

**Joint Legislative Audit and Review Commission
of the Virginia General Assembly**



**Review of Emergency Medical Services
in Virginia**

**Staff Briefing
Walt Smiley
October 12, 2004**

JLARC Staff

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Presentation Outline

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- Background**
- Statewide Availability of Emergency Medical Services**
- Recruitment, Retention, and Training**
- EMS Funding**
- Organization and Management**

Study Mandate

- **House Joint Resolution 133 (2004) directs JLARC to review emergency medical services**

- **The resolution specifically directs staff to:**
 - **Conduct a comprehensive review and assessment of emergency medical services in Virginia**
 - **Consider issues pertaining to funding, including Medicaid rates, third-party reimbursement, and**
 - **Assess the performance of the Virginia Department of Health in carrying out its statutory duties regarding EMS, including an evaluation of the need for a separate Department of Emergency Medical Services**

Overview of EMS in Virginia

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- **The EMS system is complex, including volunteer and paid providers in a variety of settings**
 - **32,897 certified EMS providers**
 - 23,339 Emergency Medical Technicians
 - 3,130 Paramedics
 - 1,675 First Responders
 - 4,753 Other Types
 - **4,054 permitted EMS vehicles**
 - **815 licensed EMS agencies**
 - 485 Volunteer
 - 63 Commercial
 - 84 Governmental
 - 166 Other Agencies
 - **300 operational medical directors (physicians)**

- **11 Regional EMS Councils**

Overview of EMS in Virginia

(continued)

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- Virginia Department of Health certifies EMS personnel, each of whom must meet State standards and operates under the license of an operational medical director
- State funding includes “\$4-for-Life,” generating \$26 million in FY 2005, although not all of this funding is appropriated for EMS activities
 - Additional funding comes from local government support, federal grants, revenue recapture efforts, individual contributions, and local fund raising activities
- 1999 VCU Commonwealth Poll found that 59 percent of respondents expect a paramedic level of service, and 55 percent of respondents rated the quality of EMS in their community as excellent or good

Objectives of Virginia's EMS System

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- ***Code of Virginia* §32.1-111.3 directs the Board of Health to:**
 - **Establish a comprehensive statewide emergency medical care system, that will improve the delivery of emergency medical services and thereby decrease morbidity, hospitalization, disability, and mortality**
 - **Reduce the time period between the identification of an acutely ill or injured patient and the definitive treatment**
 - **Increase the accessibility of high quality emergency medical services to all citizens of Virginia**

Key EMS Events in Virginia

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- **The first independent volunteer rescue squad in the country, Roanoke Life Saving and First Aid Crew, was established (1928)**
- **State involvement in EMS began with passage of Virginia Ambulance Law and creation of the Bureau of Emergency Medical Services (1968)**
- **Statewide EMS system legislation approved by General Assembly (1974)**
- **“One for Life” legislation added \$1.00 fee on motor vehicle registration to support EMS (1983)**
- **“Two for Life” legislation doubled the annual motor vehicle registration fee (1990)**
- **“Four for Life” legislation again doubled the annual motor vehicle registration fee (2002)**
- **Revised EMS regulations take effect (2003)**

JLARC Review

- **To what extent are emergency medical services available?**
- **Does Virginia's emergency medical system provide an adequate level of care across the State?**
- **Are EMS agencies able to recruit and retain adequate EMS personnel?**
- **Are current funding mechanisms for EMS services adequate, and what other sources of funding should be explored?**
- **Do current organizational and management structures promote a comprehensive and coordinated emergency medical care system in Virginia?**

Research Activities

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- **EMS Agency Survey (On-line)**
 - Conducted between June 17 and August 9, 2004
 - 712 agencies, 278 responses (39 percent response rate)
 - Paper copies were made available upon agency request

- **EMS Personnel Questionnaire (On-line)**
 - Conducted between July 1 and September 1, 2004
 - 892 individual responses

- **Regional Group Meetings**
 - Eight meetings across the State with total of 96 EMS providers

- **Structured Interviews with more than 70 individuals**

- **Analysis of OEMS Data**

- **Document Reviews**

Presentation Outline

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EMS Personnel Skill Levels

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- **State Board of Health prescribes by regulation the qualifications required for certification of the individual EMS provider**
- **The Health Department's Office of Emergency Medical Services (OEMS) works with the State's 11 regional councils, the Virginia Association of Volunteer Rescue Squads, and others to provide the necessary training for individuals**
- **OEMS maintains certification and continuing education records for all EMS personnel statewide**
 - **About 700 certification exams, 400 test waivers, and 10,000 requests for continuing education credits are processed each month**

Basic Life Support Certification

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- **Two levels of Basic Life Support (BLS) certification**
 - **First responder**
 - Requires a minimum of 40 hours of classroom and clinical instruction
 - For individuals who may be the first to arrive at the scene (law enforcement, fire) – not intended for individuals whose primary duty is provision of EMS
 - Learn to control bleeding, perform CPR, provide oxygen, and stabilize fractures
 - 1,675 individuals certified at this level
 - **EMT-Basic (EMT or EMT-B)**
 - Requires a minimum of 121 hours of classroom and clinical instruction
 - Basis for all higher levels of EMS certification
 - Provides general instruction in all areas of human body systems and initial care for a wide range of medical conditions
 - 23,339 individuals certified at this level

Advanced Life Support Certification

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■ Five levels of Advanced Life Support (ALS)

● EMT-Enhanced

- Requires a minimum of 120 hours of instruction in addition to EMT-Basic certification
- Virginia specific certification level created that serves as a bridge between EMT-Basic and EMT-Intermediate
- 441 individuals certified at this level

● EMT-Intermediate

- Requires a minimum of 272 hours of instruction in addition to EMT-Basic certification
- Nationally recognized certification
- Requires extensive in-hospital and out-of-hospital clinical experience, as well as advanced study in trauma care, pharmacology, and the cardiovascular system
- 1,014 individuals certified at this level

Advanced Life Support Certification

(continued)

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- **The highest level of EMS certification is Paramedic**
 - **Requires a minimum of 778 hours of training in medical, trauma, pediatric, and geriatric emergencies in addition to EMT-Basic certification**
 - **Fulfills all of the requirements of the National Standard Curriculum for the EMT-Paramedic established by the National Registry of Emergency Medical Technicians (NREMT)**
 - **Trained to administer a variety of medicines, employ advanced airway management techniques, provide specialized cardiac monitoring and defibrillation, and provide advanced trauma care**
 - **3,130 individuals certified as paramedics**

- **Two Virginia-specific levels (EMT-Shock Trauma and EMT-Cardiac Technician) are currently being phased out in a move to national standards**

Virginia's EMS System Is Available Statewide

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- **All Virginians have access to some level of EMS**
 - **EMS personnel are in all localities**
 - **All EMS agencies provide at least a basic life support (BLS) level of service**
 - **522 EMS agencies are licensed as advanced life support (ALS) agencies. Not all are able to provide this level of care continuously, however.**

- **Virginia has a relatively high number of EMS personnel, although there is considerable variation in the distribution of these individuals across the State**

Ratio of EMS Personnel to Total Population

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Personnel Type

Personnel to Population Ratio

**Statewide Average
(All Personnel)**

1 : 215

BLS Personnel

1 : 283

**ALS Personnel
(inc. Paramedics)**





1 : 898

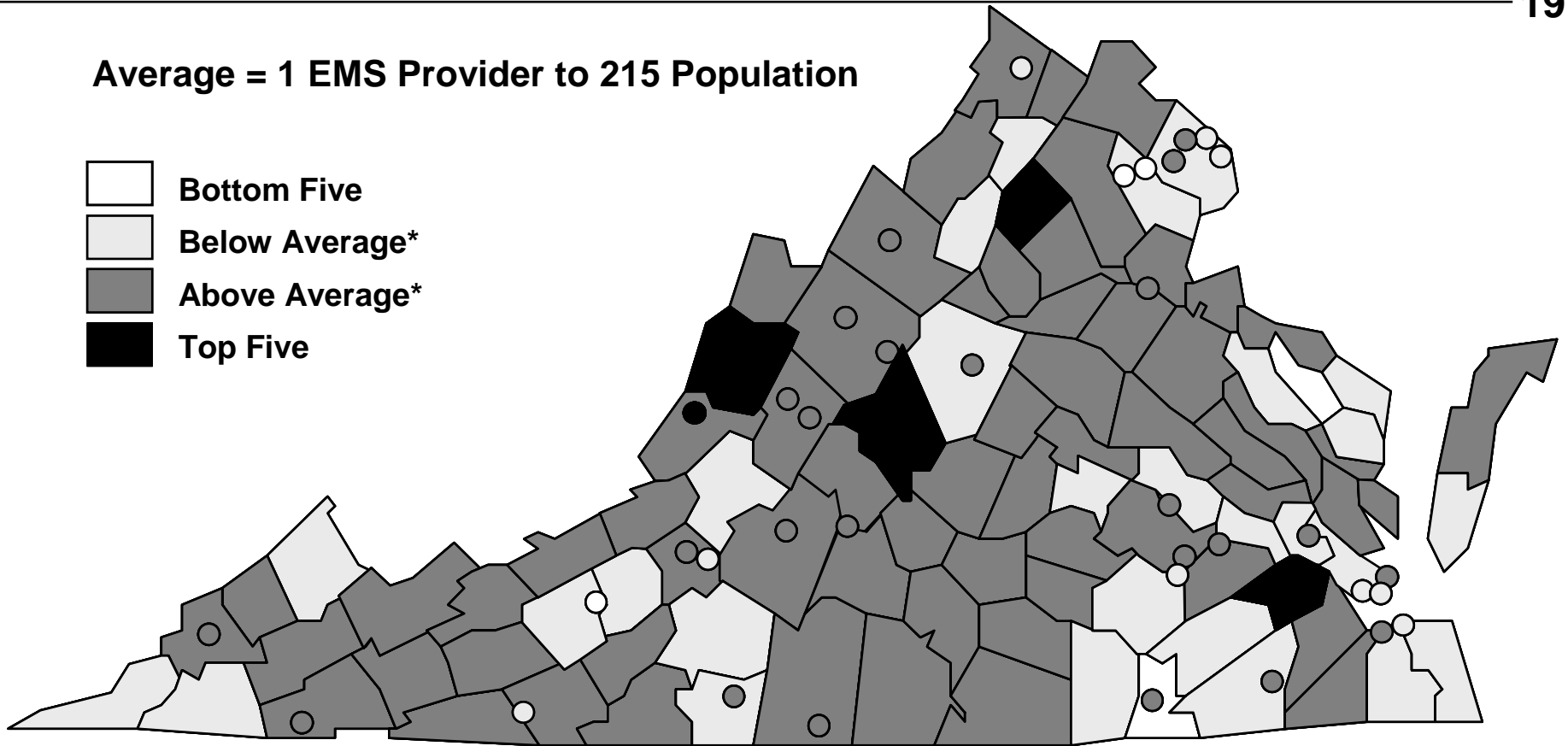
Paramedics

1 : 2,262

Ratios of EMS Personnel to Local Population

Average = 1 EMS Provider to 215 Population

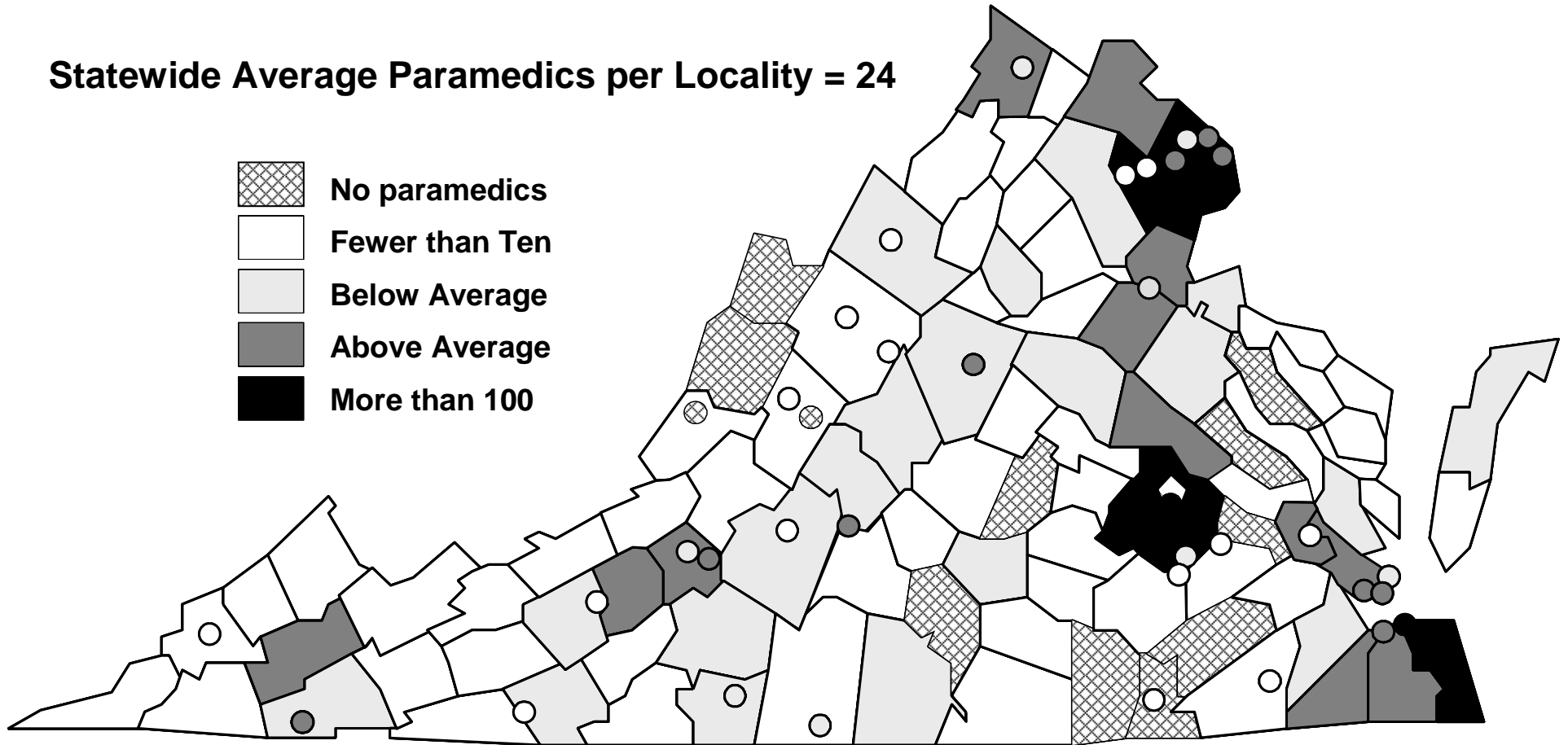
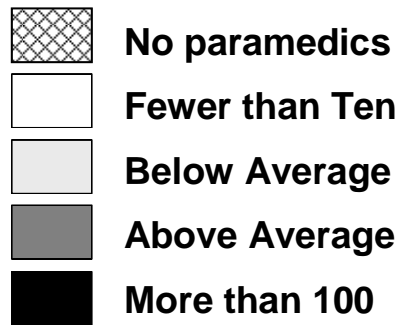
-  Bottom Five
-  Below Average*
-  Above Average*
-  Top Five



*Note: “Below” and “above” average refer to the degree of provider coverage attained. In this graphic, darker shaded areas have a *smaller* personnel-to-population *ratio*, indicating better coverage.

Total Paramedics by Locality

Statewide Average Paramedics per Locality = 24

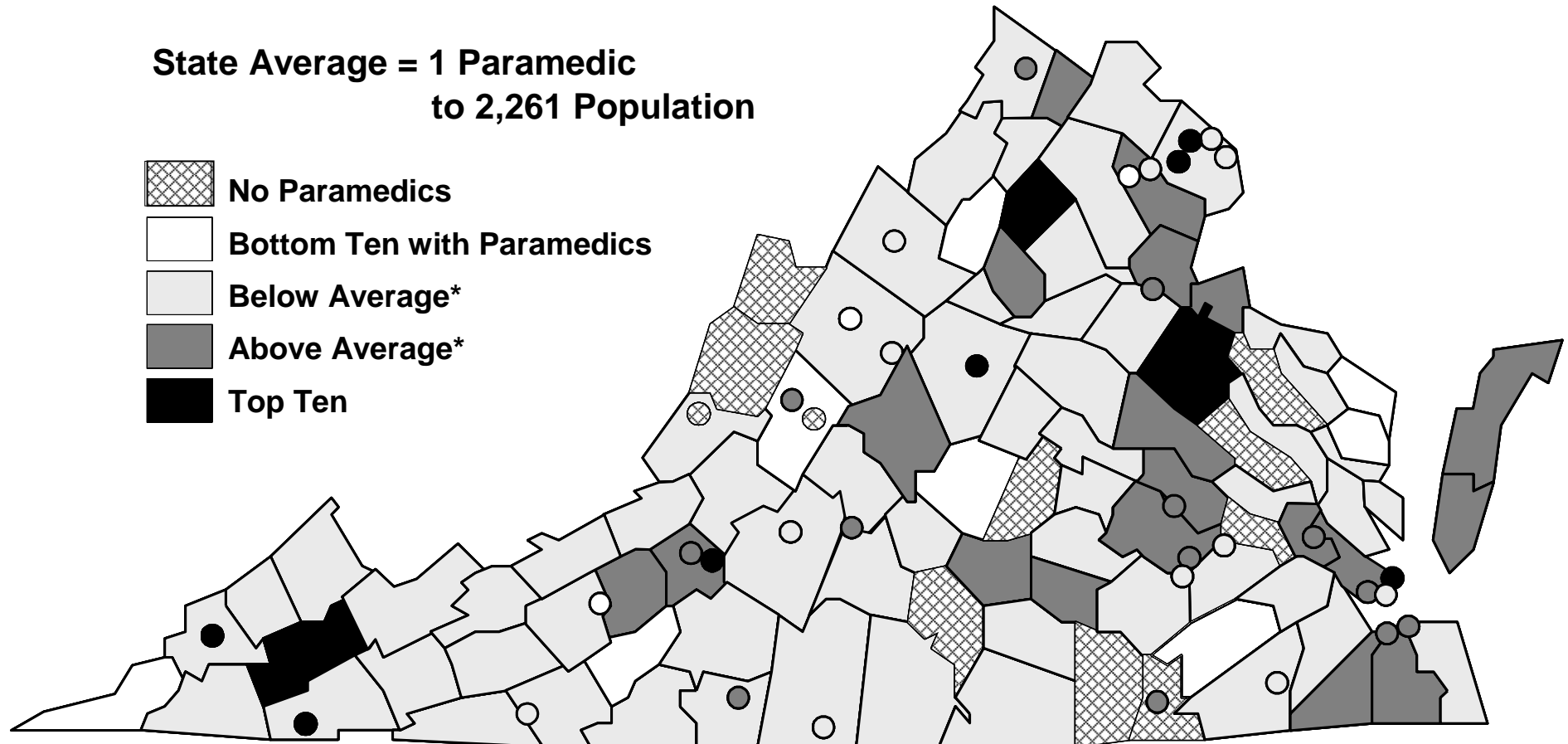


Localities with No Paramedics

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- Buena Vista City
- Covington City
- Bath County
- Brunswick County
- Charles City County
- Charlotte County
- Cumberland County
- Essex County
- Greenville County
- Highland County
- King William County
- Sussex County

Ratio of Paramedics to Local Population



*Note: “Below” and “above” average refer to the degree of paramedic coverage attained. In this graphic, darker-shaded areas have a *smaller* paramedic-to-population *ratio*, indicating better coverage.

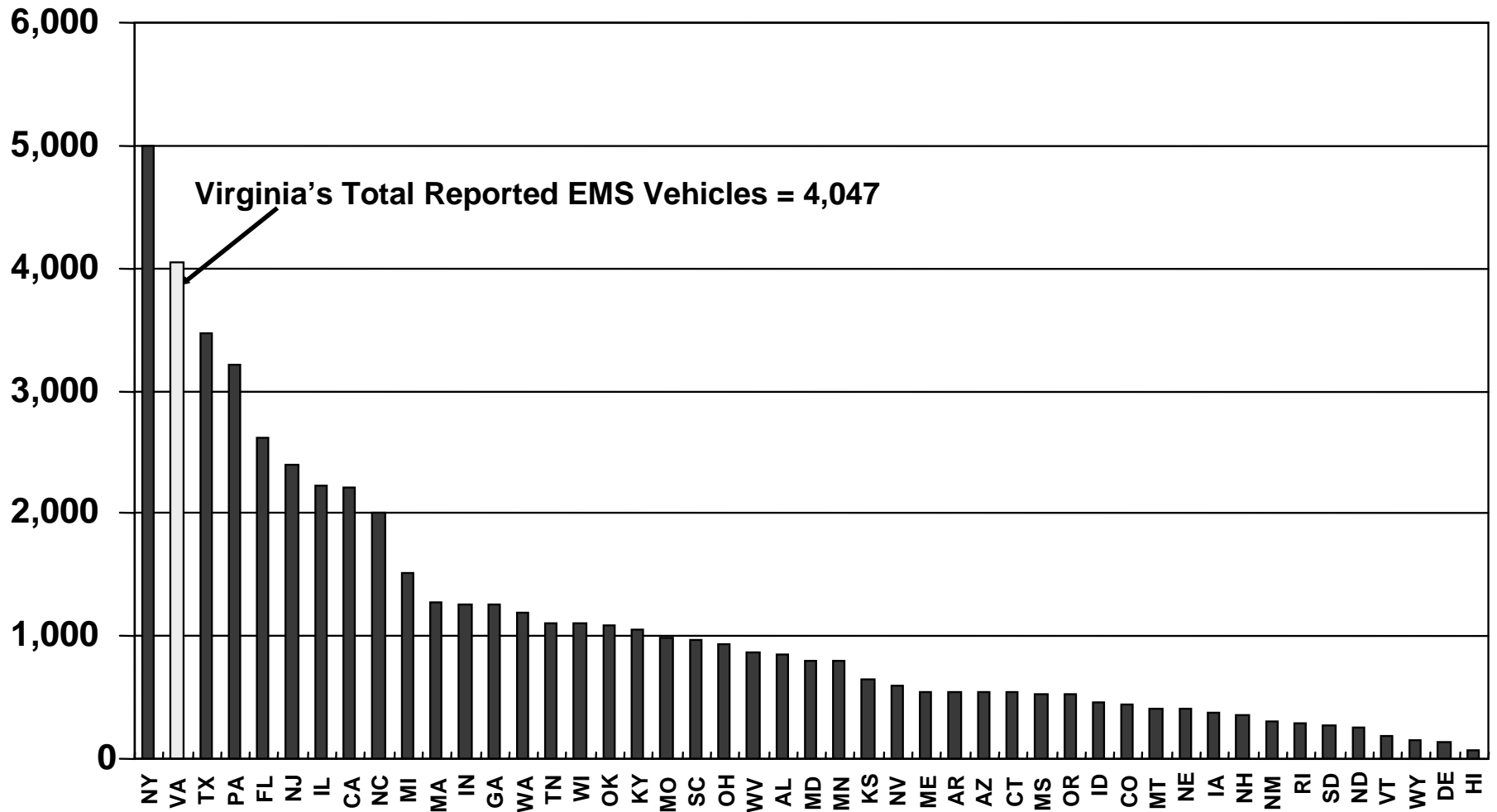
Types of Emergency Response Vehicles

(August 2004)

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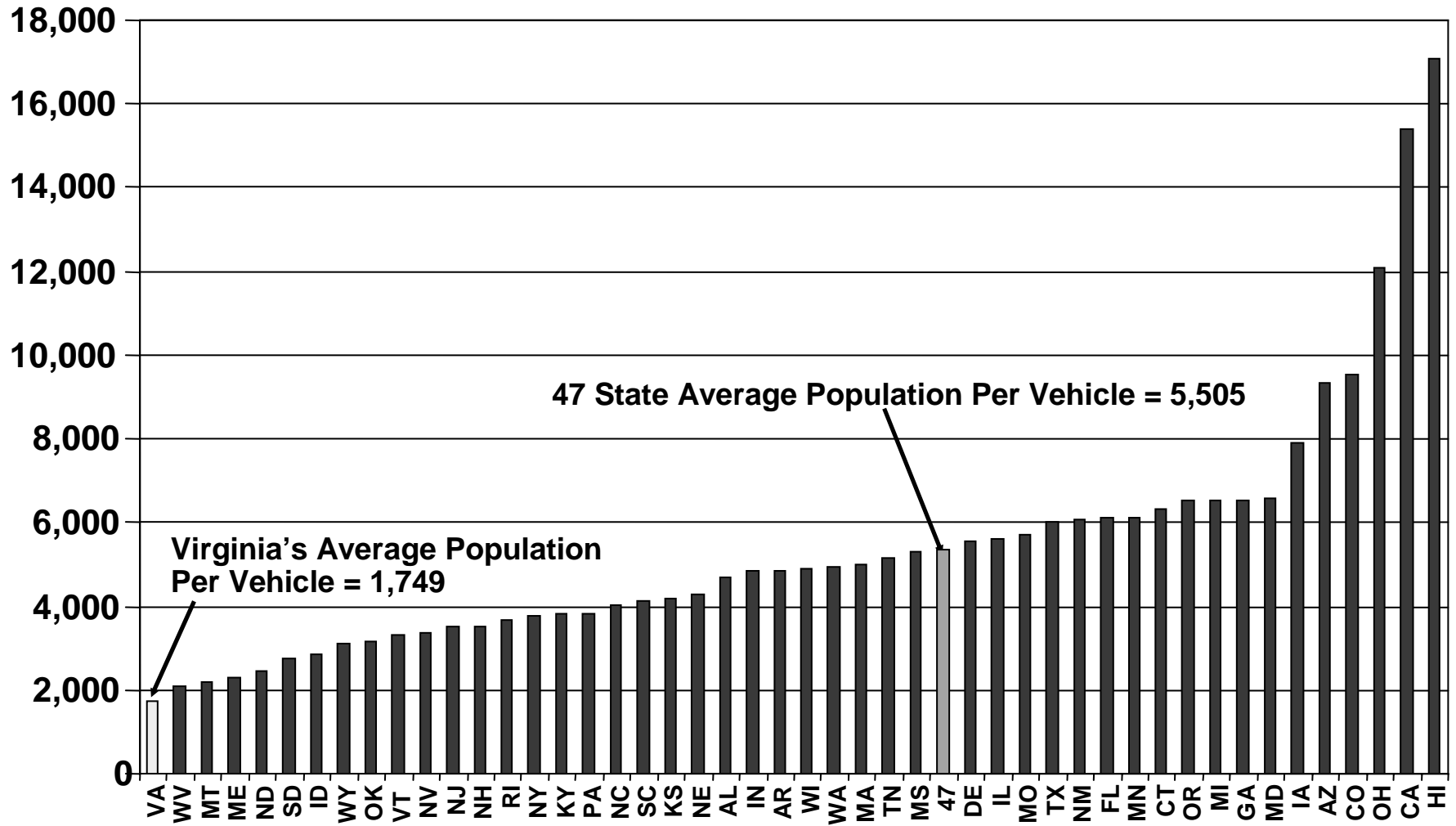
Type	Total	Percent
Ground Ambulance	2,572	63%
Non-Transportation Vehicle (fire trucks, etc)	960	24
Neo-Natal Ambulance	25	<1
Air Ambulance	32	<1
Other (non-emergency wheelchair transportation)	463	11
Total	4,054	100

Virginia Has The Second Highest Total Number of EMS Vehicles



Note: Based on all licensed EMS vehicles in 2003.

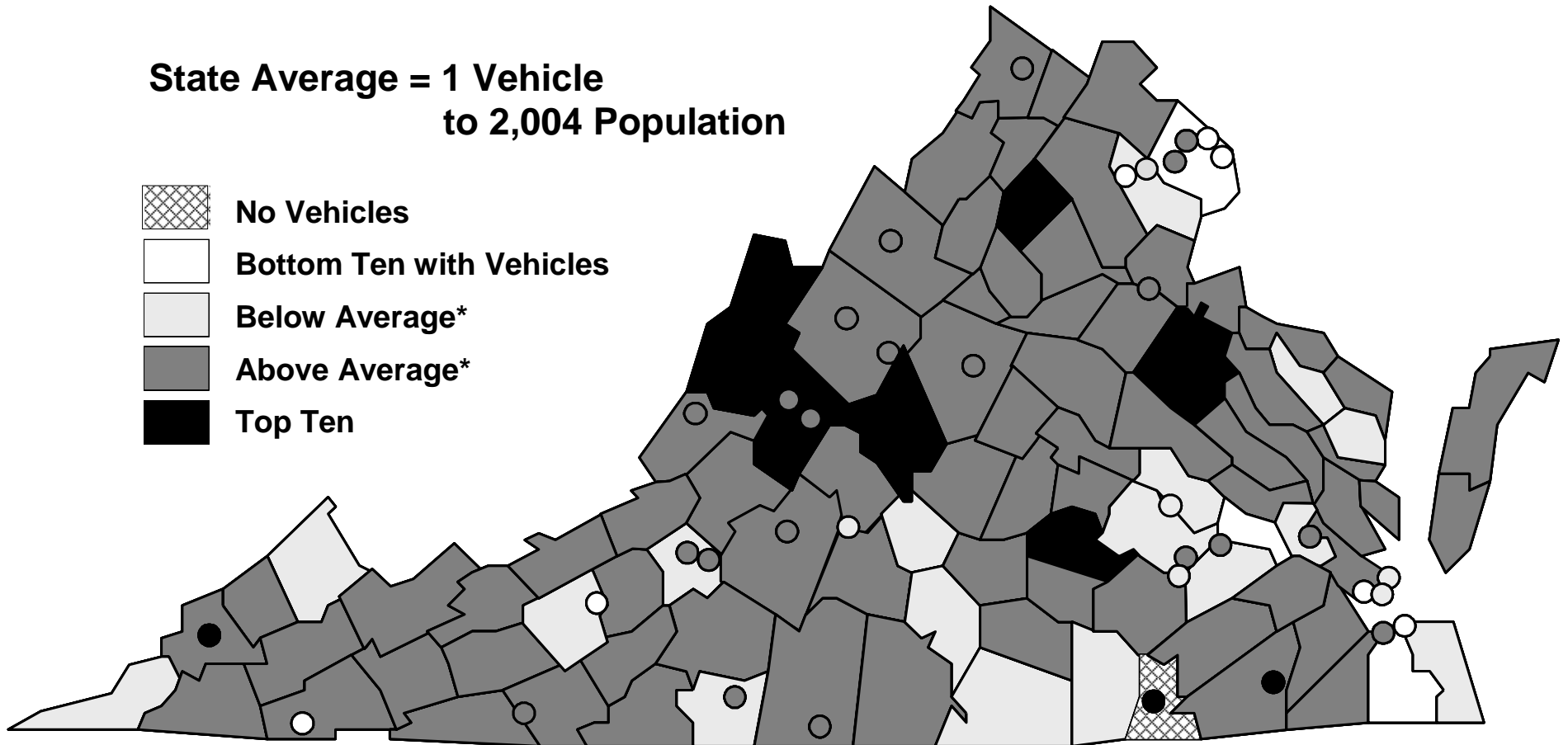
Virginia Has the Nation's Best Population to Emergency Vehicle Ratio



Note: Based on all licensed EMS vehicles in 2003.

Ratio of Emergency Ground Response Vehicles to Local Population

(August 2004)



*Note: "Below" and "above" average refer to the degree of vehicle coverage attained. In this graphic, darker-shaded areas have a *smaller* vehicle-to-population *ratio*, indicating better coverage.

Mutual Aid

- **Mutual aid helps ensure that all calls for emergency medical assistance are answered**
 - **OEMS regulations require all designated emergency response agencies to participate**
 - **Limited OEMS enforcement**
- **Some localities rely on mutual aid for all ALS coverage**
- **Many providers have noted a substantial increase in the total number of calls for mutual aid, however OEMS does not track**
 - **According to one provider, in the past 29 years the number of mutual aid calls responded to by the City of Newport News has increased from 8 or 9 per year to 8 or 9 per day**
- **Opportunities for overuse of the State's mutual aid system exist**

Localities Have Experienced Problems

The former operational medical director for squads in Louisa County indicated that, in a recent period, a 3½ hour response time was not uncommon for 911 calls that came in after midnight.

No one from the squad was available to respond because, as volunteers, they had gone home at midnight. So after midnight calls were either dispatched to squads in Goochland or Hanover, which responded through their mutual aid agreements with the Louisa squads, or waited until the paid Louisa providers came on duty at 6 a.m. In some instances, the Goochland and Hanover squads were then required to request mutual aid from other localities while responding to calls outside of their primary response area

Local Availability of EMS Should Be Mandated

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- **The *Code of Virginia* does not require localities or any other entity to ensure emergency medical services are available**
 - **Statute prohibits provision of EMS without local government authorization (*Code of Virginia* §15.2-955)**

- **It is unclear who should take corrective action when agencies close or coverage degrades**
 - **Four volunteer agencies closed in 2002-2004**

- **Requiring local governments to ensure the continuous provision of EMS would not require a change in current practice, but would make them responsible to take corrective action in the event continuity of services is jeopardized**
 - **Local governments currently operate 84 EMS agencies**

Recommendation

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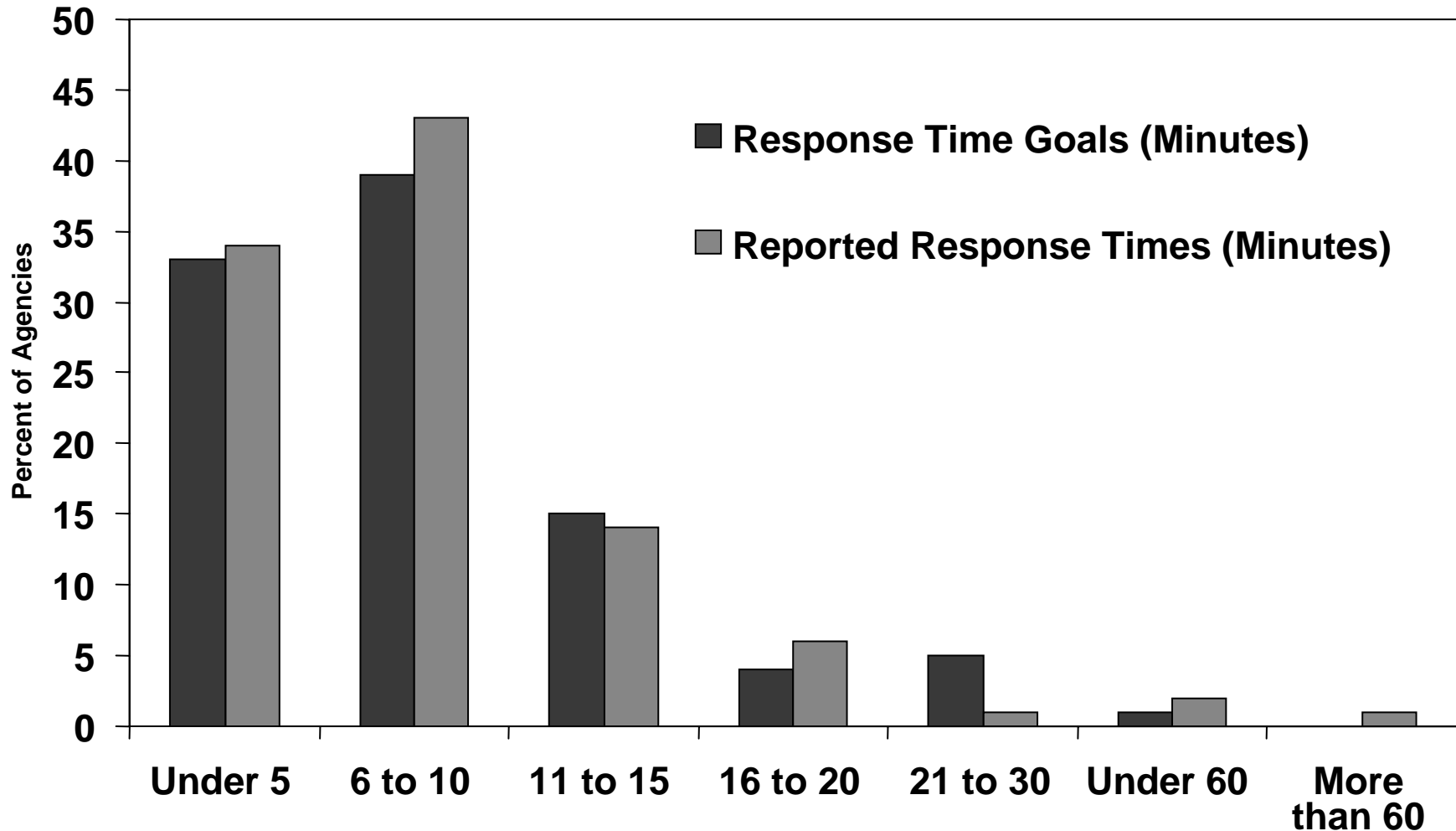
The General Assembly may wish to amend the *Code of Virginia* to require local governments to ensure the continuous provision of emergency medical services.

Response Times

- **The average time reported for an emergency vehicle to arrive on-scene from the time of dispatch was 12 minutes in 2003**
 - 87 percent of emergency responses reported arrived on-scene within 15 minutes
 - 711 calls (less than 1 percent) had reported response times in excess of one hour

- **Based on an analysis of 385,490 incidents reported to OEMS (77 percent of reported incidents) in 2003**

Reported Agency Response Times and Goals



Note: Agencies reporting response time goals are not necessarily the same agencies reporting actual responses.

Insufficient Response Time Data Available

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- **These results may not be representative, because OEMS has not enforced statutory requirement for data reporting**
 - **Prehospital patient care reporting by EMS agencies has been required since 1987 (*Code of Virginia* §32.1-116.1) but the program was discontinued by OEMS from 1994 until 2000**
 - **Since 2000, many agencies have underreported, or not reported data at all**
 - **JLARC staff identified 200 agencies for which OEMS did not have any PPCR data for 2003**

Agency Response Times Are a Local Option

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- **A reduction of response times is a statutory goal of the EMS system**
- **No State requirements for local EMS agencies to establish response time measures**
 - **No uniform definition of how response times are measured**
 - **No statewide measure of appropriate response time**
- **More than 200 agencies reported having either formal or informal response time goals**

Factors Affecting Response Times

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- **Geographic Location**
- **Population and Traffic Densities**
- **Variations in Agency Staffing Levels**
- **Increased Turnaround Time**
- **Nonessential Call Volumes**

Best Practices for Improving Agency Response Times

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- **Combination Career and Volunteer Squads**
- **Contracting for EMS Services**
- **Emergency Medical Dispatch**
- **Tiered Response Systems**
- **Zone Dispatch**
- **Temporal Demand Modeling**

Recommendations

The Office of Emergency Medical Services should develop a uniform definition for measuring agency response times.

All EMS agencies in Virginia should be required to establish response time goals based on a common statewide definition of response time.

Agency response time data should be required to be submitted to OEMS on a regular basis, and OEMS should make this information publicly available.

Presentation Outline

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Retaining and Recruiting EMS Personnel Were Identified as Key Problems

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- The total number of personnel is increasing, but so is the need for providers
- 74 percent of agencies responding to survey cited recruitment and retention as top issues
- 40 percent of EMS personnel responding to questionnaire indicated that they are considering leaving their agencies
- About one-fourth of the State's certified personnel are not affiliated with an EMS agency (8,600+ individuals)

Poor Leadership and Management Impact Agencies

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- **53 percent of EMS personnel responding cited poor leadership and management as a key reason they are considering leaving their agency**
 - **Management abilities are not always the determining factor in selecting squad captains**
 - **Squad captains are not required to have experience or training in routine management functions, such as budgeting or personnel management**

- **Weak management abilities can lead to:**
 - **Outdated management processes, which have not kept pace with changing conditions and workplaces**
 - **Interpersonal conflicts within the organization, which can make it difficult to retain staff**

Recommendation

The *Virginia EMS Regulations* should require squad captains in EMS agencies to complete management and leadership training within six months of becoming captain. OEMS and the regional councils should ensure that adequate management training opportunities are available.

Other Reasons for Recruitment and Retention Problems

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- Time commitment and personal issues are other reasons cited for the lack of volunteers
- Low pay was cited as a key problem in career agencies; providers tend to move from agency to agency, especially in urban areas
- Training problems also cited for both volunteer and career agencies (lack of access, increased requirements, cost)

Many Incentives Available to Recruit and Retain Providers

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- **The *Code of Virginia* authorizes several incentives, such as:**
 - College tuition reimbursement programs
 - Car tax exemption
 - Free motor vehicle licenses
 - Volunteer Firefighters' and Rescue Squad Workers' Service Award Fund

- **Local agencies also offer other incentives to providers, such as:**
 - Free training
 - Free uniforms and pagers
 - Travel reimbursement
 - Social functions

- **Incentives that are more expensive to implement are not used by many agencies or localities:**
 - College tuition reimbursement
 - On-call pay

Volunteer Firefighters' and Rescue Squad Workers' Service Award Fund

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- **Less than three percent of the State's EMS personnel participate in the Volunteer Firefighters' and Rescue Squad Workers' Service Award Fund**
 - **Defined contribution plan established in 1999 and administered by the Virginia Retirement System (VRS)**
 - ***Code of Virginia §51.1-1204* requires a State general fund match for member contributions, although no funds have been provided**
 - **942 members as of June 2003; fund balance of \$574,000 in FY 2004 (\$609 average per member)**
 - **VRS' administrative costs are \$78,000 per year. Since 2003, \$328,000 has been appropriated to VRS for administration**

Suggested Incentives

- **EMS personnel suggested several incentives that they thought would be useful in recruiting and retaining staff, including:**
 - **Income tax or real estate tax breaks**
 - **Participation in a retirement system such as VRS or LEOS**
 - **Participation in the heart-lung presumption benefit or worker's compensation**

- **Given the high cost of providing these incentives, few agencies, especially volunteer agencies, would be able to fund these incentives on their own**

Recommendations

The Office of Emergency Medical Services should develop and distribute to EMS personnel descriptive information about the Volunteer Firefighters' and Rescue Squad Workers' Service Award Fund in order to better publicize the fund.

OEMS should consider allocating some of the \$4-for-Life funding to help agencies fund recruitment and retention incentives. Local governments should also consider providing funds for these incentives. Agencies should be encouraged to apply for RSAF grants to help fund incentives.

OEMS and Regional Councils Offer Some Recruitment and Retention Services

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- **OEMS offers some recruitment and retention-related services to agencies, including promotional materials, maintaining an online recruitment directory, and providing some grant funding**
- **OEMS also recently contracted with a consultant to develop a retention “tool kit” for use by local agencies**
- **Only two regional councils (of the 11) had specific recruitment and retention activities in their contracts in 2004**
- **43 percent of agencies responding to the survey reported that they do not make use of OEMS’s recruitment and retention services, and 50 percent do not use their regional council’s services**

Recommendation

OEMS and the regional councils should work together to define a larger role for the regional councils in assisting agencies with recruitment and retention. This larger role could include:

- **Working with the Department of Education and local school divisions to develop EMT-B high school curricula**
- **Sponsoring region-wide job fairs**
- **Increase leadership and management training opportunities**

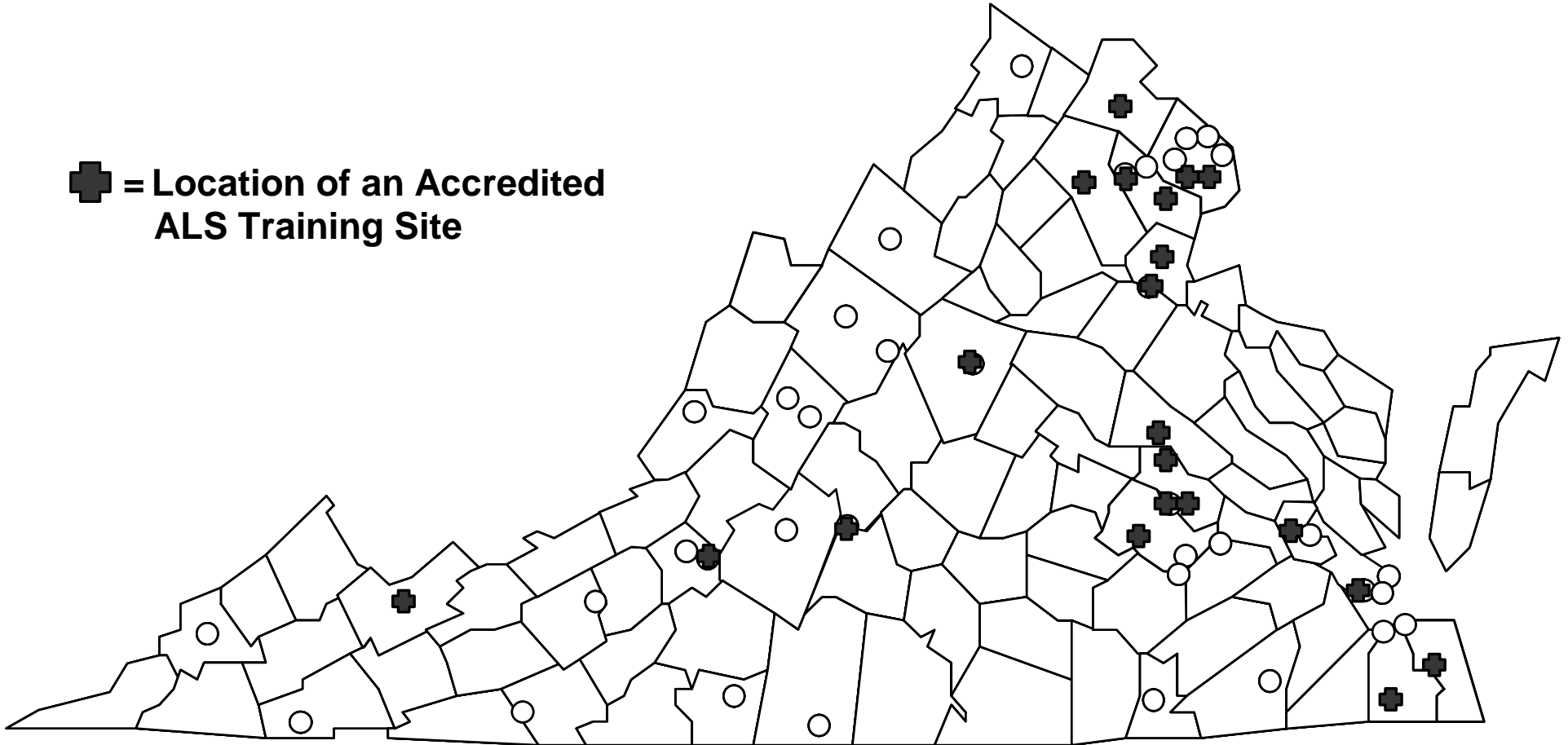
Advanced Life Support (ALS) Training

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- **ALS training leads to the highest levels of EMS certification: EMT-Intermediates, and Paramedics**
- **Effective with the January 2003 regulations, all sites providing ALS training must be accredited by OEMS**
- **Accreditation involves OEMS endorsement and approval of:**
 - **Course curriculum**
 - **Site coordinator**
 - **Physical site**
- **Accreditation process takes at least one year**
- **Currently there are 19 accredited ALS training sites across the State**

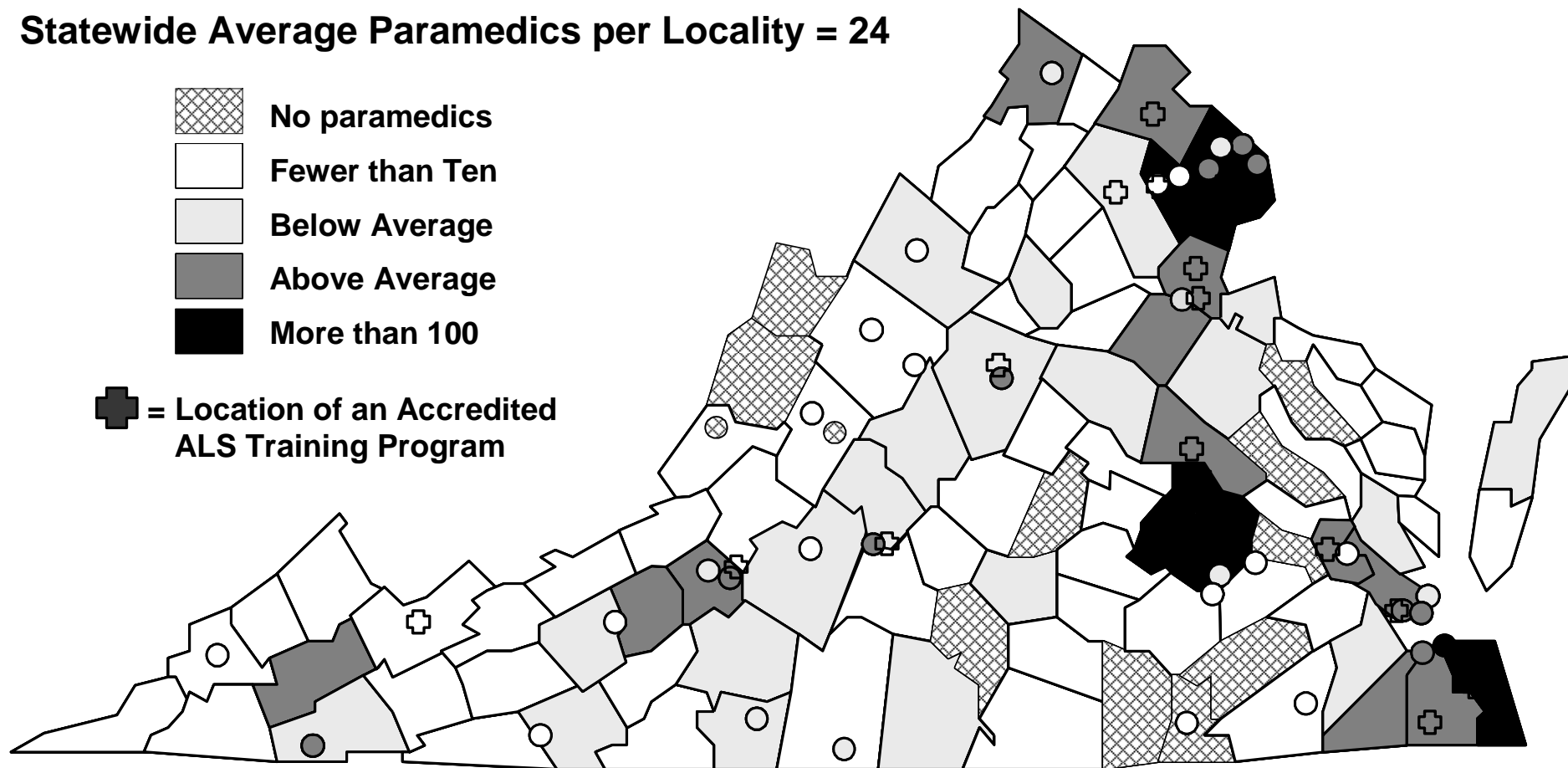
Accredited ALS Training Sites

⊕ = Location of an Accredited ALS Training Site



Location of Paramedics Compared to Accredited ALS Training Sites

Statewide Average Paramedics per Locality = 24



Source: JLARC staff analysis of OEMS data.

ALS Training Challenges

52

- **Accredited ALS training sites are primarily located in metropolitan areas, although there are sites statewide**
- **Accredited ALS training sites are provided by private companies, larger localities, and institutions of higher education**
- **ALS accreditation requirements have increased the travel time and costs of becoming an ALS provider**
 - **This is especially true in more rural areas of the state**

Recommendation

OEMS should work to expand the availability of ALS training, including:

- **Working with the Virginia Community College System and local community colleges to increase accredited ALS training programs**
- **Encouraging satellite campuses for existing sites**
- **Working with teaching hospitals to provide additional paramedic training opportunities**

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Estimated Fiscal Support for EMS

Government & Volunteer Agencies, 2003

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Volunteer agencies (including estimated value of 3.6 million volunteer hours)	\$196 - \$222 million
Local governments	\$144 - \$360 million
OEMS	\$14 million
Regional EMS councils	\$ 2 million
Total	\$358 - \$600 million

Note: Total excludes commercial and for-profit EMS agencies

Methods of Funding EMS

56

- **Funds come from many sources, including fund raising activities, local government support, revenue recovery/billing for services, State funding**

- **At least 84 localities provide EMS using a variety of methods, including directly with local employees**
 - **18 localities were reported (in grant applications) as providing little or no financial support to volunteer EMS agencies**

Revenue Recovery / Billing for Services

57

- **Significant revenue can be recovered from patients' health insurance**
- **87 percent of Virginians have health insurance, according to U.S. Census Bureau**
- **At least 107 governmental and volunteer EMS agencies currently bill for services or are actively considering it**
 - **49 volunteer and 19 governmental agencies are now billing for services**
 - **25 volunteer and 14 governmental agencies are considering it, according to the JLARC staff survey**

Some EMS Agencies Refuse to Bill

58

- **35 percent of volunteer agencies and 23 percent of career agencies said they “would never consider billing for services” in JLARC staff survey**
 - **Some of these EMS agencies receive local tax revenues yet refuse to bill for services**

- **Concerns about billing:**
 - **Core public services should not be billed for**
 - **Federal law requires billing all patients, and not all patients have health insurance or are able to pay**
 - **May lead to reduced contributions and discourage people from volunteering**
 - **Some requests for payment may be denied by health insurance reviewers**
 - **Increased paperwork and administration**

Implementing Revenue Recovery

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- **Health insurance benefits are available yet unclaimed by many EMS agencies**
- **Starting to bill for EMS services requires extensive public education campaign**
 - **Amherst County developed a short video emphasizing that revenue recovery works like billing for other health care services, and that no one would be denied services based on inability to pay**
- **Agencies have reported recovering as much as 80 percent of total operating costs through billing for services**

Recommendation

EMS agencies should actively consider billing patients' health insurance policies for the services and transportation provided. The Office of Emergency Medical Services should develop materials that agencies can use to help educate the public about revenue recovery and dispel misconceptions.

State Funding for EMS

61

- **“\$4-for-Life” is principal source of State funds for EMS**
 - **The 2002 General Assembly increased the fee from \$2.00 to \$4.00 on each motor vehicle registration and renewal, effective July 1, 2002**
 - **Will generate about \$26 million in FY 2005**
- **\$15 million of the additional revenue went to the general fund in FY 2003 and FY 2004**
- **\$3.45 million of “\$4-for-Life” revenue is appropriated to the general fund in FY 2005 and FY 2006**

Revised Formula Has Not Yet Taken Effect

62

- **2004 General Assembly adopted HB 1002, changing the distribution of the “\$4-for-Life” funds contingent on allocation of all the new revenue to EMS – so the new distribution formula has not yet taken effect**
- **The new distribution formula specifically directs more State funds towards recruitment, retention, and training programs**

Recommendation

The Governor may wish to submit an amendment to the “\$4-for-Life” funding formula to permit implementation prior to full funding from the fee, or to delete the transfer of \$3.45 million to the State general fund, which will have the effect of implementing the statutory distribution formula.

Rescue Squads Assistance Fund

64

- **31.75 percent of “\$4-for-Life” revenue goes to rescue squads assistance fund, for training and equipment**
 - **\$6.35 million available in FY 2005, up 65 percent from FY 2004 total of \$3.84 million**
 - **Only nonprofit agencies may receive funds**
 - **Local match is required**
 - **Most awards have been less than \$10,000, except for grants for new vehicles**

- **Because individual agencies separately apply for funds, opportunities to improve inter-operability of communication equipment may be missed**

- **Availability of State equipment funds may have contributed to the high number of ambulances in Virginia**

Recommendation

The State EMS Advisory Board should establish guidelines for the rescue squads assistance fund which encourage the most effective use of the funds. Guidelines for vehicles should consider factors such as the annual number of responses, mileage per vehicle, and age of existing vehicles.

Medicaid Rates

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- **121 EMS agencies are eligible to receive Medicaid payments. As more agencies begin billing, this will increase**

- **Medicaid pays:**
 - **\$75 for emergency transport up to 5 miles**
 - **\$150 for emergency transport of 6-10 miles**
 - **\$150 + \$2.50/mile for longer emergency transports**

- **Medicaid rates have only changed once since 1981**

- **Current rates were set by legal settlement in 1997**

Medicaid Rates (continued)

- **Several EMS agencies indicated that current Medicaid rates are significantly below actual costs**
 - **Consultant found that in 2000 Chesterfield County's EMS system cost per response was \$338; cost per transport was \$503**
 - **Richmond Ambulance Authority indicated their actual cost to have an Advanced Life Support (ALS) ambulance available is a minimum of \$250**

- **Other EMS agencies are concerned that Virginia regulations may hinder continued receipt of federal Medicare reimbursement**

Recommendations

The Department of Medical Assistance Services should re-evaluate reimbursement rates paid for emergency medical transports. The rates should be based on the costs incurred by Virginia EMS agencies.

The Office of Emergency Medical Services should ensure that State regulations comply with federal requirements concerning specialty care by seeking the opinion of the federal Centers for Medicare and Medicaid Services and implementing any needed changes.

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VDH Planning and Coordination Should Be Strengthened

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- ***Code of Virginia* §32.1-111.3** requires the Board of Health to develop and review a statewide EMS plan every three years
 - Plan was most recently revised in 1999
 - Also a concern in the 1999 JLARC *Review of Air Medevac Services in Virginia*

- Revised plan should address emerging issues such as:
 - Lengthy response times in some areas
 - Shortages of advanced life support providers
 - Impact of the aging EMS workforce on service provision
 - Appropriateness of revenue recovery
 - The needs of the increasing elderly population for EMS services

- **Obsolete statutory language** limits representation of all **Regional EMS Councils** on the **State EMS Advisory Board**

Recommendations

The Board of Health should revise the statewide comprehensive emergency medical services plan, as required by the *Code of Virginia*. The plan should address emerging issues and recommend appropriate strategies.

The General Assembly may wish to amend the *Code* to authorize a member from each regional council to serve on the State EMS Advisory Board, and to delete obsolete references to discontinued programs.

Problems with Current EMS Regulations

72

- **Several proposed regulations were dropped:**
 - **A response time goal requirement for designated emergency response agencies, who would have to set one and meet it 90 percent of the time**
 - **A “scope of practice” standard, to more clearly establish and enforce the services and procedures which may be performed by providers at the different levels**

- **Regulations contain confusing and contradictory language as well as certain omissions**
 - **Current EMS regulations provide OEMS authority to issue variances and exemptions in many areas, however the *Code* only allows variances to be provided to volunteer rescue squads**

- **Roles and responsibilities of Regional EMS Councils are not included**
 - **Regulations outlining the roles and responsibilities of the regional councils have been a goal of OEMS since 1997**
 - **Draft regulations are currently under development**

Recommendation

The Office of Emergency Medical Services should initiate revisions to the current Virginia EMS regulations. The concerns referenced in this report should be addressed.

OEMS Monitoring and Enforcement Activities

74

- **State EMS regulations are enforced by eight OEMS field personnel who perform scheduled biennial inspections of every squad**
 - **Ambulances are inspected to ensure compliance with State regulations**
 - **Personnel records are inspected to insure that they are current and accurate**
 - **Run reports are reviewed to monitor compliance with agency protocols for patient care**

Enforcement of Violations

75

- **If a violation is discovered, OEMS staff have a range of sanctions:**
 - **Warning – oral notice of a potential violation**
 - **Notice of Violation – written notification used for minor infractions; allows the individual or agency to remediate the concern and continue providing services**
 - **Citation – written notification used for more serious infractions; posted on the OEMS website indefinitely, even if corrective action is taken**
 - **Suspension – removal of the authorization to act as an EMS agency or provider; can occur without a hearing; posted on OEMS website indefinitely**
 - **Revocation – permanent removal of the authorization to act as an EMS agency or provider; requires notice and a hearing; posted on OEMS website indefinitely**

OEMS Has Limited Enforcement Authority

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- **Many EMS agencies worry about the stigma of a citation and work hard to avoid one**
- **Other agencies see the citation as a mere “piece of paper,” which constitutes no effective penalty**
- **Agencies that take this view are difficult for OEMS to deal with, as the only choice for further sanctions is suspension, which could leave local residents without emergency medical response**

Recommendation

The General Assembly may wish to authorize some intermediate sanctions for enforcement of emergency medical services regulations. For example, the Virginia Department of Health could be authorized to levy financial penalties for non-compliance.

OEMS Monitoring of Training Programs Could Be Increased

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- The same eight OEMS “program representatives” who monitor agency and provider compliance with regulations also monitor training and testing of individual providers
- The agency inspection workload is such that little time is available to adequately monitor training and testing quality and consistency
- While limited informal monitoring is performed by regional councils and other concerned individuals, new OEMS field officer positions would help ensure the quality of EMS training
- Funding for these positions is currently available

Recommendation

The Office of Emergency Medical Services should request some additional staffing for the purpose of ensuring quality control and monitoring of training. These positions could be located in some of the regional EMS council offices to help plan, coordinate, certify, and deliver educational and training services.

Separate EMS Agency Is Not Needed

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- **Clear consensus that EMS should continue to be linked to health and medical responsibilities of State government**
 - **Physicians play key role in quality control and operations**
 - **Medical mission is prime reason for EMS**

- **Separate agency would general additional cost without necessarily adding any benefits**

- **Many providers remain upset with relocation of OEMS from suburban Richmond to downtown**