18th, 2024

OEMS Internal Audit Report*

- Presentation of OIA report by Dr. Karen Shelton, Health Commissioner & Christopher Lindsey, VDH-COO
- Dr. Karen Shelton reported criminal fraud within the Office of EMS (OEMS). New leadership and improved processes were implemented in response, and an OEMS Director will be hired soon.
- The Office of the Internal Auditor (OIA) initiated an audit after OEMS was unable to make a \$12.5M transfer to the general fund due to insufficient funds in the “4 for Life” account, which VDH had to cover.
- **Audit findings:**
 - Leadership and fiscal process failures
 - Budgetary mismanagement
 - Trauma Center fund management
 - Equipment Mismanagement
 - Fraud investigation
- **Fitch and Associates Report***
 - Key Findings
 - Financial Oversight Failures
 - Inconsistent Council Funding
 - Poor Organizational Focus
 - Regulatory Issues
 - EMS Workforce Challenges
 - Financial Irregularities
- Strategic Options for OEMS
 - Positioning and Oversight:
 - Option 1: Keep OEMS within VDH but strengthen oversight.
 - Option 2: Establish a new OEMS within Department of Public Safety to oversee OEMS.
 - Option 3: Merge OEMS with VDFP to create a combined Department of Fire and EMS Programs.
 - Option 4: Dissolve OEMS and redistribute regulatory responsibilities to other agencies.
 - Regional Structure & Councils:
 - Reduce regional councils from 11 to 7 (aligning with VDEM and VDFP). This would require legislative changes and lead to potential co-location of OEMS within regions (or functions carried out within established entities).
 - Could also go with a more decentralized structure with more regional support and staff focused on local needs or adopt a contracting/grant model with fewer (or no) state staff at the regional level.

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- Policy & Regulatory Processes:
 - Introduce a formal process for policy changes and review. EMS Advisory Board should be granted authority to propose regulatory changes and manage its own administrative tasks.
- Community Input & EMS Oversight Enhancement:
 - Reassess the size and scope of the EMS Advisory Board and subcommittees for efficiency and better representation.
- Financial Recommendations
 - Cost Savings:
 - Reduce staff positions from 49 to 35-39, saving \$1.9M-\$2.3M.
 - Reduce councils, potentially saving \$1.5M.
 - Consider cutting or restructuring the Medflight program to save \$3M.
 - Relocate the central office to save on facility costs.
 - Renegotiate the ESO contract to save \$4M.
 - Total potential savings from these measures: \$8M-\$11.5M.
- Conclusion: Current model is not sustainable. Emphasized the need for structural reforms and financial oversight. Operations must be significantly adjusted if funding remains flat to ensure long-term sustainability.
- *The full reports are available on Virginia Townhall, and the full FITCH Report starts on page 30.
 - https://townhall.virginia.gov/L/GetFile.cfm?File=Meeting%5C58%5C40513%5CAgenda_VDH_40513_v4.pdf
 - If you are unable to get the link to work, you can pull it from the Council website [here](#) in compressed PDF format.

Provider Health and Safety

Michelle Ludeman provided the following update:

- Safe Haven Law Presentation Request: The Committee received a presentation from Ms. Carolina Craig of the Medical Society of Virginia on the Commonwealth Safe Haven program, which provides protection and confidentiality for licensed medical professionals seeking mental health services.
 - The committee believes there is an opportunity to extend these protections to EMS providers, even though they are not licensed statewide. Brian Frankel requested that Ms. Craig be allowed to present this information to the state EMS advisory board, which Chair Dillard approved for the agenda for the next meeting at GAB.
- Infection Control Workgroup Participation Request: The Infection Control Workgroup provided an update on filling gaps in training and education related to infection control throughout the Commonwealth.
 - With the Virginia EMS Symposium no longer available, the committee seeks additional participants from EMS agencies or associations to ensure comprehensive coverage of infection control processes.
 - Brian Frankel asked attendees to encourage interested members to join the workgroup.

Medical PI Committee

Kate Kramer provided the following update:

- The committee met in July, and Katie Kreider and Danny Schroeder of the Children's National Medical Center Transport Team presented on Children with Special Healthcare Needs/Technology Assistance.

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- Kate Kramer also has a dementia-friendly presentation they want to do

Trauma PI Committee

Kate Kramer provided the following update:

- The committee met yesterday and discussed blast injuries.
- Dr. Reed Smith, Arlington County Fire Department, presented a case from December 2023 and learned lessons from it.
- Our next meeting will be on December 11th, 2024.
- The topic is field resuscitation/intubation and trauma activation, where the patient codes after you intubate the patient.
 - Data shared will be for the past two years.

Medevac Committee

Rick Cohen advised of the following:

- We haven't met since the last meeting in August; the next meeting is in November

Patient Tracking Workgroup

Jamie Cooper provided the following update on this workgroup.

- There have been no new meetings.
- Chief Cooper is stepping down as chair of the workgroup and has recommended Easton Peterson for the chair.
- The workgroup will be starting over with new input and advice

Regional Medical Directors & State Medical Direction Committee

Dr. Morgan provided the following update:

- Last met on July 11th.
- There was a lot of talk about the pharmacy changes.
- Regarding whole blood, the AABB is looking for guidance documents
 - Medicare/CMS is considering moving to a critical care level of transport for EMS blood transfusion or, better yet, for line item billing for blood transfusion

Training and Certification Committee

Michelle Ludeman provided the following written report:

- Brian McIntosh, vice chair and recording secretary for the Training and Certification Committee (TCC), reported that the committee met on July 10th, with the next meeting scheduled for October 2nd. The committee continues to work on the education and training components of the State EMS strategic plan through a dedicated workgroup.
 - Mr. McIntosh presented one item for the Board's consideration: a motion to reiterate the importance of the Virginia EMS Symposium as a critical component of EMS education and recertification in the state. The motion emphasized the symposium's role in promoting high-quality patient care and called for it to be a high priority for the Office of EMS. The motion was passed unanimously.
 - Motion 2: Recognize the Virginia EMS Symposium as essential in promoting high-quality patient care across the Commonwealth and designate it as a high priority for the Office of EMS. This motion was unanimously approved.

Rescue Squad Assistance Fund

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NVEMSC received 12 RSAF grant submissions from 4 agencies. We will compile the documents and send them out for review before the grading in October.

OLD BUSINESS

Merger with NVERS

- Kristin Nickerson provided the following update:
 - She has been working with Michelle on the AHA Training Center to ensure there won't be issues with the name change.
 - There will be no change or lapse in services for the agencies.
 - The Articles of Merger are drafted, and once they have the final Board minutes from the Special Meeting on August 20th, they will send them to us for review.
 - The next step is to work on the business plan.
 - Timeline – This can be done as early as October 1st, or they can wait. It is up to NVEMSC on the timeframe.

JURISDICTIONAL REPORTS

City of Alexandria Fire Department: Erin Mustian advised of the following update

- Nine students just graduated from Paramedic class, and 5 are set to test.
- They have 5 ALS in the current recruit school of 16.
- They have completed a significant number of promotions in the last few weeks.
- Working on their pharmacy build.

Arlington County Fire Department: Kevin Troiano reports

- 18 recruits in their current recruit school class.
- Hoping to hire 40 more next year.
- 11 students are currently in the GW paramedic program.
- 11 others with the NVCC class. They just finished the class are working on testing with NREMT.
- Working on their pharmacy build.

City of Fairfax Fire Department: Tom Olander advised there is nothing new to report

Fairfax County Fire and Rescue Department: Todd Barb reports

- They are graduating 36 from the current recruit class on Friday.
- They have another 50 in a concurrent class.
- They plan to have another 50 in class in November.

Fairfax County Police Helicopter Division: Paul DeHaven advised there was nothing new to report

Fauquier County Fire & Rescue: No representation

Loudoun County Combined Fire and Rescue System: Jamie Cooper provided the following update:

- They are working on their pharmacy build.

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City of Manassas Fire & Rescue: Chief Ed Mills provided the following report

- Most of their ALS vacancies have been filled.
- Working on the pharmacy and hoping to be complete before the deadline.

City of Manassas Park Fire Department: No representation

Metropolitan Washington Airports Authority: Gary Hubble provided the following update

- They have two students in paramedic programs, and one is finishing precepting.
- They have two new hires in orientation, one of whom is a paramedic.
- The new ambulance they ordered two years ago should arrive this week.
- They are also working on their pharmacy process, waiting for security systems to be installed, and hoping to meet the deadline to continue ALS services.

Prince William County Fire & Rescue: Chris Granger reported

- On Saturday, they stood up four EMS supervisors.
- They recently transitioned seven ALS units to BLS.

Lifecare: Gary Riggan reported the following:

- They are also in the process of standing up their pharmacy program.

Northern Virginia Community College: No representation

OEMS Program Representative: Karen Owens provided the following update:

- OEMS is moving forward with Council designations.
- They are moving training classes for emergency operations and PSAPS for mass casualty incidents.
- If there are any operations courses they need OEMS to help with, please notify Karen.

PHI Aircare: Rich Cohen advised of the following update

- Aircare3 in Leesburg lost their lease, so they are currently running out of Manassas with Aircare 1.
- The goal is to be back in Leesburg in 90 days.

Physicians Transport Service/AMR: Kate Passow advised there was nothing to report.

Inova Fairfax Hospital: Craig French provided the following update

- They now have an armed behavioral health officer and EMT ready for behavioral health patients coming in via stretcher. All belongings will be security-wanded before entry.
 - For those needing immediate treatment, they will be security-wanded in the bay.
 - They are working out the process for having family in the resuscitation bay.

Reston Hospital: Beth Adams provided an update submitted by Keith Morrison.

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- As of Friday, September 20th, they will no longer be doing thrombectomies but are continuing to contract with MedStar.
- Unfortunately, the volume was insufficient for them to continue performing them.
 - Only 25 in the last year
- This leaves Fairfax and VHC doing thrombectomies

Stafford County: No representation

StoneSprings Hospital: John Wanamaker provided the following update

- They are currently going through their Joint Commission survey.
- They are working on a second Operating Room and hoping to have it running next year.

EMERGILITY: No representation.

VHC Health: No representation.

NEW BUSINESS

None

MOTION TO ADJOURN

There was a motion to adjourn at 11:00 am.

Board meetings for 2024 are as follows.

October 17th, 2024

December 19th, 2024

CERTIFICATION OF BOARD OF DIRECTORS MEETING

Northern Virginia EMS Council, Inc.
4081 University Drive, Suite 400
Fairfax, VA 22030

I, Laura Vandegrift, Interim Executive Director of the Northern Virginia EMS Council, certify that the above minutes are a true and correct transcript of the minutes of a meeting of the Board of Directors of the Northern Virginia EMS Council held at 4081 University Drive, 3rd Floor, Fairfax, VA 22030, on September 19th, 2024, and that the meeting was duly called and held in all respects in accordance with the laws of the state of Virginia and bylaws of the corporation and that a quorum was present. The minutes were officially approved at the October 17, 2024, meeting of the Board of Directors of the Northern Virginia EMS Council.

Laura Vandegrift

10/17/2024

Laura Vandegrift
Northern Virginia EMS Council

Date



**Northern Virginia EMS Council, Inc.
Board of Directors Meeting Attendance**

Meeting Date:
9/19/2024

First Name	Last Name	Agency/Hospital Affiliation	Email Address	Attendance
Andrew	Duke	Alexandria Fire Department	andrew.duke@alexandriava.gov	Did Not Attend
Erin	Mustian	Alexandria Fire Department	erin.mustian@alexandriava.gov	Attended
Joseph	Marfori, MD	Alexandria Fire Department	joseph.marfori@alexandriava.gov	Did Not Attend
Kelsea	Bonkoski	Alexandria Fire Department	Kelsea.bonkoski@alexandriava.gov	Attended
Ramiro	Galvez	Alexandria Fire Department	ramiro.galvez@alexandriava.gov	Attended
E. Reed	Smith, MD	Arlington County Fire Department	rsmith@arlingtonva.us	Attended
Ibrahim	Abdul-Jawad	Arlington County Fire Department	labdul-jawad@arlingtonva.us	Did Not Attend
Jason	Jenkins	Arlington County Fire Department	jjenkins3@arlingtonva.us	Did Not Attend
Kate	Kramer, PA-C	Arlington County Fire Department	kkramer@arlingtonva.us	Attended
Kevin	Troiano	Arlington County Fire Department	ktroiano@arlingtonva.us	Attended
Brian	Orndoff	City of Fairfax Fire Department	brian.orndoff@fairfaxva.gov	Attended
David	Arrington	City of Fairfax Fire Department	david.arrington@fairfaxva.gov	Did Not Attend
John	O'Neal	City of Fairfax Fire Department	john.o'neal@fairfaxva.gov	Did Not Attend
Nicholas	Sutingco, MD	City of Fairfax Fire Department	nicholas.sutingco@inova.org	Did Not Attend
Tom	Olander	City of Fairfax Fire Department	olander@verizon.net	Attended
Danielle	Pesce, MD	City of Manassas Fire & Rescue	dpesce@manassasva.gov	Attended
Edward	Mills	City of Manassas Fire & Rescue	emills@manassasva.gov	Attended
Justin	Jenkins	City of Manassas Fire & Rescue	jjenkins@manassasva.gov	Attended
Kevin	Franzello	City of Manassas Fire & Rescue	kfranzello@manassasva.gov	Did Not Attend
Rebecca	Wilson	City of Manassas Fire & Rescue	rwilson@manassasva.gov	Attended
William	Barton	City of Manassas Fire & Rescue	wbarton@manassasva.gov	Attended
Aaron	Schutt	City of Manassas Park Fire & Rescue	a.schutt@Manassasparkva.gov	Did Not Attend
Adam	Jones	City of Manassas Park Fire & Rescue	a.jones@manassasparkva.gov	Did Not Attend
James	Soaper	City of Manassas Park Fire & Rescue	j.soaper@manassasparkva.gov	Did Not Attend
James	Tharp	City of Manassas Park Fire & Rescue	j.tharp@manassasparkva.gov	Did Not Attend
Josh	Brandon	City of Manassas Park Fire & Rescue	j.brandon@manassasparkva.gov	Did Not Attend
Tom	Oliver	City of Manassas Park Fire & Rescue	t.oliver@manassasparkva.gov	Did Not Attend
Tony	Barone	Emergility	Tony@emergility.com	Did Not Attend
Beth	Adams	Fairfax County Fire & Rescue	beth.adams@fairfaxcounty.gov	Attended
Steve	Hartman	Fairfax County Fire & Rescue	steven.hartman@fairfaxcounty.gov	Did Not Attend
Christopher	Warner	Fairfax County Fire & Rescue	christopher.warner@fairfaxcounty.gov	Did Not Attend
Rocco	Alvaro	Fairfax County Fire & Rescue	rocco.alvaro@fairfaxcounty.gov	Did Not Attend
Scott	Weir, MD	Fairfax County Fire & Rescue	scott.weir@fairfaxcounty.gov	Did Not Attend
Todd	Barb	Fairfax County Fire & Rescue	todd.barb@fairfaxcounty.gov	Attended
Dan	Avstreich, MD	Fairfax County Fire & Rescue	dan.avstreich@fairfaxcounty.gov	Did Not Attend
Kari	Scantlebury, MD	Fairfax County Police - Helicopter Division	karibury@gmail.com	Did Not Attend
Paul	DeHaven	Fairfax County Police - Helicopter Division	paul.dehaven@fairfaxcounty.gov	Attended
R. J.	Arft	Fauquier County DFREM	r.j.arft@fauquiercounty.gov	Did Not Attend
Rich	Cluff	Fauquier County DFREM	rich.cluff@fauquiercounty.gov	Did Not Attend
Craig	French	Inova Health System	craig.french@inova.org	Attended
Steve	Kling	Inova Health System	steven.kling@inova.org	Did Not Attend
Gary	Riggan, Jr.	LifeCare Medical Transports	griggan@lifecare94.com	Attended
Al	Pacifico, PA-C	Loudoun County Fire & Rescue	alfred.pacifico@loudoun.gov	Attended
Andrew	Hopkins	Loudoun County Fire & Rescue	andrew.hopkins@loudoun.gov	Did Not Attend
Jamie	Cooper	Loudoun County Fire & Rescue	jamie.cooper@loudoun.gov	Attended
John	Morgan, MD	Loudoun County Fire & Rescue	john.morgan@loudoun.gov	Attended
Kathleen	Harasek	Loudoun County Fire & Rescue	kharasek@sterlingrescue.org	Did Not Attend
Michelle	Beatty	Loudoun County Fire & Rescue	michelle.beatty@loudoun.gov	Did Not Attend
David	Wielgosz	Metropolitan Washington Airports Authority	david.wielgosz@mwa.com	Attended
Gary	Hubble	Metropolitan Washington Airports Authority	gary.hubble@mwa.com	Attended
Michael	Semchyshyn, MD	Metropolitan Washington Airports Authority	mikesem@hotmail.com	Did Not Attend
Richard	Bonnett	Metropolitan Washington Airports Authority	richard.bonnett@mwa.com	Did Not Attend

Mark	Franke, MD	Northern Virginia Community College	mfranke@nvcc.edu	Did Not Attend
Wanda	Gardner	Northern Virginia Community College	wgardner@nvcc.edu	Did Not Attend
Estee	Warring	Northern Virginia EMS Council	estee@vaems.org	Attended
Laura	Vandegrift	Northern Virginia EMS Council	laura@vaems.org	Attended
Michelle	Ludeman	Northern Virginia EMS Council	michelle@vaems.org	Attended
Karen	Owens	OEMS Deputy Director of Operations	karen.owens@vdh.virginia.gov	Attended
Chris	Vernovai	OEMS Systems Planner	chris.vernovai@vdh.virginia.gov	Did Not Attend
Laura	Diegelmann, MD	PHI Air Medical	ldiegelmann@phiairmedical.com	Did Not Attend
Rick	Cohen	PHI Air Medical	rcohen@phiairmedical.com	Attended
Serdar	Serttas	PHI Air Medical	sserttas@phiairmedical.com	Did Not Attend
Dave	Coullahan	Physicians Transport Service	dcoullahan@gmr.net	Did Not Attend
Kate	Passow	Physicians Transport Service	kate.passow@gmr.net	Attended
Ken	Lavelle, MD	Physicians Transport Service	ken.lavelle@gmr.net	Did Not Attend
Andrew	Sanders	Prince William County Fire & Rescue	asanders@pwcgov.org	Did Not Attend
Chris	Granger	Prince William County Fire & Rescue	cgranger@pwcgov.org	Attended
Jason	Knight	Prince William County Fire & Rescue	jwknight@pwcgov.org	Did Not Attend
Kevin	Campbell, MD	Prince William County Fire & Rescue	kccampbell26@gmail.com	Did Not Attend
Nathan	Strong	Prince William County Fire & Rescue	nstrong@pwcgov.org	Attended
Tom	Arnoto	Prince William County Fire & Rescue	tarnoto@pwcgov.org	Did Not Attend
Keith	Morrison	Reston Hospital Center	keith.morrison@hcahealthcare.com	Did Not Attend
Tracey	Taylor	Reston Hospital Center	tracey.taylor@hcahealthcare.com	Did Not Attend
John	Wanamaker	StoneSprings Hospital Center	john.wanamaker@hcahealthcare.com	Attended
Justin	Nelson	VHC Health	jnelson@vhchealth.org	Did Not Attend
Courtney	Caton	VHC Health	ccaton@vhchealth.org	Did Not Attend
Byron	Andrews		bandrews@sterlingrescue.org	Did Not Attend

White Paper: Securing the Vital Role and Future of Virginia's Regional Emergency Medical Services (EMS) Councils

Prepared By
VIRGINIA'S REGIONAL EMS COUNCILS
DIRECTOR'S GROUP



Prepared For
VIRGINIA LEGISLATORS
2024



White Paper: Securing the Vital Role and Future of Virginia's Regional Emergency Medical Services (EMS) Councils

Summary of Key Points

Purpose of the Paper: This white paper addresses the critical importance of Virginia's 11 Regional Emergency Medical Services (EMS) Councils and their essential role in maintaining an effective and equitable EMS system across the Commonwealth. It outlines the challenges faced by the Councils, including inconsistent funding and oversight issues, and proposes legislative actions to safeguard their continued operation and enhance their effectiveness.

In the following pages, you will see a detailed discussion of these issues and the proposed solutions. The recommendations outlined aim to ensure that the Regional EMS Councils remain a robust and integral component of Virginia's EMS infrastructure.

Key Highlights and Recommendations:

- **Affirm the Need for 11 Regional EMS Councils:**
 - Reinforce in the Code of Virginia the continued existence and boundaries of the 11 Regional EMS Councils.
 - Maintain the 2008 Budget Amendment to protect against attempts to reduce the number of Councils or alter their structure.
- **Codify Dedicated Funding for Regional EMS Councils:**
 - Amend the Code of Virginia to allocate approximately half of the 30% Contracts and Procurement funding from the "Four-for-Life" program specifically to the Regional EMS Councils.
 - Ensure transparency in the allocation process and specify the Councils in the amendment to guarantee direct funding.
- **Strengthen Accountability:**
 - Implement stricter oversight and auditing mechanisms for the Virginia Department of Health (VDH) Office of EMS (OEMS) to prevent financial mismanagement and ensure appropriate use of EMS funds.

This summary provides an overview of the white paper's intent, and the primary legislative actions sought to support and enhance the Regional EMS Councils.

White Paper: Securing the Vital Role and Future of Virginia’s Regional Emergency Medical Services (EMS) Councils

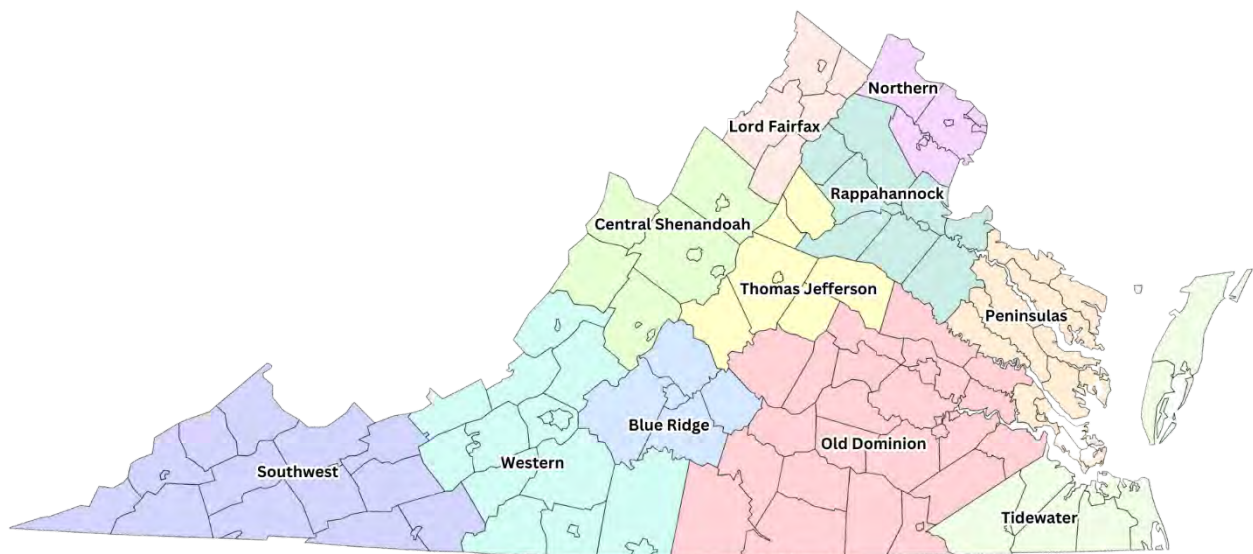
Executive Summary

Virginia's Regional Emergency Medical Services (EMS) Councils are a cornerstone of the Commonwealth's EMS system, ensuring efficient and effective emergency medical care delivery across the state. These Councils, authorized under § 32.1-111.4:2 of the Code of Virginia, are tasked with developing and implementing regional EMS delivery systems that cater to the unique needs of their communities. Regional EMS Councils in Virginia are integral to the effective functioning of the state's emergency medical services (EMS) system. Through collaboration, planning, training and advocacy, the councils play a pivotal role in the Commonwealth’s EMS system, ensuring coordinated, effective and efficient regional EMS delivery systems.

Despite their importance, the Councils continue to face challenges related to inconsistent funding and oversight by the Virginia Department of Health (VDH) and the Office of EMS (OEMS).

This white paper provides an overview of the historical context, legislative framework, vital contributions, and funding challenges of the Regional EMS Councils and proposes legislative actions to ensure their continued viability. Further, it underscores the importance of continued legislative support and funding to uphold the quality of EMS in Virginia. Key recommendations include maintaining the current 11 Virginia Regional EMS Councils and boundaries, codifying a dedicated funding percentage for the Councils thus removing VDH/OEMS’s control over their funding and designating the Regional EMS Councils as “Political Subdivisions”.

Virginia’s Regional EMS Councils



1. Introduction

The Regional EMS Councils of Virginia are the backbone of the Commonwealth's EMS infrastructure, ensuring that EMS services are tailored to the diverse needs of communities across the Commonwealth. Virginia's EMS system is a model of regional collaboration, established to provide high-quality emergency medical care across diverse geographic areas. The Regional EMS Councils were created to address the need for coordinated, region-specific EMS services, which were identified as a national priority following the publication of the 1966 "White Paper" by the National Academy of Sciences, National Research Council. This landmark report highlighted the deficiencies in emergency medical care and laid the groundwork for a structured EMS system.

The Councils operate under the authority of the Code of Virginia (§ 32.1-111.4:2) and are responsible for the development and implementation of regional EMS delivery systems. However, the Councils' ability to fulfill their mission is compromised by inconsistent and inadequate funding, and support which is currently determined by the VDH/OEMS. It is further exacerbated by a history of mismanagement within VDH and OEMS.

This white paper seeks to present a compelling case for the continued support and proper funding of the Regional EMS Councils, highlighting their vital contributions to the EMS system and proposing legislative reforms to secure their future. This proposal is supported by historical precedent and multiple studies affirming the necessity of these Councils.

2. The Importance of Regional EMS Councils

Virginia's EMS system is diverse, reflecting the varied geography and population density of the Commonwealth. For instance, Northern Virginia, with its proximity to Washington D.C., benefits from federal grants and a well-funded EMS infrastructure. In contrast, Southwest Virginia, a sparsely populated area, struggles with limited EMS resources. The disparity extends within regions, where parts of a single region may have EMS agencies that handle tens of thousands of calls annually with robust infrastructure, while others manage a few hundred calls with minimal resources.

The Regional EMS Councils understand these differences and provide tailored support to ensure that all communities, regardless of their size or resources, receive effective and efficient EMS services. The Councils' ability to customize solutions to meet regional needs is crucial to maintaining a responsive and equitable EMS system in Virginia.

The authority and responsibilities of the Regional EMS Councils are firmly established in the Code of Virginia.

- **§ 32.1-111.4:2:** Requires the Virginia Board of Health to designate the Regional EMS Councils, granting them the authority to receive and distribute public funds. It also mandates their oversight in developing and implementing regional EMS systems, and provides guidelines for their designation, renewal, organization, and collaboration with the Board in creating regional EMS plans.

Additionally, various sections of the Code of Virginia further specify the Councils' roles and responsibilities:

- **§ 32.1-111.3:** Involves the Councils in the Statewide Emergency Medical Services Plan, including the Trauma and Stroke Triage Plans.
- **§ 32.1-111.12:01:** Outlines the Councils' involvement with the Rescue Squad Assistance Fund and the Financial Assistance and Review Committee.
- **§ 32.1-116.1 and § 32.1-116.2:** Detail the Councils' responsibilities in prehospital patient care reporting and the confidentiality of patient data.
- **§ 22.1-279.8:** Assigns the Councils the duty of creating public school safety audits and crisis response plans to ensure the protection and safety of students.

These provisions, along with multiple references in Chapter 31 of the Code of Virginia, which details the standards for Council designation and provides a comprehensive legal framework, support the Councils' operational authority and responsibilities. This robust legislative foundation underscores the critical role of the Regional EMS Councils in ensuring effective EMS delivery throughout Virginia.

3. Historical Context and Legislative Support

Prior to the 1960s, emergency medical services were largely uncoordinated, often provided by volunteer rescue squads with most operating out of funeral homes. The publication of the 1966 "White Paper," *Accidental Death and Disability: The Neglected Disease of Modern Society*, exposed the inadequacies of this fragmented system and recommended the creation of a coordinated national EMS system.

In response, the federal government enacted the Highway Safety Act of 1966, which led to the establishment of the National Highway Traffic Safety Administration (NHTSA) and the development of standardized EMS training curricula. The subsequent Federal EMS Systems Act of 1973 further outlined a 15-component architecture for comprehensive EMS delivery and reinforced the need for regional EMS systems.

Virginia was an early adopter of the regional EMS approach, establishing Councils to manage EMS delivery within specific geographic areas. By the late 1970s, all of Virginia's Regional EMS Councils were formally established, although many had been operating in some capacity prior to their official incorporation. These Councils were crucial in developing the EMS infrastructure that is still in place today.

In 1983, Virginia passed the "One-for-Life" legislation, introducing a motor vehicle registration fee to fund EMS, which has since evolved into the current "Four-for-Life" program (currently \$6.25). This funding has been critical in sustaining emergency medical services throughout the Commonwealth, with the Regional EMS Councils utilizing a small portion of the funds, enabling them to provide essential services across the Commonwealth.

However, the Councils' existence has not been without challenges.

In 2008, the Office of EMS attempted to reduce the number of Councils, sparking widespread opposition from EMS providers, EMS agencies and citizens that rely on the Councils services. The backlash led to a legislative Budget Amendment that remains in place to prevent OEMS from making similar attempts in the future, while preserving and protecting the current Regional Council structure and service areas. This historical context underscores the importance of protecting the Councils from future attempts to undermine their existence.

In fact, three studies have been commissioned since 1998 to evaluate the effectiveness of the Virginia regional EMS council system:

1. **An Assessment of the Virginia Regional Emergency Medical Services System** (1998), prepared for the Virginia Office of EMS/Virginia Department of Health by the EMSSTAR Group.
2. **Review of Emergency Medical Services in Virginia** (2004), prepared for the Virginia General Assembly by the Joint Legislative Audit and Review Commission.
3. **Regional Emergency Medical Services Council Study** (2007), prepared for the Virginia Department of Health/Office of EMS by ASMI, Inc.

While some recommendations regarding regional council structure arose from those reports, each affirmed the essential role and importance of the Virginia Regional EMS Councils. Despite the Office of EMS spending taxpayer funds every 3-6 years on these evaluations, the consistent conclusion is that the Regional EMS Councils are crucial and should be adequately funded and supported.

4. Contributions of the Regional EMS Councils

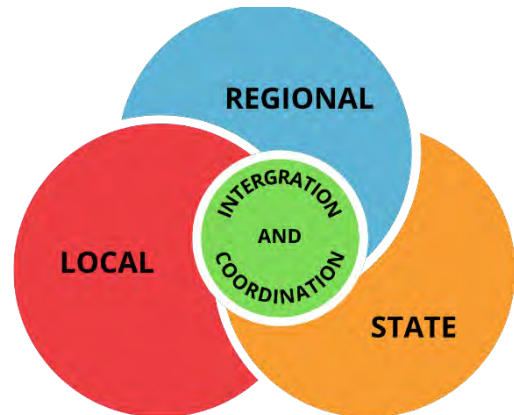
The Regional EMS Councils provide a wide range of vital services that are essential to the EMS system in Virginia. These include but are not limited to:

- **EMS Protocol Development:** Councils develop and implement medical protocols that are tailored to the specific needs of their regions, ensuring consistent and high-quality care.
- **EMS Medication Program:** Councils facilitate programs that allow EMS agencies to utilize life-saving medications. In most cases this involves working with hospital Pharmacists who offer their expertise.
- **Mass Casualty Incident Planning:** Councils create and maintain mass casualty plans, ensuring that their regions are prepared for large-scale emergencies.
- **EMS Training Programs:** Councils offer training and certification programs for EMS personnel, helping to maintain a skilled and knowledgeable workforce.
- **Resource Coordination:** Councils facilitate the coordination of resources, including equipment, personnel, and information, within and across regional boundaries.
- **Quality Assurance:** Councils conduct quality assurance programs to monitor and improve the performance of EMS agencies within their regions.
- **Public Health Collaboration:** Councils work closely with public health agencies to integrate EMS into broader public health initiatives, enhancing community health outcomes.
- **Beyond Code Requirements:** Councils exceed the mandates of the Code and contracts with VDH, offering additional services like offering CPR training sites, Pearson Vue Testing Centers and protocols, mobile integrated healthcare development, whole blood distribution — a life-saving program.

These contributions highlight the indispensable role that the Councils play in supporting EMS agencies, particularly in underserved areas where local resources are limited.

5. The Integration of Local and Regional EMS Systems

Localities in Virginia generally prefer to manage their own Emergency Medical Services (EMS) systems due to their deep understanding of community-specific needs and the ability to respond effectively at the local level. However, local agencies cannot operate in isolation. They often rely on regional and state resources to ensure comprehensive emergency response and support, especially during large-scale emergencies or when facing resource constraints.



5.1 Local Control and Regional Coordination

Local EMS agencies are the primary service providers within their jurisdictions, adept at addressing immediate and specific needs of their communities. Despite their strong local presence, these agencies sometimes face limitations such as high call volumes, specialized equipment needs, or personnel shortages. To overcome these challenges, they depend on regional coordination. This coordination allows for the efficient allocation of resources, sharing of information, and implementation of unified protocols across neighboring areas. By working together, local EMS agencies can provide a higher standard of care and operational efficiency.

5.2 Regional Coordination and the Need for a Regional Delivery System

Regional coordination is essential for managing EMS resources effectively across multiple localities. A regional delivery system facilitates this coordination, linking local EMS agencies with each other and ensuring that resources are allocated where they are needed most. This system supports the integration of local agencies into a broader framework, enabling them to collaborate on emergencies that exceed local capabilities or require specialized resources.

5.3 The Role of Regional Delivery Systems and Regional EMS Councils

Regional delivery systems are designed to connect local EMS agencies with necessary resources and support. Regional EMS Councils are instrumental in developing and maintaining these systems. They facilitate regional collaboration by creating and implementing plans, organizing training programs, and coordinating resource distribution. While the state's role is minimal, the Councils ensure that the regional delivery system operates smoothly and effectively.

By reinforcing the importance of the Regional EMS Councils, we acknowledge their vital role in supporting and enhancing the regional delivery system. The Councils enable local agencies to integrate into a cohesive network, ensuring that all areas, including those with limited resources, are well-prepared for emergencies. This collaborative approach underscores the importance of the Councils in bridging local and regional efforts, ultimately enhancing the overall EMS system across the Commonwealth.

6. Funding Challenges and the Need for Reform

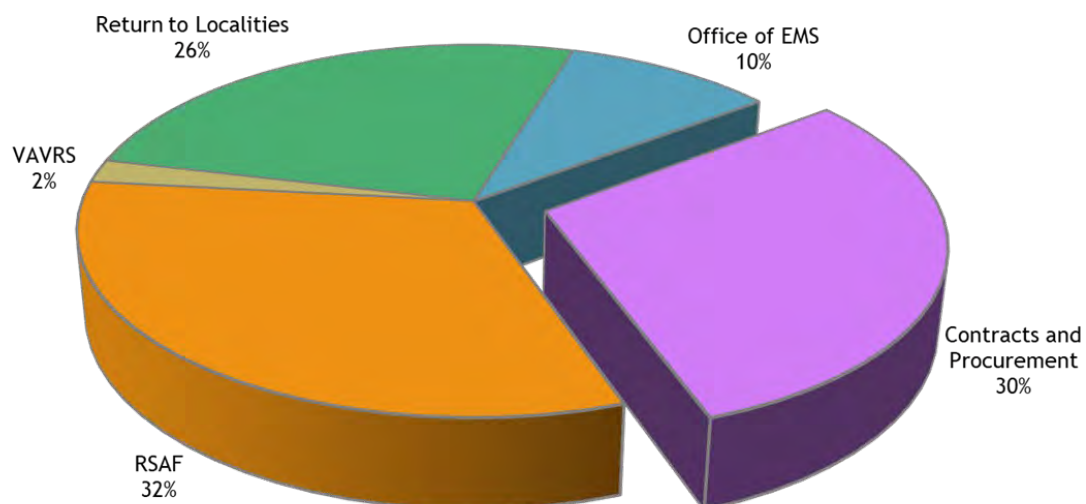
Despite their critical role, and despite the fact that the Councils exist via the Code of Virginia, the funding for Regional EMS Councils is not guaranteed by the Code of Virginia. Currently, the Councils receive funding from the "Four-for-Life" program, specifically from the 30% allocated for "Contracts and Procurement." However, this category lacks transparency, allowing OEMS considerable discretion in fund distribution. As OEMS's administrative needs have grown, there are concerns that funds intended for the Councils and other contracts have been diverted to cover OEMS's internal expenses.

6.1 Current Funding Mechanism

The primary source of funding for EMS in Virginia is the "Four-for-Life" program, which allocates \$6.25 from each motor vehicle registration fee to support EMS initiatives. Of this amount, \$2.00 is considered pass-through money, with \$12.5 million going to the Virginia General Fund and \$2 million to the Virginia State Police MedFlight Program. Per Code of Virginia § 46.2-694. A.13a-e, \$0.25 is deposited into the Rescue Squad Assistance Fund and used only to pay for the costs associated with the certification and recertification training of emergency medical services personnel. The remaining \$4.00 is divided, by percentages, among various EMS-related entities and programs, as dictated in Code. The Rescue Squad Assistance Fund receives 32%, the Localities receive 26%, OEMS Administration 10%, the Virginia Association of Rescue Squads 2%, and 30% allocated for "Contracts and Procurement."

The Regional EMS Councils are funded within the 30% "Contracts and Procurement" section, which is problematic. The Councils are not informed of what portion of this 30% funding they receive. There is no transparency and there appears to be no consistent approach or rationale as to how the money is allocated. There is reason to believe that OEMS has used this as a discretionary funding source, diverting resources away from the Councils, and other contracts, in this category to cover their own administrative costs and programs.

Four-for-Life Funds



6.2 Mismanagement and Financial Irregularities at Virginia Office of EMS

The need for reform is underscored by recent financial scandals within OEMS. In 2023, an internal audit by the VDH revealed a \$33 million budget deficit within OEMS, \$4.5 million of which was due to embezzlement by a now-former employee. The remaining \$29 million resulted from severe mismanagement by both OEMS and VDH, reflecting a broader pattern of financial irresponsibility.

This is not an isolated incident. In 1995, another OEMS employee was found guilty of embezzling \$870,000. These repeated failures demonstrate that VDH/OEMS is incapable of effectively managing the funds allocated to them, raising serious concerns about their ability to appropriately fund the Regional EMS Councils. These repeated failures jeopardize the EMS system and patient care, as a whole.

It should be noted, in both cases, the embezzlement occurred over many years before the Department of Health discovered it.

6.3 Legislative Safeguards

In 2008, the OEMS attempted to reduce the number of Regional EMS Councils, a move that was met with widespread opposition from EMS providers, EMS agencies, and citizens across the Commonwealth. This opposition led to the enactment of a legislative Budget Amendment, which effectively halted OEMS's efforts. The Budget Amendment remains in place as a safeguard against any future attempts by OEMS to undermine the Regional EMS Council structure. This legislative action underscores the importance of the Councils and the strong support they have from the community they serve.

It should be noted that when OEMS was blocked from reducing the number of Councils, funding for many of the Councils did not increase for over a decade.

7. Legislative Proposal

To address these challenges and ensure the continued effectiveness of the Regional EMS Councils, we propose the following legislative actions:

- 1. Affirm the Need for 11 Regional EMS Councils:** Reinforce in the Code of Virginia the critical role and continued existence of the 11 Regional EMS Councils, including their current boundaries. This legislative action will protect the Councils from any attempts to reduce their number or alter their structure. Additionally, maintain the 2008 Budget Amendment that prevents the reduction in the number of Regional EMS Councils and preserves their current boundaries. This safeguard will ensure that the Councils continue to operate effectively across the Commonwealth.
- 2. Codify Dedicated Funding for Regional EMS Councils:** Amend the Code of Virginia to approximately half of the 30% Contracts and Procurement funding from the "Four-for-Life" program specifically to the Regional EMS Councils. This funding will cover essential operational costs, including staff salaries, audits, accounting services, office expenses, and program implementation. Additionally, mandate OEMS to develop a transparent process for dividing the allocation among the 11 Regional Councils. **NOTE:** *This will not deplete funds from other "Four-for-Life" categories. The Regional Councils are already funded within the*

30% Contracts and Procurement section. The Regional Councils should be specifically named in the amendment, similar to how VAVRS is identified, to ensure clear and direct allocation of the funding.

3. **Strengthen Accountability:** Implement stricter oversight and auditing mechanisms for OEMS to prevent further financial scandals and ensure that EMS funds are used appropriately.

8. Conclusion

The Regional EMS Councils are integral to the health and safety of Virginians, providing essential services that ensure effective and equitable EMS delivery across the Commonwealth. However, their ability to fulfill this role is jeopardized by the current funding structure, which is controlled by a state agency with a history of financial mismanagement.

To safeguard the future of Virginia's EMS system, it is imperative that the funding for the Regional EMS Councils be codified, ensuring they receive the resources needed to continue their essential work. The General Assembly should take immediate action to secure the Councils' funding and protect them from further attempts to undermine their existence. By doing so, legislators will ensure that all Virginians, regardless of where they live, have access to high-quality emergency medical services.

Appendix

Past Studies Affirming the Need for Regional EMS Councils:

- **An Assessment of the Virginia Regional Emergency Medical Services System** (1998)
- **Review of Emergency Medical Services in Virginia** (2004)
- **Regional Emergency Medical Services Council Study** (2007)

Legislation Referenced:

- Code of Virginia § 32.1-111.4:2- - Regional Emergency Medical Services Councils
- Code of Virginia § 32.1-111.3- Statewide Emergency Medical Services Plan; Trauma Triage Plan; Stroke Triage Plan.
- Code of Virginia § 32.1-111.12:0- Financial Assistance and Review Committee; Appointment; Terms; Duties.
- Code of Virginia § 32.1-116.1- Prehospital Patient Care Reporting Procedure; Trauma Registry; Confidentiality.
- Code of Virginia § 32.1-116.2- Confidential Nature of Information Supplied; Publication; Liability Protections.
- Code of Virginia § 32.1-127.1:03- Health Records Privacy.

- Code of Virginia § 22.1-279.8- School Safety Audits and School Crisis; Emergency Management; and Emergency Response Plans Required.
- Code of Virginia Chapter 31- Virginia Emergency Medical Services Regulations.
- Code of Virginia § 46.2-694. A.13a-e- "Four-for-Life" Program Legislation.
- 2008 Legislative Budget Amendment re: Regional EMS Councils Boundaries

Financial Audit Reports:

- 1995 OEMS Embezzlement Case Report
- 2023 VDH Internal Audit Report

Other:

- Virginia Regional EMS Councils Map
- Virginia "Four-for-Life" Chart



DEA guidance on EMS Schedule II-V Medications

(Based on email from Justin Wood, DEA Diversion Program Manager Virginia, Maryland, DC dated 7/3/24. Same information shared with DEA supervisors in Virginia. Reference: Title 21 US Code Section 823(k))

Definitions:

Registered location means a location that appears on the certificate of registration issued to an emergency medical services agency under 21 U.S.C 823(k)(13) or 21 U.S.C.823(g).

Designated location means a location designated by a Registered EMS agency under 21 U.S.C.823(k)(13) paragraph 5.


1. In order to procure and administer Schedule II-V medications, the EMS agency must hold a DEA license as a registered location or be listed as a designated location under a registered location.
2. An EMS agency may hold a single DEA registration in a state instead of requiring registration at each location of the EMS agency (21 U.S.C823(k)(2)). The EMS agency may then identify designated locations that operate under the registered location.
 - a. Leased space in a hospital could be a designated location of a EMS registered location. The location should be provided to the local DEA office as a "designated" location for the main EMS DEA registrant.
3. A registered EMS agency may deliver Schedule II-V controlled substances from a registered location of the agency to an unregistered location of the agency only if the agency designates the unregistered location for such delivery (21 U.S.C. 823(k)(5)).
4. When using the option of a designated location, the EMS agency must notify the DEA of the location of designated location(s) at least 30 days prior to delivery of Schedule II-V controlled substances to the designated location.
5. Storage of Schedule II-V controlled substances (21 U.S.C.823(k)(6)). A registered EMS agency may store Schedule II-V controlled substances
 - a. At a registered location of the agency
 - b. At any designated location of the agency or in an emergency services vehicle situated at a registered or designated location of the agency, or
 - c. In an emergency medical services vehicle used by the agency that is
 - i. Traveling from, ore returning to, a registered or designated location of the agency in the course of responding to an emergency, or
 - ii. Otherwise actively in use by the agency under circumstances that provide for security of the controlled substances consistent with the requirements established by the regulations of the Attorney General
6. EMS agencies should notify their local DEA office of designated locations under the primary registered location
7. A DEA 222 or CSOS is only used to transfer Schedule II-V between DEA registrants. To transfer Schedule II- V between a registered location and one of their designated locations, a DEA 222/CSOS is not utilized, but a record of transfer with all required information should be maintained (reference Virginia Board of Pharmacy emergency regulation for recordkeeping requirements)
8. While wholesale distributors may require CSOS for the purchase of Schedule II-V, Form 222s are still allowable under federal law.

Commonwealth of Virginia Office of EMS Consultant Report



September 18, 2024

Executive Summary

- OEMS uncovered \$33M in unpaid debts, over-obligations by July 2023
 - Director, Associate Director resigned amid financial mismanagement
 - Associate Director convicted for \$4.3M embezzlement by September 2023
 - Weak oversight in OEMS and VDH led to crisis
 - FITCH through MedServ, contracted in January 2024 to provide onsite leadership, assist in resolving the financial crisis, provide recommendations
- 
- **Financial:** OEMS failed \$12.5M transfer, prompting \$8M carryover, \$25M allocation.
 - **Legal:** Both hybrid EMS models bypassed legal review, and State employees were supervised by non-state boards. Compliance concerns were raised related to adherence to the State Code.
 - **Cultural:** OEMS's perceived as an enforcement agency, non-customer centric, and poor responsiveness drove agencies to rely on Regional EMS Councils, eroding trust and making OEMS appear more as an enforcement body than a supportive partner.
 - **Operational:** In 2022, EMS symposium costs soared to \$1.6M while funding was through the Western EMS Council. Changes in education and the education coordinator process created staffing challenges in rural communities. The SW region has experienced a 27% decline since 2004.
 - **Oversight:** Before recent changes, the EMS Advisory Board's annual costs topped \$400,000, with 28 members and 21 subcommittees showing limited influence and selective OEMS adherence to its advice, fostering conflict and mistrust.

Critical Findings

FAILURE OF FISCAL OVERSIGHT AND CONTROL

- VDH senior leadership and the former OEMS director failed to oversee financial controls, resulting in \$33M in unpaid debts, \$4.3M in embezzlement, and a fraud conviction.
- Virginia EMS Symposium costs soared to \$1.6M annually, with mismanagement and overspending exacerbated by unfunded programs and improper expense approvals.
- DMV revenue is stagnant, with a projected \$6M deficit for FY 2025.

HYBRID COUNCILS CREATE CONCERNS IN CURRENT STRUCTURE

- The Hybrid EMS Council model was established without VDH's decision process or legal review, raising compliance issues with Virginia Code.
- VDH's authority does not cover supervising state employees by non-state boards or managing non-profit councils.
- VDH should reconsider the Hybrid EMS Council model due to non-compliance with decision-making and legal standards.

REGIONAL EMS COUNCILS ARE NO LONGER RELEVANT IN THEIR CURRENT STATE, STRUCTURE, AND FUNCTION

- VDH and OEMS should update the Regional EMS Councils to match the evolving EMS landscape, as the current model is outdated.
- Hybrid and traditional Councils differ in operations and funding, causing inconsistencies in services and \$5,619,055 in annual expenditures.
- Inconsistent funding and unclear missions lead EMS agencies to use multiple Councils, highlighting the need for a unified model.

CURRENT CULTURE IS NOT CUSTOMER CENTRIC

- The EMS agencies reported unreliable communication and negative interactions with OEMS, leading to criticism and a perception of enforcement rather than support.
- The lack of responsiveness from OEMS has not only eroded trust but also forced agencies to seek help from Regional EMS Councils, highlighting the crucial role these councils play in providing support.
- Inconsistent OEMS & Council inconsistent messaging confuses and exacerbates the divide between OEMS and EMS providers.

Critical Findings

NO SYSTEMATIC MISSION, EXPECTATIONS, OR CONTROLS

- OEMS is isolated from VDH and EMS Councils, leading to a disconnect from local needs and policy impacts.
- Poor communication has created an adversarial relationship between OEMS and Regional EMS Councils.
- Internal issues, including siloed divisions and unclear policies, result in mismanagement, frustration, and lack of transparency.

MISSION CREEP AND MANDATES HAVE INCREASED COST WITHOUT ADDITIONAL RESOURCES

- OEMS has expanded beyond its core role to include programs like Emergency Medical Dispatching, PSAP accreditation, and Trauma Designation.
- This mission creep has caused funding issues, with no additional funds allocated for these expanded duties, including the \$500,000 annual cost for Trauma Center Designation.

EMS ADVISORY BOARD MISSION NEEDS TO EVOLVE AND IS COSTLY IN ITS CURRENT STRUCTURE

- EMSAB lacks functionality and an effective mechanism for system change, and before recent changes, costs exceeded \$400,000 annually.
- Minimal turnover and stagnation hinder its ability to drive change.
- EMSAB needs a redefined mission, alignment with OEMS objectives, and authority to propose regulatory changes akin to VDH's relationship with the State Board of Health.

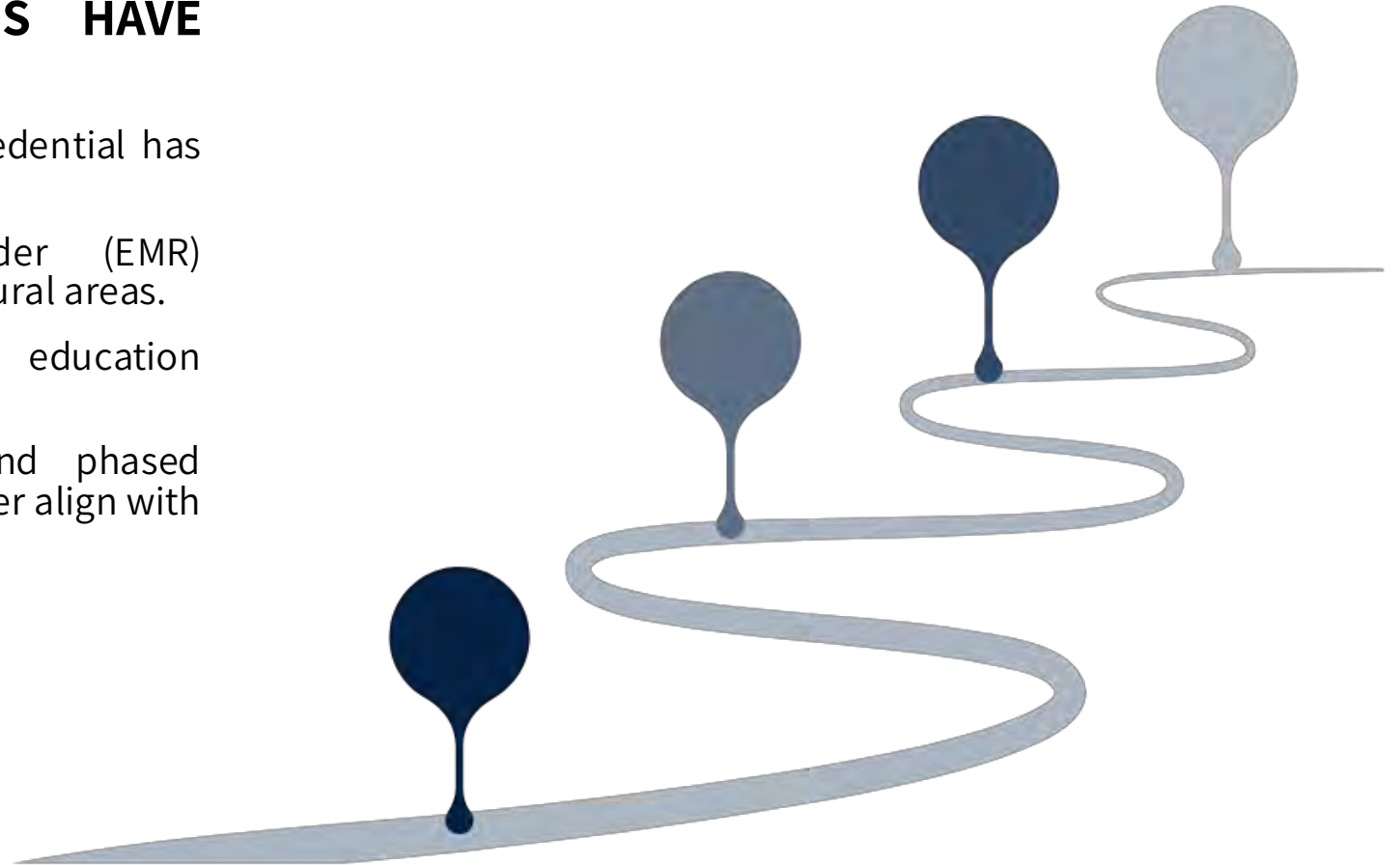
EVOLUTION OF THE VIRGINIA EMS SYSTEM NECESSITATES REVIEW OF THE OEMS ORGANIZATION POSITION WITHIN THE COMMONWEALTH GOVERNMENT HIERARCHY

- Debate exists on the best placement of OEMS within the government to support EMS.
- Challenges within OEMS highlight the need for structural changes.
- Commonwealth should address expanding EMS services, hospital needs, community paramedicine, & public health activities.

Critical Findings

EMS EDUCATION PROGRAM CHANGES HAVE NEGATIVELY IMPACTED THE WORKFORCE

- The introduction of the Education Coordinator credential has complicated certification processes.
- Reduction in Emergency Medical Responder (EMR) certifications has decreased volunteer numbers in rural areas.
- Lack of accountability for underperforming education programs has exacerbated staffing issues.
- These changes require thorough planning and phased implementation to avoid negative impacts and better align with OEMS's mission.



Methodology

FITCH Strategy Overview:

- Provided daily operational support to OEMS and developed future options.
- Initial objectives: Place an experienced leader, support the Interim Director, and guide OEMS towards its future state.

FITCH Approach:

- Engaged directly with OEMS leadership to address issues and operational challenges.
- Interacted with stakeholders (Regional EMS Councils, EMS agencies, state agencies) to gather context.
- Surveyed EMS agencies to assess future needs and provide qualitative insights.

Key Stakeholder Engagement:

- Engaged with Regional EMS Councils, public and private EMS agencies, state agencies (e.g., Virginia Department of Emergency Management), and associations (e.g., Virginia Association of Volunteer Rescue Squads).
- Consulted with education staff, VDH, government stakeholders, the State Emergency Medical Services Advisory Board, and the EMS Next Steps Workgroup.

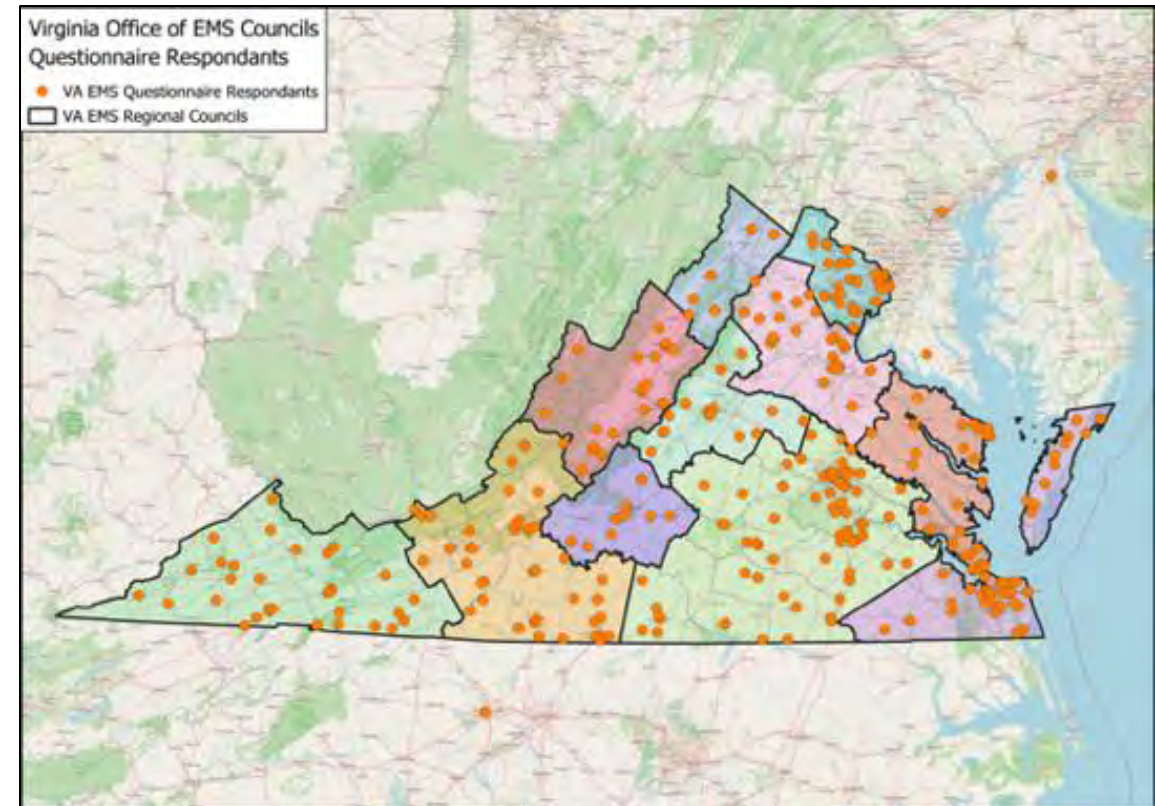
Methodology

Survey Findings:

- Administered surveys to EMS agencies and leaders for OEMS and Regional EMS Councils insights.
- Achieved a 95% confidence level with a 3.2% margin of error from 355 responses out of 567 agencies and 441 responses from 940 individual recipients.
- Produced a comprehensive survey report to guide the future design of OEMS.



Survey Respondent Locations:



Office of Emergency Medical Services

Establishment and Structure:

- Founded in 1974 to enhance Emergency Medical Services across Virginia.
- Part of the Virginia Department of Health (VDH), led by the Commissioner of Health, reporting to the Secretary of Health and Human Resources.
- Directed by a leader who reports to the Deputy Commissioner of Population Health and Preparedness.

FITCH Review Scope:

- Examined OEMS divisions, Regional EMS Councils, State EMS Advisory Board and committees.
- Reviewed regulatory issues, education, NREMT testing, EMS portal, data availability, and other OEMS functions.
- Assessed EMS agencies and workforce.

OEMS Divisions:

- Regulations and Compliance Enforcement
- Emergency Operations
- Community Health and Technical Resources
- Accreditation, Certification, and Education
- Trauma and Critical Care
- Administration and Fiscal
- EMS System Funding
- Patient Care Informatics and Epidemiology



Regional Councils

Origins and Recognition:

- Regional EMS Councils established in the early 1970s; formally recognized by Code of Virginia in 1978 (§ 32.1-111.4:2).
- In 2009, a lobbyist secured a legislative change to fix the number of Regional EMS Councils at 11, a provision included in the budget code since.
- Develop and implement regional EMS systems, including training, medical protocols, and emergency plans (per the 2000 JLARC report).

Regulation and Funding:

- VDH designates and reviews Councils every three years, setting conditions for renewal.
- Councils are 501(c)(3) nonprofits under contract with OEMS, required to match state funding with local funds (local funds not legally mandated).
- Hybrid model: Some Council staff are directly employed by OEMS, creating a dual-reporting structure.

Impact and Dependence:

- Larger urban EMS agencies have reduced reliance on Councils; smaller rural agencies remain dependent for education and training.
- Key reasons for maintaining Councils: Statewide drug box replacement program will expire by 2024 and regional EMS medical protocols.
- Regional EMS medical protocols remain the primary reason for continuing Councils.

Funding Dependence:

- Regional EMS Councils heavily rely on state funds, making them vulnerable to funding reductions.
- The cessation of OEMS payments in 2023 forced many Councils to use reserve funds, pushing some towards closure.

Lack of Legislative Basis:

- No guaranteed financial support as § 32.1-111.4:2 does not provide a legislative funding basis, straining stability and service capacity.

Contractual Agreements:

- "Availability of Funds" clause: OEMS commitments are contingent on available funds.
- The "Cancellation of Agreement" clause: Allows OEMS and contractors to terminate contracts with 60 days' notice, offering flexibility amid funding uncertainties.

Need for Model Evolution:

- Dependence on state funds, payment stoppages, and lack of funding mandate highlights the need for a revised council model.

State EMS Advisory Board

Establishment and Structure:

- Created under Code of Virginia, § 32.1-111.4:1.
- Comprised of 28 members appointed by the Governor, including representatives from Regional EMS Councils, medical associations, and EMS organizations.
- Advises the State Board of Health on the statewide emergency medical care system.

Roles and Responsibilities:

- Reviews and recommends changes to the statewide Emergency Medical Services Plan.
- Examines annual financial reports of the Virginia Association of Volunteer Rescue Squads.
- Reviews status reports on the Rescue Squads Assistance Fund, regional EMS Councils, and emergency medical services vehicles.

Committee Structure and Costs:

- 21 committees provide stakeholder input.
- High hosting costs previously exceeding \$400,000 annually reduced to approximately \$150,000 in FY 2024 through cost containment strategies.

Challenges:

- Large size and numerous committees lead to inefficiencies and difficulties in decision-making.
- Perceived limited impact on improving OEMS and EMS system.
- Lack of transparency: Meetings not recorded or available online and delays in posting minutes.
- Only an advisory board and reminded as such from OEMS.
- In-person meetings in Richmond limit participation and inclusivity.

Improvement Opportunities:

- Review the size and scope of the EMSAB, (later in Decision Points).
- Update format and communication strategies.
- Increase transparency and accessibility.
- Ensure equal engagement opportunities for all EMS agencies and providers.



Changes in EMS Agencies, Volume, and Workforce

Decrease in EMS Agencies (2019-Present):

- Overall decrease: -6.45% (38 fewer agencies).
- Community and non-profit agencies: -15.29% (39 fewer agencies).
- Government non-fire and fire department agencies: +6.9% (7 more agencies).
- Hospital-based EMS agencies: Doubled to +8 (4 new agencies)

Increase in EMS Call Volume:

- 20.88% increase since 2017 (295,162 more calls).

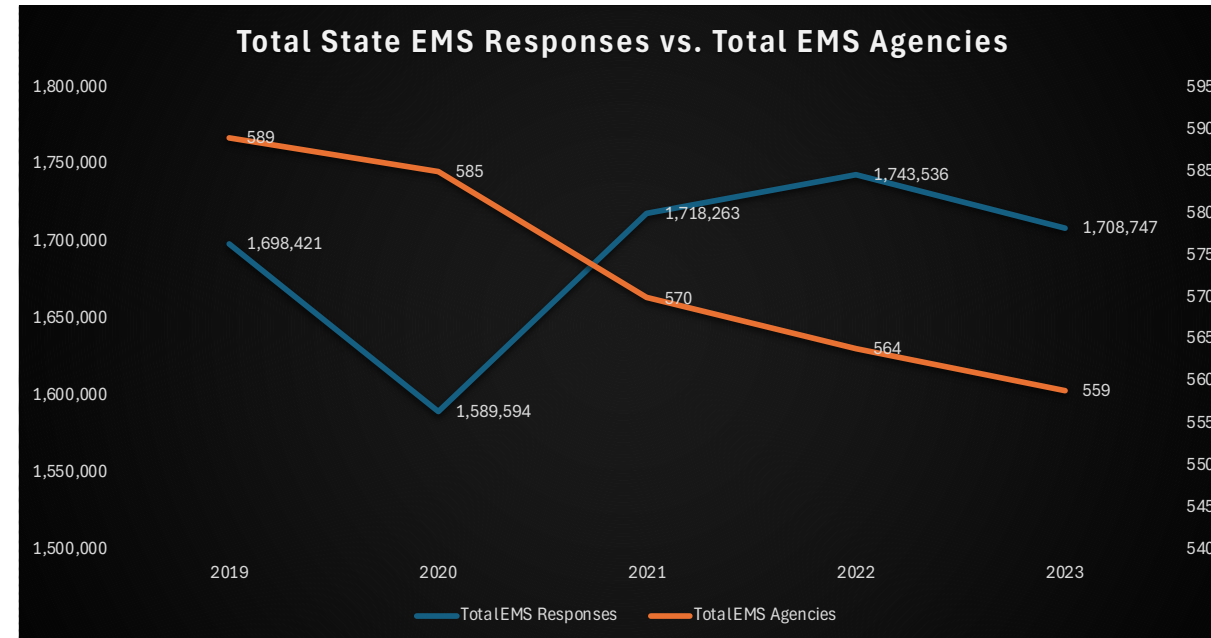
Growth in Provider Workforce:

- 7.9% increase (2,774 additional providers).

Reduction in Emergency Medical Responder (EMR) Certifications:

- 43.9% reduction (340 fewer certifications).
- Likely reflects a decline in volunteerism.

EMS Responses Vs. Total EMS Agencies YOY Change



Limitation: OEMS does not track active vs. inactive providers, affecting analysis. FITCH lacked raw data; aggregated data showed a 1.2% discrepancy.

Financial Review Overview

Mid-2023 Financial Issues:

- VDH and OEMS identified \$33M in financial discrepancies due to overspending, poor management, and fraud.
- Funding was frozen for all non-essential obligations, affecting programs like RSAF and RTL.
- EMS Next Steps Workgroup formed to prioritize and manage OEMS payments.

Investigation and Support:

- Office of Internal Audit audited OEMS financial records.
- VDH appointed a new Business Manager to stabilize finances.
- Leadership structure in OEMS remained unchanged at the time.

Budget and Funding Challenges:

- Governor Youngkin and the Legislature allocated \$33M over two years to address debts.
- FITCH initially projected a \$2.4M annually overspent; the 2025 review estimates a \$6M annually overspent.
- Without significant changes, the \$33M will be insufficient beyond the two years.



Financial Review

Identified Key Causes

Years of Minimal VDH Oversight:

- OEMS operated independently with minimal VDH oversight, leading to unchecked spending and poor financial decisions.
- Lack of focus on fund reallocation, checks and balances, and expenditure scrutiny.
- Minimal improvement from previous audits and neglected corrective actions compromised OEMS's financial integrity.

Lack of Internal Policies and Financial Controls:

- Serious deficiencies in financial governance were identified, including absent internal guidelines and poor adherence to procurement standards.
- Contracts, such as the \$9M ESO contract, bypassed procurement policies.
- Concentrated spending approvals and mismatched invoices in accounting systems.

Challenges with Manual Financial Tracking:

- Reliance on Microsoft Excel spreadsheets for financial tracking, causing transparency issues.
- Manual tracking led to unpaid invoices and increased risk of error and fraud.
- VDH and OEMS now meet daily to review finances; as of the report, invoice tracking is current.

Use of Regional Councils to Circumvent Procurement Policies:

- EMS Councils used to bypass Commonwealth procurement policies.
- Contracts with Councils were amended to handle procurement, including items like ESO software and IT security.
- Avoidance of formal oversight led to misallocation of funds.

Escalating Costs of the Virginia EMS Symposium:

- Virginia's EMS Symposium costs rose to over \$1.6 in 2022, primarily funded by the Western EMS Council.
- The symposium was canceled in 2023 due to financial challenges, but local symposiums and virtual training emerged as alternatives.



Financial Review

Identified Key Causes



Funding to Struggling Regional Councils by OEMS:

- **Establishment of Regional EMS Councils:**
 - Created as independent bodies to address local EMS needs with self-reliant financial resources.
- **Challenges Due to Funding Reductions:**
 - Funding cuts from EMS agencies, local communities, and supportive programs impacted service quality.
- **OEMS Financial Support, Hybrid Funding, and Disparities:**
 - Annual allocations range from \$229,273 to \$725,309 per Council based on needs and operational scale.
 - Traditional Councils receive base funding; Hybrid Councils receive additional personnel and infrastructure funding.
- **Special Projects Excluded:**
 - Funding excludes "pass-through" projects like ESO, Symposium, Regional IT, and Scholarships.
- **2019 OEMS Partnership with Four Councils:**
 - OEMS collaboration to support financially struggling Councils with staffing, educational funding, and infrastructure.

FITCH Recommendations for Fiscal Accountability:

- Future Commonwealth allocations should include provisions for audits.
- Annual internal financial audits are recommended, with findings submitted to OEMS.

Council Type	EMS Council	Salary \$ w/ Benefits	Base Contract Annual	Annual Contract Addons	Total Annual Cost
Hybrid	Blue Ridge	\$ 355,591	\$ 250,000		\$ 605,591
Hybrid	Central Shenandoah	\$ 475,309	\$ 250,000		\$ 725,309
Hybrid	Rappahannock	\$ 363,414	\$ 250,000		\$ 613,414
Hybrid	Southwest Virginia	\$ 126,116	\$ 250,000		\$ 376,116
Traditional	Lord Fairfax		\$ 272,121	\$ 48,000	\$ 320,121
Traditional	Northern Virginia		\$ 346,537	\$ 174,000	\$ 520,537
Traditional	Old Dominion		\$ 483,667		\$ 483,667
Traditional	Peninsulas		\$ 457,952	\$ 99,383	\$ 557,335
Traditional	Tidewater		\$ 476,775	\$ 56,298	\$ 533,073
Traditional	Thomas Jefferson		\$ 229,273		\$ 229,273
Traditional	Western Virginia		\$ 625,018	\$ 29,600	\$ 654,618
	Totals	\$ 1,320,430	\$ 3,891,343	\$ 407,281	\$ 5,619,054

Financial Review Identified Key Causes

Unfunded Mandates and Financial Challenges in OEMS

- Program Expansion Without Funding
- OEMS expanded programs (Trauma Fund, E911, CHaTR, etc.) without securing long-term funding, resulting in financial strain.
- Example: Trauma Fund Management now costs \$500,000 annually with no budget increase.

EMS Advisory Board Expansion

- EMSAB expanded to 28 members across 21 subcommittees.
- Meeting costs peaked at \$400,000 in 2023, later reduced to \$150,000 with cost-saving measures.

Costly Facilities and Fleet

- OEMS spends over \$500,000 annually on office space and maintains a large fleet, including ATVs.
- VDH should consider office relocation and downsizing the fleet for cost savings.

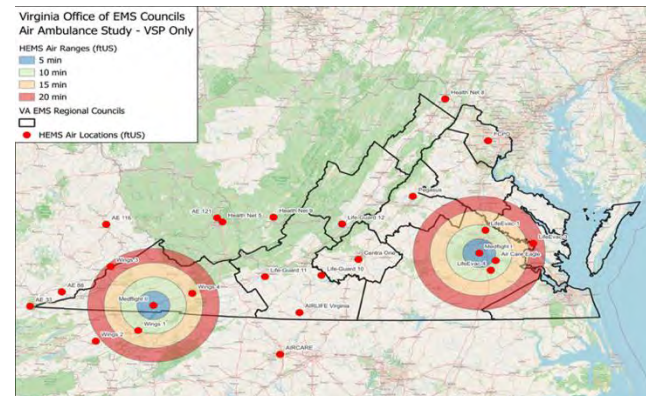
Fixed Revenue Mechanism

- "Four-for-Life" program funding is fixed at \$6.25 per vehicle registration.
- Funding does not adjust for inflation, leading to misalignment with rising operational costs.

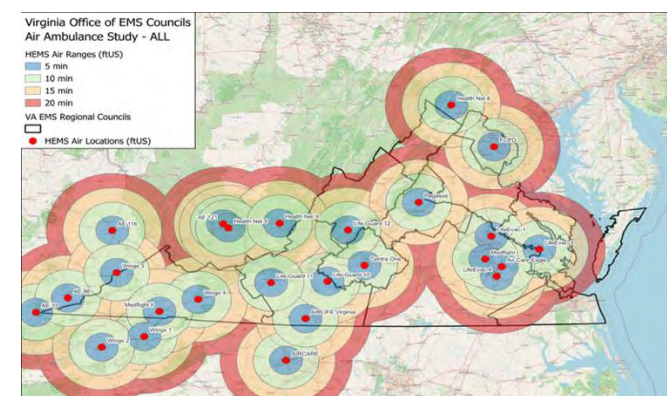
Virginia State Police Med-Flight Program

- OEMS allocates \$3.1M annually to Med-Flight, which will increase in FY2026 by an additional 1.2M mainly from Hospitals.
- Funds sourced from DMV, RSAF, and trauma center grants, impacting EMS agency grants.
- Operates as a first-right-of-refusal service but is not always the closest provider due to outdated response protocols and differing billing practices.
- A reevaluation of funding allocation and service overlap is needed.

MedFlight Air Ambulance Locations



Air Ambulance Locations Across the State



Financial Review

Budgetary Actuals and Associated Expenditures

Financial Documentation Issues

- FITCH's evaluation faced challenges due to insufficient documentation, neglected accounts payable, and poor record-keeping at OEMS.

Misclassification of Expenses

- Regional EMS Councils often categorized purchases as "pass-throughs" instead of OEMS expenses, complicating accurate financial assessment.
- \$5.619M of pass-through funding should be counted as part of OEMS operational costs, raising total costs to \$13.4M, not \$7.8M.

Budget Deficit

- OEMS operates with an annual budget of \$56M.
- Annual expenses include \$7.8M in salaries, leading to an initial estimated \$2.4M deficit.
- Internal projections \$6M is expected for FY 2025.

Fixed and Inadequate Revenues

- Primary revenue from DMV registration fees remains flat, with no adjustments for inflation, new programs, or cost-of-living increases.
- A more adaptive funding model is needed to sustain operations.

Expand Funding for Agencies and Workforce Development

- There is an urgent need for a more robust financial strategy to support EMS agencies and workforce development, especially in regions facing EMT shortages.
- Nationwide financial strain impacts EMS services, leading to closures or reduced coverage.
- EMS workforce shortages are critical in Virginia, with a 27% reduction in EMTs in the Southwestern region.
- RSAF should expand to include private and for-profit agencies to address funding gaps and equipment needs.

Recent Interventions, Short and Long-Term Recommendations

Recent Interventions by VDH and FITCH Regarding OEMS Financial Oversight

Introduction of Daily and Monthly Financial Reviews

- Continuous monitoring and accountability to detect discrepancies early.
- Greater transparency and fiscal discipline.

Centralization of Contracts

- Contracts previously managed by Regional EMS Councils are now transferred back to OEMS or discontinued.
- Streamlined operations under OEMS control.

Restructuring Leadership

- Previous structure: OEMS Director had 11 direct reports, causing inefficiency.
- New structure: 3 Deputy Directors added, improving oversight, communication, and accountability.

Strengthened Financial Integrity

- Comprehensive policies, workflows, and control systems introduced.
- A dedicated business manager was appointed to conduct fiscal analysis and ongoing operations.
- Measures set a foundation for sustainable practices and effective resource management.

Optimization of Financial Operations

- The new business manager (appointed April 2024) now reports to the Deputy Director.
- Focus on optimizing grant funding processes and strengthening financial management.

Renegotiation of ESO Contract

- \$9M ESO contract is now managed directly by OEMS and is in the process of renegotiation.
- Ensures better alignment with organizational goals and future sustainment.

Decision Point #1

OEMS Positioning for Strong Oversight

- **Remain within the Virginia Department of Health (VDH)** – requires no legislative action and supports the evolving role of EMS within the broader healthcare continuum
- **Establishing a Department within the Department of Public Safety** – requires legislative action to transition OEMS from VDH to a new Department of EMS and this alignment could streamline coordination and oversight.
- **Merge with the Virginia Department of Fire Programs (VDFFP) creating a new Virginia Department of EMS & Fire Programs** – requires legislative action to transition OEMS to a new Department and implementing this would likely be complex, time-consuming, and require a significant review of legal and financial implications.
- **Dissolve OEMS completely, parsing the various regulatory requirements to other agencies** – requires legislative action to dissolve OEMS and reallocate OEMS functions to other departments. This reorganization could cause significant confusion within the EMS community.

Decision Point #2

Regional Structure and Support

- **Reducing the current 11 Regional Councils to 7** – Budget language must be stuck that currently requires no less than the 11 existing councils. This would allow OEMS to reduce the number of Regional EMS Councils from 11 to seven and align these with existing public safety agencies. Further, co-locating the restructured EMS regions with other public safety entities would streamline operations and enhance coordination.
- **Proposed organizational structure changes** – requires legislative action to redesign OEMS to include seven regions and a new structure.
 - **Option 1** – Decentralized Structure, More Regional Support, All State Staff – leverages local expertise to address community-specific challenges, ensures those closest to the issues are involved in solutions, allows for OEMS to align with its core mission.
 - **Option 2** – Integrated model, Enhanced Local Autonomy, Non-State Staff - integrates centralized oversight with regional autonomy, balancing overarching standards with local responsiveness. The state would maintain central authority for compliance and standards, while the seven Regional EMS Councils gain enhanced autonomy to address local needs.

Decision Point #3

Policy and Regulatory Process Review

Option: Introduce an OEMS formal approval process for policy or guideline modifications.

This would involve:

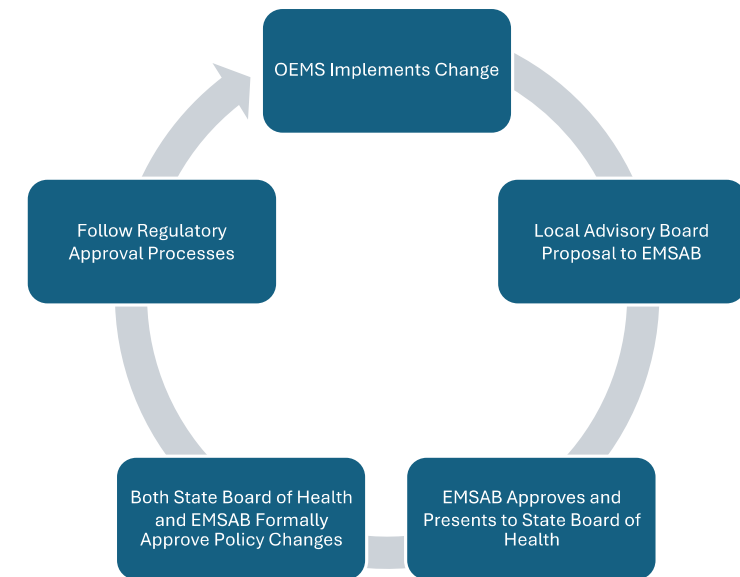
- Utilizing VDH's current approval processes through the Commissioner's office for policy and guidance document modifications.
- OEMS following the public comment process established in the Administrative Process Act for all OEMS policy guidance documents that have been modified and/or revised.
- Securing approval from the EMS Advisory Board for guidelines and policy adjustments, and if process requires approval from VDH and the State Board of Health prior to final adoption of the policy/guidance document.
- Documenting the date and time of changes and communicating them effectively to relevant agencies and stakeholders.

Adoption of this option will improve transparency, stakeholder engagement, and compliance with legislative requirements.

Decision Point #4

Community Input and EMS Oversight Enhancements

- Grant EMSAB authority to propose regulations for State Board of Health consideration.
- Enable collaboration between EMSAB, local advisory boards, and Regions.
- EMSAB to manage its own administrative tasks independently.
- Reassess EMSAB size and subcommittees for better representation and efficiency.



Decision Point #5

Education, EMS Portal, and Departmental Functions

- OEMS should revise the certification for education coordinators, expand testing access, accept out-of-state CE credits, improve the EMS Portal, and hire key positions in Regulation and Compliance Enforcement – requires no legislative changes.
- OEMS must create a succession plan with the ACE division as it poses a critical risk to the EMS system – requires no legislative action.
- OEMS should enhance the financial transparency in DMV revenue allocation, expand the RSAF Grant Program, implement a funding escalator to address rising costs, and ensure equitable distribution of funds based on regional demographics – requires no legislative changes.
- VDH should reallocate the epidemiologist and replace them with a data analyst focused on patient care informatics, which would enhance OEMS's data analysis and care outcomes – requires no legislative changes.

Financial Impact

- FITCH conducted an extensive analysis to address OEMS's overspending and identify cost-saving measures.
 - The analysis reviewed current personnel costs and other expenses to find effective expenditure reductions.
 - FITCH's review revealed total expenditures of \$5,784,204 for 49 positions, including salary and fringe benefits.
- Based on this review, FITCH proposed three staffing options to manage and reduce costs.
 - Option 1: Small Central Office with Seven Regional Offices.
 - Option 2: Small Central Office with Seven Regional Offices, excluding the administrative assistant.
 - Option 3: Small Central Office with Seven Regional Offices, excluding the administrative assistant, emergency operations staff, and emergency medical dispatch functions.
- The analysis aimed to identify potential cost savings through staffing adjustments and reductions in program expenses.

Financial Impact

Staffing Options and Cost Reductions

Option 1 - Small Central Office and Seven Regional Offices		Option 2 - Small Central Office and Seven Regional Offices (No AA)		Option 3 - Small Central Office and Seven Regional Offices (No AA - Eops and EMD Inc.)	
Staffing Plan		Staffing Plan		Staffing Plan	
1 - OEMS Director		1 - OEMS Director		1 - OEMS Director	
2 - Regional Coordinators		2 - Regional Coordinators		2 - Regional Coordinators	
7 - Regional Office Director		7 - Regional Office Director		7 - Regional Office Director	
7 - Program Representative		7 - Program Representative		7 - Program Representative	
2 - Division Directors Reg & Comp, ACE		2 - Division Directors Reg & Comp, ACE		2 - Division Directors Reg & Comp, ACE	
5 - Admin Assistants Shared in Regions		1 - Admin Assistant		3 - EOPs and EMD	
1 - Business Manager		1 - Business Manager		1 - Business Manager	
3 - Data/IT, Portal		3 - Data/IT, Portal		3 - Data/IT, Portal	
2 - Certification Staff (cards, etc.)		2 - Certification Staff (cards, etc.)		2 - Certification Staff (cards, etc.)	
7 - Regional Educators		7 - Regional Educators		7 - Regional Educators	
1 - RSAF/RTL Manager		1 - RSAF/RTL Manager		1 - RSAF/RTL Manager	
1 - Fiscal Techs		1 - Fiscal Techs		1 - Fiscal Techs	
Location	Total Staff	Location	Total Staff	Location	Total Staff
Central Office	18	Central Office	18	Central Office	18
Regional	21	Regional	17	Regional	19
Total	39	Total	35	Total	37

Other Expenses Cost Reductions

Item	Amount
Reduction to Seven Councils	\$ 1,517,873
Med-Flight Reduction (Med-Flight and RASF Grant)	\$ 3,074,262
Office, Leases and Maintenance Reduction	\$ 525,000
Trauma Site Visit Honorarium	\$ 50,000
ESO Reduction (no ePCR)	\$ 4,000,000
Expense Reduction from all Categories	\$ 9,167,135
Expense Reduction from all Categories minus Medflight	\$ 6,092,873

Models for Consideration	Current		Proposed		Differences	
	Count of FTE's	Sum of Total Personal Cost of Employees	FTE Count	Cost (FTE*Average Personnel Cost by Employee)	FTE Count Change	Cost (FTE*Average Personnel Cost by Employee)
Option 1 - Small Central Office and Seven Regional Offices	49	\$ 5,784,204	40	\$ 3,889,964	-9	\$ (1,894,240)
Option 2 - Small Central Office and Seven Regional Offices (No AA)	49	\$ 5,784,204	35	\$ 3,502,079	-14	\$ (2,282,125)
Option 3 - Small Central Office and Seven Regional Offices (No AA - Eops and EMD Inc.)	49	\$ 5,784,204	38	\$ 3,779,453	-11	\$ (2,004,750)

Financial Impact

	Option 1 - Small Central Office and Seven Regional Offices	Option 2 - Small Central Office and Seven Regional Offices (No AA)	Option 3 - Small Central Office and Seven Regional Offices (No AA - Eops and EMD Inc.)
Staffing Cost Reduction	\$ (1,894,240)	\$ (2,282,125)	\$ (2,004,750)
Total Savings Without Medflight Reduction	\$ (6,092,873)	\$ (6,092,873)	\$ (6,092,873)
Reduction of Cost Without Medflight Reduction	\$ (7,987,113)	\$ (8,374,997)	\$ (8,097,623)
	Option 1 - Small Central Office and Seven Regional Offices	Option 2 - Small Central Office and Seven Regional Offices (No AA)	Option 3 - Small Central Office and Seven Regional Offices (No AA - Eops and EMD Inc.)
Staffing Cost Reduction	\$ (1,894,240)	\$ (2,282,125)	\$ (2,004,750)
Total Savings With Medflight Reduction	\$ (9,167,135)	\$ (9,167,135)	\$ (9,167,135)
Reduction of Cost With Medflight Reduction	\$ (11,061,375)	\$ (11,449,259)	\$ (11,171,885)
Minimum Reduction in Costs	\$ (7,987,113)		
Maximum Reduction in Costs	\$ (11,449,259)		

Conclusion

- Outlined a strategic roadmap for the Commonwealth, emphasizing a comprehensive and incremental approach to address complex challenges in oversight, regional support, policy revision, community involvement, education, and emergency services.
- The recommendations include a range of options for legislative, regulatory, structural, employee, and funding changes, highlighting the need for a flexible and adaptive strategy.
- The plan's focus on industry best practices and recommendations for immediate and midterm strategic actions ensure it is robust and forward-thinking.
- By implementing a carefully phased strategy, the Commonwealth can navigate its challenges with agility and achieve positive governance and community service outcomes.
- This methodology promotes ongoing improvement and responsiveness, positioning the Commonwealth for sustained success and enhanced service delivery.