

FITCH

& ASSOCIATES

CONSULTANT REPORT

Commonwealth of Virginia Office of EMS



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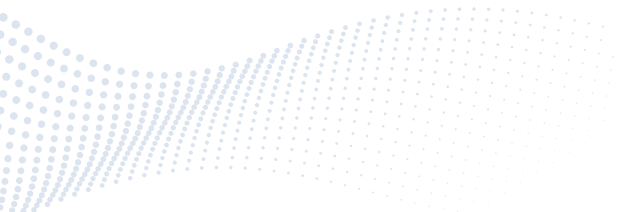
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Executive Summary

Under new leadership, the Virginia Department of Health (VDH) began comprehensive and regular budget reviews of programs in the spring of 2023. During the Office of Emergency Medical Services (OEMS) review, irregularities were found, leading to an in-depth investigation by the current VDH senior leadership team. By July 2023, OEMS was estimated to have unpaid debts and over-obligations totaling \$33 million, and evidence of fraud led to the Associate Director's conviction for embezzling over \$4.3 million. Poor financial decisions and weak oversight within OEMS, historical lack of senior leadership involvement from VDH central office, and disregard for Commonwealth of Virginia procurement policies and mandated EMS funding responsibilities led to a systemic failure and a financial crisis.

In January 2024, VDH contracted MedServ Management Services, an affiliate of Fitch & Associates (FITCH), to provide on-site leadership, assist in resolving the financial crisis, and provide both financial and operational recommendations.

Summarized Findings

This report identifies critical findings within OEMS and its oversight by VDH, including financial mismanagement, legal concerns, cultural challenges, operational inefficiencies, and ineffective oversight. Major points of significance regarding the findings are:

- **Financial:** Due to unpaid debt, over-obligations, and fraudulent spending, OEMS was unable to transfer \$12.5 million to the Treasury from the Four-For-Life program at the end of Fiscal Year 2023 as required by the Appropriations Act. Further, OEMS continued to have significant unpaid obligations, prompting Governor Youngkin to approve an \$8 million carryover of VDH's remaining balances from Fiscal Year 2023 into Fiscal Year 2024 and include an additional \$25 million in his bi-annual budget to address the crisis.
- **Legal:** The Hybrid EMS Council model was established without following VDH's established decision process or undergoing legal review, raising concerns of the Hybrid Council model under Virginia Code. Issues include state employees being supervised by non-state Regional Boards, oversight of non-state employees, and fund allocation to non-profit Regional EMS Councils for expenses not aligned with procurement regulations.
- **Cultural:** EMS agencies perceive OEMS to be an enforcement agency, not a customer-centric entity. The agencies complain that OEMS central staff is often unresponsive and unreliable,



leading them to turn to Regional EMS Councils for assistance. In turn, inconsistent communication among the 11 Regional Councils leads to confusion and lack of accountability.

- **Operational:** The annual EMS symposium's costs escalated to over \$1.6 million in 2022, with funds funneled through the Western EMS Council, bypassing state approval processes. Additionally, the Southwest region experienced a 27% decline in EMS providers from 2,198 in 2004 to 1,593 in 2024. This was attributed to changes in the education and the education coordinator process, which created staffing challenges in the rural communities.
- **Oversight:** Before recent changes, the EMS Advisory Board (EMSAB) incurred annual costs exceeding \$400,000, with minimal turnover leading to stagnation. Comprising 28 members and 21 subcommittees, the board had limited influence in driving change. Additionally, OEMS leadership selectively followed the board's advice, contributing to conflict and mistrust between the two entities.

Summarized Pathway Forward

VDH leadership must stabilize the Office of Emergency Medical Services (OEMS) and establish a sustainable path forward. FITCH provided key decision points to enhance OEMS functionality and position within the Commonwealth.

Decision Point 1: OEMS Positioning for Strong Oversight

OEMS could either remain within the Virginia Department of Health (VDH), shift to the Public Safety Secretariat, merge with the Virginia Department of Fire Programs (VDFP) to create a combined Department of EMS & Fire, or be dissolved with its regulatory functions reassigned. These options aim to optimize oversight and integration with other state entities.

Decision Point 2: Regional Structure and Support

FITCH recommends reducing the current 11 Regional Councils to seven, aligning them with other public safety agencies. Two structural models were proposed: a decentralized model where state staff support both central and regional offices or an integrated model where regional offices have more autonomy with non-state staff. Both models could incorporate Community Integrated EMS initiatives to strengthen local services. The current Hybrid model should be discontinued to comply with Commonwealth procurement and hiring practices.



Decision Point 3: Policy and Regulatory Process Review

OEMS policies and guidelines are not consistently formalized through a documented process compliant with Virginia code. The public comment process established in the Administrative Process Act is not followed. This lack of formalization and clear documentation for policy and guidance document adoption can lead to inconsistent application and potential harm to individuals and agencies. The option presented will improve transparency, stakeholder engagement, and compliance with legislative requirements.

Decision Point 4: Community Input and EMS Oversight Enhancements

The EMS Advisory Board (EMSAB) is comprised of 28 members and lacks any authority other than advisory. FITCH recommends reducing the size of the EMSAB and affording the Board more authority to propose regulatory and legislative changes directly to the State Board of Health. This option aims to foster collaboration with local boards to better shape EMS policies and expectations.

Decision Point 5: Education, EMS Portal, and Departmental Functions

FITCH recommends revising the certification process for education coordinators, expanding testing access, and improving the acceptance of out-of-state continuing education credits. Additionally, FITCH proposes enhancements to the EMS portal to improve data management, as well as establishing appropriate oversight of the portal by subject matter experts. Divisions such as Regulation and Compliance Enforcement were recommended to facilitate the hiring of key open positions.

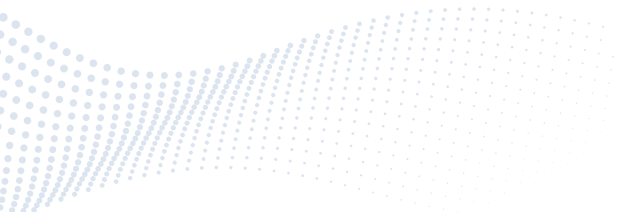
Improving financial transparency in revenue allocation from DMV and expanding the RSAF Grant Program were emphasized. FITCH also recommended implementing a funding escalator to account for rising costs and ensure equitable distribution of funds based on regional demographics.

Finally, the reassignment of the epidemiologist within VDH and creation of a data analyst position that is solely focused on patient care informatics would ensure that OEMS is better equipped to assess technology solutions and improve healthcare services.



Estimated Financial Impact

FITCH projects that reducing the regions to seven and decentralizing staff, while dependent on the chosen staffing model, could yield annual salary savings of \$1.89 to \$2.28 million. Additional changes in expenses could result in annual savings of \$6.09 to \$9.17 million. Thus, total potential annual savings for the Commonwealth could range from \$7.99 to \$11.45 million.



Critical Findings

FITCH's comprehensive analysis identified nine critical findings. These findings underscore issues that require immediate attention and action and provide the foundation for the pathway forward.

1. Failure of Fiscal Oversight and Control
2. Regional EMS Councils Are No Longer Relevant in Their Current State, Structure, And Function
3. Hybrid Councils Create Concerns in Current Structure
4. Current Culture Is Not Customer-Centric
5. No Systematic Mission, Expectations, or Controls
6. EMS Advisory Board Mission Needs to Evolve and is Costly in its Current Structure
7. Mission Creep and Mandates Have Increased Cost Without Additional Resources
8. Evolution Of the Virginia EMS System Necessitates Review of The OEMS Organization Position Within the Commonwealth Government Hierarchy
9. EMS Education Program Changes Have Negatively Impacted the Workforce

Critical Finding #1: Failure of Fiscal Oversight and Control

Before 2023, VDH senior leadership failed to properly oversee OEMS, while the former OEMS director failed to provide the financial oversight needed to ensure compliance with Commonwealth financial policies. These failures led to \$33 million in unpaid debts and over-obligations, facilitated \$4.3 million in embezzlement, and resulted in a fraud conviction of a former employee.

The Virginia EMS Symposium's costs increased annually, reaching \$1.6 million in its final year before being suspended by the VDH. Regional EMS Councils were also used to bypass state purchasing guidelines, and poor internal controls led to further overspending and improper fund reallocations. Ongoing financial control issues have been noted in prior Commonwealth internal audit reports.

Four-for-Life revenue from the Department of Motor Vehicles has remained flat while OEMS operation costs have grown significantly. Without the recent suspension of the \$12.5 million transfer from the Four-for-Life to the general fund, OEMS would be unable to sustain operation in its current form.

Critical Finding #2: Regional EMS Councils are No Longer Relevant in Their Current State, Structure, And Function

To remain relevant in the evolving EMS landscape, VDH and OEMS should revise the Regional EMS Councils and their service delivery models. While larger career EMS agencies find the Councils'



assistance limited, smaller and volunteer organizations rely heavily on their support. The current model was established when more volunteer EMS agencies were operating and dependent on the Council for support. This model has become outdated with the increase in career agencies and thus requires less reliance on Councils' services. With many functions now managed at the agency level, the Councils face challenges in maintaining relevance. This situation has been further complicated by the creation of hybrid models, where some Councils include OEMS employees and receive increased funding.

The hybrid and traditional Councils differ in their operational and funding structures, contributing to inconsistency in services and expenditures, totaling \$5,619,055 annually. Such inconsistencies have led EMS agencies to seek services from different Councils based on their needs, highlighting the necessity for a more unified and adaptable model. Additionally, the Councils' unclear mission, coupled with inadequate funding, exacerbates these issues.

Critical Finding #3: Hybrid Councils Create Concerns in Current Structure

The Hybrid EMS Council model was established without adhering to VDH's existing decision process or legal review, raising concerns about its compliance with Virginia Code. Regional EMS Councils, as defined by Virginia Code § 32.1-111.4:2, are independent entities. Although VDH and OEMS have the authority to create councils, this authority does not cover supervision of state employees by non-state Regional Boards, oversight of non-state employees, or fund allocation to non-profit Regional EMS Councils for expenses not aligned with procurement regulations. Given the significance of the above referenced issues, VDH should reassess the viability of continuing the Hybrid EMS Council model.

Critical Finding #4: Current Culture Is Not Customer-Centric

FITCH's discussions with EMS agencies revealed complaints about the OEMS central office staff, including unreliable communication and negative interactions. As a result, EMS agencies often turned to the Regional EMS Councils for assistance, only to face criticism from the OEMS for these interactions. This lack of responsiveness and customer service from the OEMS has eroded trust and created the perception that the office is more focused on enforcement rather than support.

OEMS messages are often interpreted and relayed differently by each Council. This variability leads to inconsistent information across agencies and fosters confusion, creating an "us-vs-them" environment between the OEMS and the Councils. The lack of clear and uniform communication further diminishes accountability, exacerbates the divide between the OEMS and EMS providers, and creates confusion for the agencies and providers.



Critical Finding #5: No Systematic Mission, Expectations, or Controls

The OEMS was found to be isolated from the VDH, Regional EMS Councils, and the broader EMS system, thus leading to a lack of understanding of local EMS agencies' needs. This disconnect also hampers the OEMS's grasp of the impact of its policies statewide. Additionally, ineffective communication with the Regional EMS Councils has fostered an adversarial relationship, with conflicting perceptions that the Councils overstep in their duties and the OEMS is generally uncooperative.

Internally, the OEMS suffers from siloed divisions and poor communication, compounded by unclear or misaligned policies and expectations. The resulting frustration and stagnation in initiatives have directly contributed to mismanagement of resources, poor accountability, and lack of transparency, all undermining long-term success.

Critical Finding #6: EMS Advisory Board Mission Needs to Evolve and is Costly in its Current Structure

The EMS Advisory Board (EMSAB) currently lacks functionality and effective mechanisms for system change. Its success depends on collaboration with OEMS and the 11 Councils, a process proven ineffective given the current communication issues.

While advisory boards are standard in many EMS systems, the EMSAB faces significant challenges. Member turnover is minimal, leading to stagnation and disengagement. Without comprehensive reform, EMSAB lacks the capacity to drive necessary changes.

The EMSAB and its committees are also costly, with annual expenses exceeding \$400,000 for meetings and member reimbursements prior to recent changes instituted in Fiscal Year 2024 by VDH.

To be effective, the EMSAB must redefine its mission and composition to align with OEMS' core objectives and budget. It should have the authority to review and propose changes to Virginia's EMS policies and regulations and make such recommendations to the State Board of Health. FITCH recommends a relationship between OEMS and EMSAB be developed, similar to that between VDH and the State Board of Health.

Critical Finding #7: Mission Creep and Mandates Have Increased Cost Without Additional Resources

The OEMS has experienced mission creep by expanding its primary role of planning and coordinating an effective statewide EMS system. This expansion includes taking on non-core programs such as Emergency Medical Dispatching and PSAP accreditation, as well as providing statewide Electronic



Patient Care Reporting (ePCR) programs to agencies. In addition, the state legislature expanded the core mission of the OEMS to handle Trauma Designation for hospitals.

These expanded duties for OEMS's operational controls have led to financial issues as no additional funds were allocated to cover the management of these programs. For example, the Trauma Center Designation program incurs costs of approximately \$500,000 annually with no corresponding support from the Trauma Center Fund.

Critical Finding #8: Evolution Of the Virginia EMS System Necessitates Review of The OEMS Organization Position Within the Commonwealth Government Hierarchy

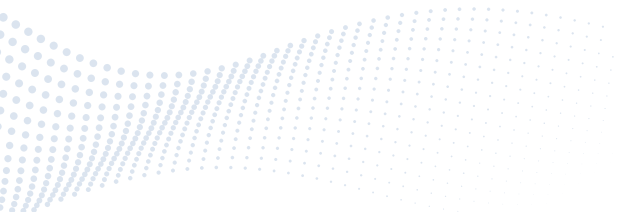
As EMS evolves, there is increasing debate about the optimal placement of the OEMS within the government hierarchy to benefit the EMS system. Interviews with agencies, local leaders, and stakeholders have highlighted challenges within the OEMS. Moving forward, the Commonwealth will need to consider the expansion of municipal and fire-based services handling EMS, hospital needs, patient movement activities, the emergence of community paramedicine, hospital and home programs, and expansion into public health activities following the COVID-19 pandemic.

Critical Finding #9: EMS Education Program Changes Have Negatively Impacted the Workforce

Recent changes in EMS education have negatively impacted the workforce, particularly in recruiting and training volunteers crucial to many smaller organizations. These issues reflect a lack of foresight and planning by OEMS. Specific changes made by OEMS include:

- Transition from NREMT skills-based testing to Virginia-specific competency-based scenarios
- Introduction of the Education Coordinator credential, which has complicated certification processes
- Reduction in Emergency Medical Responder (EMR) certifications, leading to fewer volunteers in rural areas
- Lack of accountability for education programs performing below the 16th percentile benchmark

Such changes, which affect staffing and resource availability, must be carefully weighed against their intended goals. Significant modifications should include thorough planning and, if feasible, a phased implementation to mitigate unintended consequences. Given the ongoing decline in EMS providers, these changes appear counterproductive and contrary to the OEMS' mission.



Methodology

The FITCH strategy involved providing daily operational support to OEMS while evaluating and developing future options. Initial objectives included placing an experienced leader to aid the Interim Director and guide OEMS toward its future state. FITCH assessed existing programs, the office structure, and financial modeling to support OEMS' core functions while identifying improvement opportunities that support and maintain the statewide EMS system. The team collaborated with VDH and the EMS Next Steps Workgroup to collect data, assist with findings, and report recommendations.

FITCH employed three distinct approaches to support this review:

1. Directly engage with office leadership to address current issues and operational challenges
2. Interact with stakeholders across OEMS, Regional EMS Councils, EMS agencies, and other groups to gather evaluation context
3. Survey EMS agencies to assess future needs and provide a qualitative review

FITCH engaged with office staff to understand office operations and its community interactions, supported leadership transitions, and assisted with daily activities. Additionally, FITCH implemented improvements in office workflows, financial reporting, policy adjustments, and both office and council reporting structures. These efforts aimed to enhance operational efficiency and prepare OEMS for future challenges.

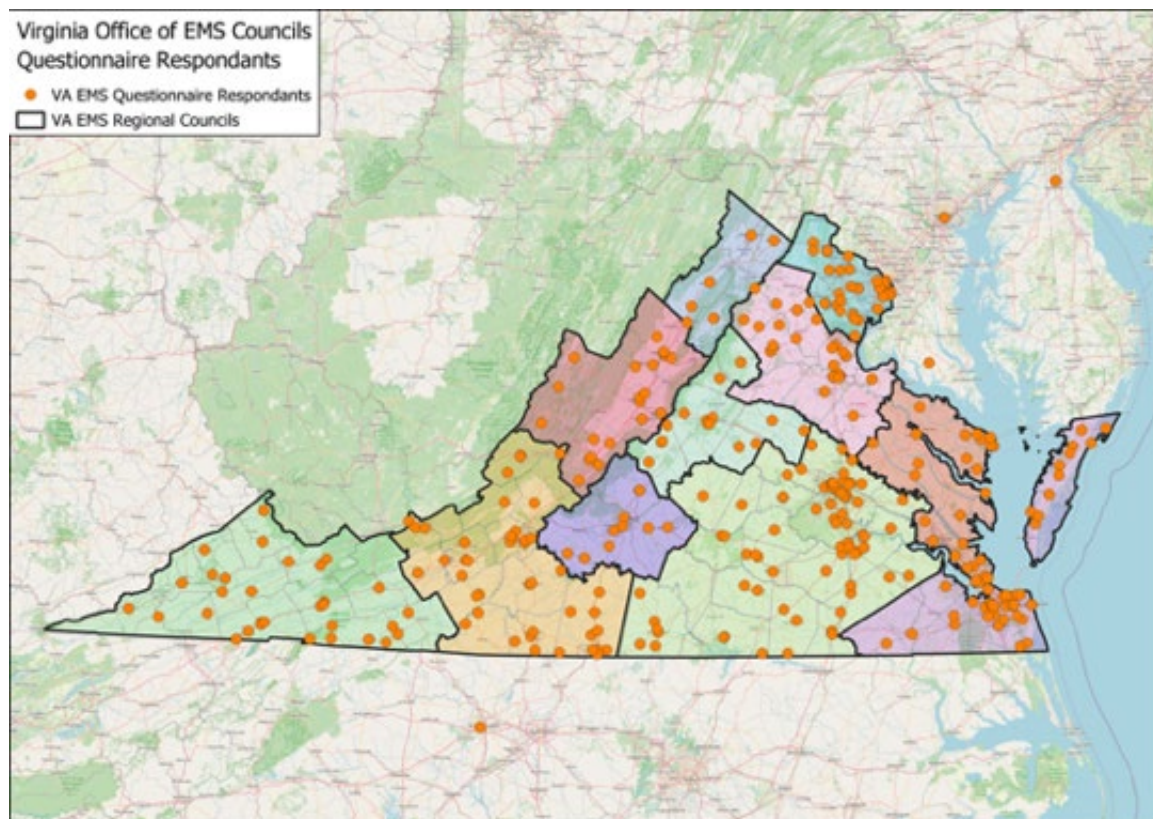
To better understand community and EMS agency needs, FITCH deployed team members to engage with a broad range of stakeholders across the Commonwealth. Key stakeholders included, but were not limited to:

- All Regional EMS Councils
- Many EMS agencies, including both public and private
- State agencies, including Virginia Department of Emergency Management and Virginia Department of Fire Programs
- Virginia Association of Volunteer Rescue Squads
- Virginia Fire Chiefs Association
- Education staff, both internal to the OEMS and external
- VDH and other government stakeholders
- The State Emergency Medical Services Advisory Board
- The EMS Next Steps Workgroup

The goal of these meetings was to identify current challenges from stakeholders' perspectives and assess their needs for OEMS support. FITCH also gathered feedback and opinions on how to best evolve the EMS system to address stakeholder concerns and adapt to future changes.

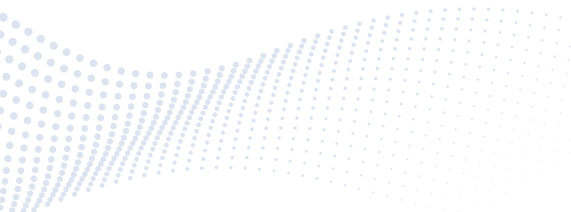
FITCH developed and administered a survey to EMS agencies and leaders to determine future roles for OEMS and Regional EMS Councils. The survey aimed for a 95% confidence level with less than a 5% margin of error. From 567 licensed agencies, FITCH received 355 responses, surpassing the required 230 responses for a 95% confidence level at a 3.2% margin of error. From the 940 individual recipients, 441 responses were obtained, exceeding the 273 needed for a 95% confidence level at a 3.41% margin of error. A comprehensive survey report was produced to guide the future design of OEMS.¹

Figure 1: Survey Respondent Locations²



¹ <https://www.surveymonkey.com/mp/sample-size-calculator/>

² There were 940 requests for responses sent to 567 agencies. Of the 567 licensed agencies in the state, FITCH received 355 unique agency responses, which exceeded the required 230 to achieve a 95% confidence level with a 3.2% margin of error. Additionally, out of the 940 survey recipients, 441 responses were received, which surpassed the 273 needed to achieve a 95% confidence level with a 3.41% margin of error.



Office of Emergency Medical Services

Overview

The Office of Emergency Medical Services (OEMS) was established in 1974 to formalize and enhance Emergency Medical Services across Virginia. OEMS is an office within the VDH, which is led by the Commissioner of Health, reporting to the Secretary of Health and Human Resources. OEMS is led by a Director who reports to the Deputy Commissioner of Population Health and Preparedness, who then reports to the Commissioner.³

FITCH reviewed OEMS divisions, Regional EMS Councils, the State EMS Advisory Board and committees, regulatory issues, education, NREMT testing, EMS portal and data availability, other OEMS services and functions, and the EMS agencies and workforce.

OEMS has eight operating divisions, each with distinct responsibilities. However, they operate in silos with limited communication beyond their own division. These divisions include:

- 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

Regulation and Compliance Enforcement

The Regulation and Compliance Enforcement Division oversees the licensure of EMS agencies, endorsement of EMS physicians, and permitting of EMS vehicles, aircraft, and watercraft. It also enforces regulations and maintains legal and professional standards for EMS operations, as detailed in the Code of Virginia (§ 32.1-111.6:1 – 9) and the Virginia Administrative Code (12VAC5-31).

³ www.vdh.virginia.gov



Due to financial constraints, the division has transitioned from routine to less stringent spot inspections conducted during EMS vehicles' operational activities, including at hospitals. This shift has elicited significant negative feedback from EMS agencies who perceive these inspections as problematic, particularly when conducted post-patient transport. Agencies reported dissatisfaction with customer service, citing a focus on problem identification rather than solutions, and difficulty in contacting representatives. Despite these issues, field program representatives received praise for their service from agencies and Councils.

Emergency Operations

The Division of Emergency Operations aims to enhance emergency response capabilities within the Virginia EMS system and promote provider health and safety. Its responsibilities include developing comprehensive emergency plans, coordinating with local, state, and federal agencies, and ensuring effective response strategies as outlined in the Virginia Emergency Operations Plan. The division also oversees the EMS-focused Public Safety Answering Point (PSAP) accreditation program and ensures compliance with emergency medical dispatch (EMD) protocols, as per Code of Virginia § 56-484.16:1, despite lacking additional funding for this mandate.

Additionally, the division also manages the State EMS Plan, Trauma Triage Plan, Stroke Triage Plan, and crisis intervention requirements per Code of Virginia § 32.1-111.3. It employs a communications technician to assist with EMS radio systems statewide. There is some overlap with functions of the Virginia Department of Emergency Management (VDEM), which recently assumed 9-1-1 Advisory Board responsibilities. Enhanced coordination with VDEM and exploration of further alignment in disaster response will benefit EMS operations.

Community Health and Technical Resources

The Community Health and Technical Resources Division integrates public health initiatives with EMS services and collaborates on the state EMS plan with the Emergency Operations Division. It develops public health programs such as injury prevention and education campaigns under the community paramedicine/mobile integrated healthcare category. The Technical Assistance section supports EMS agencies with technology, data management, and grant applications, ensuring efficient and effective operations.

The division is involved in EMS workforce development, including the creation of the Virginia EMS Officer I and II training curriculums and the EMS Safety Officer program. While some programs may overlap with national certification processes, they are tailored to Virginia's needs and may not align with other state departments like the Virginia Department of Fire Programs.



Additionally, the division oversees the grant-funded EMS for Children program which aims to enhance pediatric care through federal funding. Prior to the March 2024 organizational changes, this division managed traditional Regional EMS Councils, which presented challenges due to differing management and funding structures. The division's functions are outlined in the Code of Virginia §§ 32.1-111.3.A.1, 3, 6, 9, 14, 17 and include the development of the state telehealth plan per § 32.1-122.03:1.

Accreditation, Certification, and Education

The Accreditation, Certification, and Education (ACE) Division is essential to EMS personnel development and certification in Virginia. It manages certification and continuing education for all EMS professionals, ensuring that providers meet required standards. Staffed by four positions with two vacancies, the division handles certifications, education programs, and policy updates, with two individuals primarily managing the EMS portal, education coordination, and inter-state communication.

The division's functions are defined in:

- § 32.1-111.5 (Certification and recertification of EMS providers; appeals process)
- Part III, EMS Education and Certification, 12VAC5-31-1305 – 1720

However, the division faces issues due to its reliance on just two individuals for its broad scope of responsibilities. One of these individuals is nearing retirement, raising concerns about succession planning. Feedback from leaders and FITCH indicated problems with the EMS portal, including its user-unfriendliness, lack of updates, and inadequate reporting capabilities. These issues hinder data collection and reporting that are essential for program development and grant reporting. A concern voiced among EMS agencies is that the individual currently managing the EC program is not a certified EMS provider in the Commonwealth, however this is no longer an issue with the position being vacated.

The expansion of the Education Coordinator (EC) program statewide has faced notable challenges, particularly in rural communities, due to limited local support and stringent requirements. FITCH recommends enhancing support and oversight from the Office of Emergency Medical Services (OEMS) and increasing local involvement to address these issues.

Trauma and Critical Care

The Trauma and Critical Care Division manages and coordinates care for trauma and critically ill patients, ensuring an efficient statewide trauma system through protocol development and guideline enforcement. It oversees the trauma center designation plan and trauma triage plan, as specified in Code of Virginia §§ 32.1-111.3 A10, A12, and B1-B3, and supports the statewide stroke triage plan under §§ 32.1-111.3 C1 and C2.



A 2015 assessment by the American College of Surgeons (ACS) identified inconsistencies in applying trauma center standards and noted that some centers sought additional ACS-COT verification.

The division administers state trauma funds primarily derived from fees for reinstating revoked or suspended drivers' licenses, especially from repeat DUI offenders. The fund accumulates about \$9 million annually, which is distributed to certified trauma centers based on the Trauma Fund Distribution Policy.

Administration and Fiscal

The Administration and Fiscal Division of OEMS provides essential administrative and financial support, including invoice processing, accounts receivable management, budgeting, purchasing, and contracting. The division manages fleet and logistics operations as well.

The implementation of the Shared Business Services (SBS) model in year 2020 resulted in less stringent controls and segregation of duties. This model focuses on developing processes that ensure segregation of duties and compliance with budgetary management standards established by the Commonwealth. The Division utilizes manual Microsoft Excel spreadsheets to facilitate all its financial management and bookkeeping tasks, thus increasing the risk for human errors, both unintentional or possibly intentional.

EMS System Funding

The EMS System Funding Division, staffed by two individuals, administers the Rescue Squad Assistance Fund (RSAF) and provides guidance to the Financial Assistance Review Committee (FARC). The RSAF, funded by the Four-For-Life program, supports nonprofit EMS agencies as per § 32.1-111.12 of the Code of Virginia. The division also manages the "Return to Locality" program, which allocates 26% of Four-For-Life funds for training and equipment for local nonprofit EMS agencies under § 46.2-694.13e.

Four-For-Life funds are distributed according to a fixed fee structure, with \$4 of the \$6.25 vehicle fee allocated as follows:

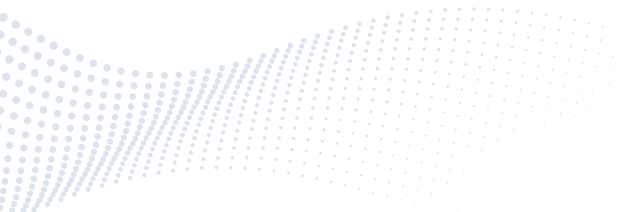
- 30% to OEMS for RSAF
- 26% to localities for training and equipment

Concerns with the RSAF include the exclusion of private, for-profit entities and large metro departments, which some agencies argue impair their ability to meet capital needs. The funding distribution model does not increase with inflation or vehicle value; rather, it is based solely on new vehicle registration, which is relatively flat year over year.



Patient Care Informatics and Epidemiology

The Patient Care Informatics and Epidemiology Division is responsible for two code-mandated functions: developing a comprehensive EMS patient care data collection and performance improvement system (§ 32.1-111.3.11) and creating a trauma registry (§ 32.1-116.1). Although there is no requirement for patient care reporting programs for EMS agencies, they must submit data to the state system. The division ensures compliance with NEMSIS standards and maintains the State Trauma Registry. Staffed with two epidemiologists, the division supports data gathering, reporting, and FOIA requests, and provides information to EMSAB, VDH, and other entities. Despite its role, there is a noted deficiency in the dissemination of useful information, highlighting a need for improved customer service and more valuable data for the EMS community.



Other System Components

Regional EMS Councils

The concept of Regional EMS Councils emerged in the early 1970s to provide local support and coordination for EMS agencies, aiming to enhance overall care. Formally recognized by the Code of Virginia in 1978 (§ 32.1-111.4:2), there are currently 11 Regional EMS Councils. According to a 2000 Joint Legislative Audit and Review Commission (JLARC) report, these Councils are responsible for developing and implementing efficient regional EMS systems, including training, medical protocols, and emergency plans.

The Virginia Department of Health (VDH) designates these Councils, reviews their applications every three years, and sets conditions for their renewal. Each Council is composed of representatives from various local agencies and other professionals and is required to adopt a regional EMS plan in cooperation with VDH. In 2009, a lobbyist was hired by the Regional EMS Councils to advocate for a legislative change to the budget code, which fixed the number of Regional EMS Councils at 11. This effort was successful, and the provision has been included in the budget code since then.

Councils are 501(c)(3) nonprofit organizations under contract with OEMS, expected to meet specific objectives to receive state funding. They must match state funds with local funds, though local governments are not legally required to provide these funds. A new hybrid model has emerged where some Council staff are directly employed by OEMS, creating a dual-reporting structure.

The impact of the Councils varies across the state. Larger career EMS agencies in urban areas have decreased reliance on Councils for education and training, while smaller rural agencies continue to depend on them for these services.

Agencies cited the statewide drug box replacement program and regional EMS medical protocols as key reasons for maintaining Regional Councils. However, by the end of 2024, the drug box replacement program will end due to DEA and board of Pharmacy changes. This leaves regional EMS medical protocols as the main reason for the continuation of Regional Councils.

Funding Challenges

The Regional EMS Councils face significant challenges due to funding constraints impacting their operations and development. A primary challenge is their reliance on state funds, which means any reduction directly affects their ability to function. The cessation of OEMS payments in 2023 worsened



the situation, forcing many Councils to deplete their reserve funds for essential expenses, pushing several towards closure.

The lack of a legislative basis for funding, as outlined in § 32.1-111.4:2, means there is no guaranteed financial support, further straining their stability and service capacity. To manage these issues, contractual agreements include clauses to address financial uncertainties: the "Availability of Funds" clause stipulates that OEMS commitments are contingent on available funds, and the "Cancellation of Agreement" clause allows the OEMS and contractors to terminate contracts with 60 days' notice, providing some flexibility in response to funding volatility. Despite these provisions, the dependence on state funds, the impact of payment stoppages, and the absence of a funding mandate underscore the pressing need for an evolution of the current council model.

State EMS Advisory Board and Committees

The State Emergency Medical Services Advisory Board (EMSAB) was created under the Code of Virginia, § 32.1-111.4:1 and is comprised of 28 members appointed by the Governor. Membership includes representatives from the Regional EMS Councils, medical associations, and EMS organizations. The primary role of the EMSAB is to advise the State Board of Health on the administration of the statewide emergency medical care system. This includes reviewing and recommending changes to the statewide Emergency Medical Services Plan and examining the annual financial report of the Virginia Association of Volunteer Rescue Squads. The EMSAB reviews status reports from the OEMS on the Rescue Squads Assistance Fund, regional EMS Councils, and emergency medical services vehicles.

As part of the advisory board structure, there are 21 committees that function in support of the EMSAB providing for a wide array of stakeholder input. These committees include:

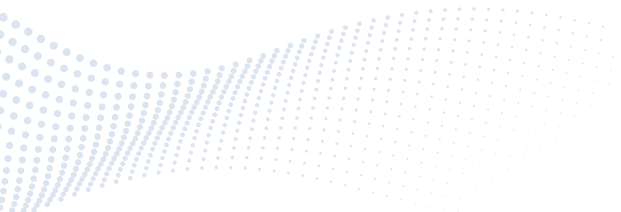
- Advisory Board Executive Committee
- Communications Committee
- Emergency Management Committee
- EMS for Children Committee
- Financial Assistance and Review Committee
- Legislative & Planning Committee
- Medevac Committee
- Medical Direction Committee
- Provider Health and Safety Committee
- Rules and Regulations Committee
- Training and Certification Committee
- Transportation Committee
- Trauma System Committees

- 
- Workforce Development Committee
 - Trauma Administrative and Governance Committee
 - System Improvement Committee
 - Injury and Violence Prevention Committee
 - Prehospital Care Committee
 - Acute Care Committee
 - Post-Acute Care Committee
 - Emergency Preparedness and Response

Hosting costs for EMSAB meetings were previously high, exceeding \$400,000 annually, due to expenses associated with meeting logistics, travel reimbursement, and meals for attendees. However, following cost containment strategies implemented in FY 2024, these expenses have been reduced to approximately \$150,000 per year. This reduction is indicative of broader fiscal constraints and efforts to manage the OEMS budget more efficiently.

Despite these efforts, the EMSAB faces significant challenges. The large size of the board, including its committees, with over 75 members, has led to inefficiencies in decision-making. The board's extensive membership and numerous committees often result in difficulties in reaching consensus and managing complex logistical and organizational issues. This has impeded the board's ability to fulfill its mission effectively, as decision-making can become bogged down by minor details and procedural hurdles. Moreover, the EMSAB has been reminded on several occasions by previous OEMS leadership that its role is advisory and it lacks the authority to regulate or directly influence the OEMS operations.

EMS agencies perceive the EMSAB as having limited impact on improving the OEMS and the EMS system in Virginia. This perception is worsened by the board's lack of transparency and accessibility. EMSAB meetings are neither recorded nor available online, and delays in posting minutes hinder remote agencies' ability to stay informed. The in-person meeting format in Richmond further limits participation from across the state, leading to a sense of exclusion. To improve effectiveness and inclusivity, the EMSAB needs to update its format and communication strategies, ensuring equal engagement opportunities for all EMS agencies and providers in the Commonwealth.



Changes in EMS Agencies, Volume, and Workforce

Summary

The ACE Division provided EMS agency data in an aggregated format but did not supply raw data, preventing FITCH from analyzing the number of providers by agency type or certification level. As a result, FITCH could not verify the accuracy or activity status of the reported provider numbers. Despite this limitation, FITCH analyzed the available data and provided summary findings.

Since 2019, EMS agencies have decreased by 6.45% (38 fewer agencies), with community and non-profit agencies dropping by 15.29% (39 fewer agencies). Meanwhile, government non-fire and fire department agencies increased by 6.9% (7 agencies), and hospital-based EMS agencies doubled to a total of eight (4 new agencies). During this period, EMS call volume increased by 20.88% (295,162 more since 2017), and the provider workforce grew by 7.9% (2,774) additional providers. However, there was a 43.9% reduction (340 fewer) in Emergency Medical Responder (EMR) certifications, likely reflecting a decline in volunteerism.

Interviews with Councils, agencies, and providers indicated a perception of fewer EMS providers compared to previous years. However, the workforce has expanded, and the loss of volunteers continues to create gaps that the current growth has not fully addressed.

The following tables reflect the FITCH analysis of the available data.

The figure below reflects the change in number of agency types.

Figure 2: Number of EMS Agencies by Type

Agency Type	2019	2020	2021	2022	2023	2024	Change	% Change
Total EMS Agencies	589	585	570	564	559	551	(38)	(6.45%)
Community, Non-Profit	255	254	245	234	227	216	(39)	(15.29%)
Fire Department	188	190	187	190	193	193	5	2.65%
Government, Non-Fire	47	43	43	43	46	49	2	4.25%
Hospital	4	5	6	9	8	8	4	100%
Private, Non-Hospital	95	93	89	88	85	85	(10)	(10.52%)
Tribal	0	0	0	0	0	0	0	
Federal EMS Agencies					15	15	15	
Active Vehicle Permits	4283	4326	4170	4144	3994	4007	(276)	(6.44%)

Of note, the data was aggregated by OEMS, and FITCH did not receive the raw data for independent analysis.

The figure below illustrates EMS call volume across the state, including both emergency responses (primarily 911 calls) and non-emergency responses (such as hospital transfers, nursing home transports, and dialysis patient transports).

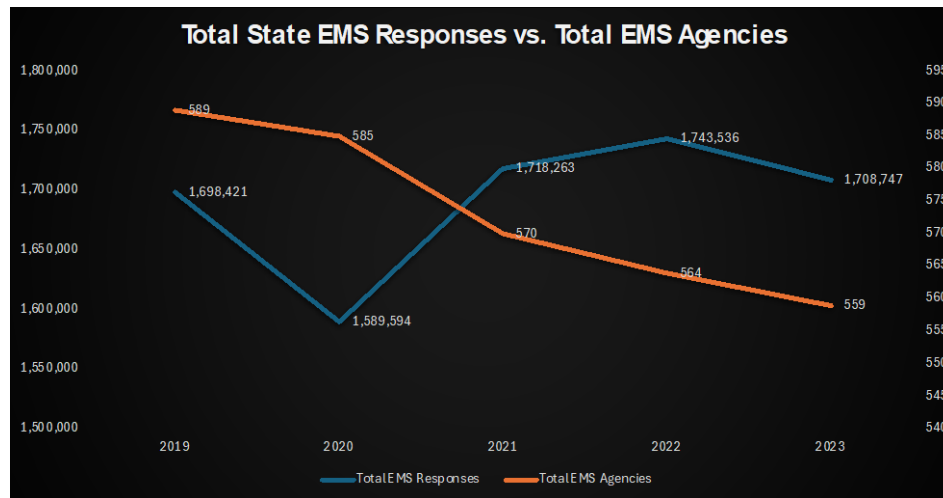
Figure 3: EMS Response Data

Years	Total Emergency Responses	Total Non-Emergency Responses	Total EMS Responses	Percent Change from 2017
2017	1,121,273	292,312	1,413,585	
2018	1,159,293	412,116	1,571,409	11.16%
2019	1,204,619	493,802	1,698,421	20.15%
2020	1,139,957	449,637	1,589,594	12.45%
2021	1,300,001	418,262	1,718,263	21.55%
2022	1,356,210	387,326	1,743,536	23.34%
2023	1,335,764	386,810	1,708,747	20.88%

Again, the data was aggregated by OEMS, and FITCH did not receive the raw data for independent analysis.

The EMS responses relative to the number of agencies show that critical issues emerged between 2020 and 2021.

Figure 4: EMS Responses Vs. Total EMS Agencies



FITCH would have compared provider numbers against call volume, but OEMS does not track active versus inactive providers, which could impact the analysis.

The figure below shows the average number of EMS providers by certification type.

Figure 5: Number of EMS Providers by Certification Type

Certification	2017	2018	2019	2020	2021	2022	2023	Change	% Change
Total Providers	34952	35518	36187	36471	36663	37217	37726	2774	7.9%
EMR	775	710	649	594	512	442	435	(340)	(43.9%)
EMT	22855	23353	23856	23956	24144	24616	25264	2409	10.5%
Advanced EMT	2027	1931	1995	2121	2227	2335	2406	379	18.7%
Intermediate	2883	2760	2521	2348	2146	1983	1815	(1068)	(37.0%)
Paramedic	6413	6764	7165	7543	7585	7843	8241	1828	28.5%

The decision to stop certifying at the Intermediate level resulted in a 37% decrease in certified personnel, with 1,068 Intermediate providers' status remaining unclear—whether they obtained another EMS certification or left EMS entirely. Additionally, OEMS does not track active versus inactive providers. FITCH evaluated the provided data and noted discrepancies within the information from the ACE Division EMS portal.

Figure 6: EMS Portal Provider Data Discrepancy

Certification	2017	2018	2019	2020	2021	2022	2023	Change	% Change
Total Providers	34953	35518	36187	36562	36614	37219	38161	3208	9.1%
Discrepancy	1	0	0	91	-49	2	435	434	1.2%

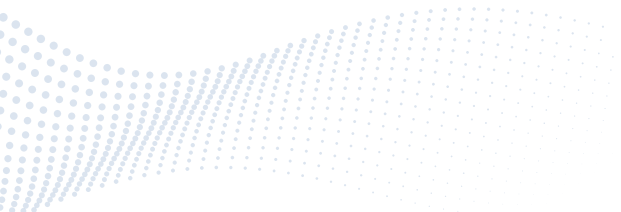
The 1.2% overall difference is concerning because the ACE Division promotes the EMS portal system as the primary and most accurate repository for all Accreditation, Certification, and Education data.

A data request was submitted to the ACE Division to address concerns raised in meetings regarding the difficulty of obtaining Education Coordinator certification for the Education and Ancillary levels. The table below displays the number of Education and Ancillary providers.

Figure 7: Number of Education and Ancillary Providers

Certification	2017	2018	2019	2020	2021	2022	2023	Change	% Change
ALS Coordinator	120	99	83	75	69	53	45	(75)	-62.5%
Education Coordinator	572	605	595	655	686	725	731	159	27.8%
Emergency Ops. Inst.	81	50	70	68	91	128	103	22	27.2%
EMS Physicians	225	228	222	221	224	225	224	(1)	-0.4%

The table shows a 27.8% increase in Education Coordinators from 2017 to 2023, adding 159 more in the Commonwealth. In contrast, ALS Coordinators saw a 62.5% decrease due to the sunseting of this certification and the introduction of the Education Coordinator level.



Financial Review

Financial Discrepancies Discovered

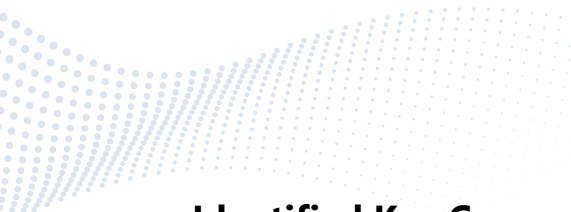
In mid-2023, VDH and OEMS identified \$33 million in financial discrepancies caused by overspending, poor fiscal management, and fraud. As a result, funding for all but essential obligations, such as payroll, was frozen, severely impacting programs like the Rescue Squad Assistance Fund (RSAF) and Return to Locality (RTL) program. The EMS Next Steps Workgroup was formed to assist in prioritizing and managing OEMS payments.

An extensive investigation followed. The Office of Internal Audit was tasked with auditing OEMS financial records, and VDH assigned a new Business Manager to assess the situation and help stabilize finances. However, the leadership structure in OEMS remained unchanged at that time.

FITCH identified key causes:

- Years of minimal Virginia Department of Health (VDH) oversight
- Lack of internal policies, financial controls, and adherence to procurement policies
- Absence of modern accounting or financial management software
- Challenges with Manual Financial Tracking and Invoice Management
- Use of Regional Councils to circumvent procurement policies
- Escalating costs of the Virginia EMS Symposium
- Funding to struggling Regional Councils by OEMS
- Hybrid Regional EMS Councils Model adds cost and disparity
- Unfunded mandated programs
- Expansion of EMS Advisory Board costs
- Expensive facilities and assets
- A fixed revenue mechanism unable to accommodate normal expenditure increases

Governor Youngkin and the Legislature allocated \$33 million over two years to address debts and over-obligations. However, FITCH now projects that the \$33 million additional allocation will be insufficient to cover all debts and obligations over the two-year period without significant changes. Additionally, after this two-year period, if no changes occur within OEMS, the significant annual shortfall will continue.



Identified Key Causes

Years of Minimal Virginia Department of Health (VDH) Oversight

OEMS operated mostly independent for years with minimal oversight from the VDH, leading to unchecked spending and financial decisions that were not in the best interest of the organization or the public. Before current leadership uncovered years of overspending, there was little focus on reallocating funds, implementing checks and balances, or scrutinizing expenditures. Previous internal audits showed minimal improvement, and corrective actions were neglected. This lack of oversight, coupled with absent or unethical management, compromised the financial integrity and efficiency of OEMS, resulting in wasted resources that could have been better allocated to essential services, equipment, and training, ultimately undermining its mission.

Lack of Internal Policies, Financial Controls, and Adherence to Procurement Policies

FITCH's evaluation uncovered serious deficiencies in OEMS's financial governance, including a lack of controls that heightened the risk of overspending and fraud. FITCH and VDH discovered the absence of internal guidelines and policies for financial controls, raising concerns about compliance with Commonwealth procurement standards. Contracts with Councils were modified to bypass procurement policies, such as the \$6 to \$9 million ESO⁴ contract through the Western EMS Council.⁵ Additionally, spending approvals were concentrated in single points, and invoices were not properly matched within the Commonwealth's accounting system to ensure funds were spent on approved and budgeted items.

In response, VDH and FITCH implemented comprehensive reforms to enhance transparency, accountability, and efficiency. Key measures included establishing internal policies for financial discipline, instituting monthly financial review meetings, and enforcing rigorous internal controls to monitor transactions and prevent unauthorized spending. The policy framework also required multiple approvals for significant expenses, ensuring a robust system of checks and balances.

Challenges with Manual Financial Tracking and Invoice Management

The Commonwealth uses a centralized accounting system for the government; however, at the agency level, leadership is reliant on spreadsheets to track finances to monitor revenues and expenditures. VDH and OEMS leadership now meet daily to review financial positions and allocate resources, but this process is hampered by the limitations of manually updated Microsoft Excel spreadsheets, creating

⁴ Patient care reporting system

⁵ The ESO contract was entered into with no clear understanding of the final cost with the relationship. The terms of the agreement allowed for agencies across the commonwealth the option to join. The range for total cost depended on the number of agencies that chose to join the contract as the OEMS committed to paying for all of these agencies to join, there was no accurate forecast on the cost to the Commonwealth.



transparency issues. FITCH found 527 unpaid invoices within the first week of this engagement and worked with VDH, OEMS, and the EMS Next Steps Workgroup to document and prioritize payments. This manual approach slows decision-making, increases the risk of human error, invites fraud, and lacks the audit trails provided by modern financial software, complicating the tracking of changes and the rationale behind financial decisions. As of this report, OEMS is up to date with its invoice tracking.

Use of Regional Councils to Circumvent Procurement Policies

OEMS operates under the regulatory constraints imposed by the Commonwealth, whereas the 11 EMS Councils function as 501(c)(3) nonprofit entities with contractual relationships with OEMS. This structural arrangement provided OEMS with the opportunity to bypass the stringent Commonwealth procurement policies.

To leverage this setup, OEMS utilized existing contracts with the Councils, which were initially established for operational collaborations and base funding. By amending these contracts, OEMS transferred purchasing responsibilities to the Councils, effectively allowing it to improperly sidestep the Commonwealth's procurement regulations. This indirect procurement strategy enabled OEMS to acquire specific items and services through the Councils, thus avoiding the procedural and approval constraints typically enforced within the Commonwealth's procurement framework.

Items and services procured through this method included:

- Symposium and associated expenses
- ESO software, a data repository and patient care reporting system, costing \$6 to \$9 million
- Information technology security and project implementation
- Costs associated with the Hybrid Council model, covering labor, materials, and infrastructure
- Vector Training
- Blackboard

While this approach allowed OEMS to meet its procurement needs, it also circumvented formal regulatory oversight, potentially leading to issues with the proper allocation of funds to cover associated costs.

Escalating Costs of the Virginia EMS Symposium

Established in 1980, the Virginia EMS Symposium evolved into a major event for EMS training, providing educational sessions, workshops, and networking opportunities for professionals across Virginia and beyond. However, the Symposium was predominantly paid for through the Western EMS Council, and costs rose, surpassing \$1.6 million in 2022.



OEMS financial challenges uncovered in 2023 led to the cancellation of the Symposium. In its absence, Regional EMS Councils and Health Care organizations developed local symposiums to provide continuing education. These smaller, localized events were often valued more than the larger statewide symposium, highlighting the effectiveness of targeted regional training. Despite this, the value of convening EMS thought leaders in a single location remained significant.

The situation highlights the need for localized educational events and regional leadership meetings to foster collaboration and peer learning. Continuing virtual training is also essential for supporting EMS providers. The Commonwealth should continue supporting local training and education initiatives as opposed to the larger Symposium model.

Funding to Struggling Regional Councils by OEMS

The Regional EMS Councils were established as independent bodies with self-reliant financial resources to address local EMS needs and ensure high-quality service through innovation, oversight, and strategic planning in their respective regions. However, funding reductions from various EMS agencies, local communities, and supportive programs created significant operational challenges, leaving many Councils struggling to maintain service quality.

In response, OEMS stepped in to provide direct financial support with annual allocations ranging from \$229,273 to \$654,618 per Council, reflecting their varied needs, operational scales, and Council type. Traditional Councils receive base funding from agencies, localities, and the Commonwealth, while Hybrid Councils receive additional personnel and infrastructure funding from the Commonwealth. This funding range below does not include "pass-through" funds for specific projects, special grants, or other financial assistance, which are handled separately. This is representative of the Commonwealth's cost to support the 11 Regional Councils.

Figure 8: Annual Cost of Regional EMS Councils

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

The table excludes special add-on projects like ESO, Symposium, Regional IT, and Scholarships. The listed add-ons pertain only to specific positions (e.g., Medical Director, Administrative Assistant, QA/QI).

Hybrid Regional EMS Councils Model Add Cost and Disparity

In 2019, the OEMS established a strategic partnership with four Regional EMS Councils due to their inadequate financial resources. This collaboration provided OEMS staffing, educational funding, operational costs, and infrastructure support. However, it led to funding disparities among the 11 Councils resulting in tension and perceived inequalities.

A FITCH review revealed differences in funding across Regional EMS Councils. Contributions from EMS agencies and municipalities varied widely, with some regions allocating RTL funds to support their Councils, while others provided what they could afford. Many agencies reported insufficient value from these arrangements or believed they could manage independently, thus reducing or forgoing future payments to Councils.

To ensure fiscal accountability and transparency, it is recommended that future Commonwealth allocations to Regional EMS Councils include provisions for audits at any time during the contract period. Additionally, FITCH recommends that each Regional EMS Council conducts an annual internal financial



audit, with findings submitted to the OEMS. This policy aligns with practices used by organizations like the VCU Health System in Richmond, Virginia.⁶

Unfunded Mandates

Over the years, the OEMS has expanded its functions to include Trauma Fund Management, E911 Dispatch accreditation, Community Health and Technical Resources (CHaTR), and Emergency Preparedness. These expansions were often undertaken without securing long-term funding, leading to the implementation of legislatively mandated programs without a clear financial strategy. As a result, the added costs of managing new programs have exceeded the office's budget.

For example, the annual operational costs of Trauma Fund Management have escalated to \$500,000 without a corresponding budget increase. This situation underscores the importance of financial planning and sustainability in public services, where program expansion is driven by legislative mandates rather than economic viability. Effective financial oversight is essential to ensure that service expansions are adequately funded and do not compromise organizational stability.

EMS Advisory Board Expansion Cost

The EMS Advisory Board (EMSAB) has expanded to 28 members across 21 specialized subcommittees. The OEMS traditionally covered all essential expenses for members to attend quarterly meetings in Richmond, including travel, accommodations, conference room leases, and meals. By 2023, these costs exceeded \$400,000 annually, raising concerns about budgetary pressures and fiscal responsibility.

In response, VDH implemented strategic cost-reduction measures, cutting the annual meeting expenses to just over \$150,000. However, this reduced amount remains a significant budget item, requiring ongoing scrutiny to ensure that spending directly enhances the quality and efficiency of emergency medical services. VDH continues to explore additional strategies to ensure that resources are allocated to serve the public's best interests, including virtual meetings and the reduction of EMSAB membership.

⁶ **State Code:** The Code of Virginia mandates that certain public institutions and entities, including VCU Health System, must have their financial statements audited annually. For example, Section 23.1-306 of the Code of Virginia requires the financial statements of public institutions to be audited annually by the Auditor of Public Accounts or a certified public accountant.

Contracts: Specific contracts between VCU Health System and state agencies may also include clauses requiring annual financial audits. These contracts are typically structured to ensure transparency and accountability, aligning with state requirements.



Expensive Facilities and Assets

The OEMS, located in Glen Allen, Virginia, occupies a large, costly office space. The OEMS also leases and maintains other facilities. In total, the annual leasing and maintenance expenses exceed \$500,000. To reduce costs, VDH should consider relocating the OEMS to a shared facility with other VDH programs at the central office or co-locate with other Commonwealth entities. This move could significantly cut expenses and improve financial oversight.

The OEMS also manages an extensive fleet, including vehicles and ATVs, which has raised concerns regarding its alignment with the OEMS's coordination role. A fleet review will enhance resource allocation and efficiency. Despite previous VDH efforts, progress in reducing the fleet has been limited, highlighting the need for renewed focus on downsizing and optimization.

A strategic evaluation of both the office space and fleet management will yield substantial cost savings, better resource utilization, and improved operational efficiency. This requires a concerted effort to critically assess current practices and embrace changes that promote fiscal responsibility and effective public service.

Fixed Revenue Mechanism Unable to Accommodate Normal Expenditure Increases

Over a decade ago, the Four-for-Life program was established to support the OEMS by earmarking \$4.00 from each vehicle registration fee collected by the DMV exclusively for EMS funding. This was later increased to \$6.25 to meet growing demands. However, this funding remains tied to the original budget structure, which does not account for changes in the Consumer Price Index (CPI). As a result, the fixed nature of this funding is increasingly misaligned with rising costs, leading to over-expenditure and threatening the long-term sustainability of EMS programs.

The disparity between static funding and escalating costs highlights the need for a more adaptive funding model. Future OEMS funding must consider the dynamic economic environment, including inflation, to ensure EMS services can continue to meet community needs effectively. A model that adjusts for CPI and accommodates the expanding demands on EMS infrastructure would better sustain robust and responsive services, upholding the Commonwealth's commitment to public health.

Virginia State Police Med-Flight

The Virginia State Police (VSP) initiated air medical operations in 1987 with two helicopters serving Central and Southwest Virginia, facilitating rapid transport for critically injured patients. The Med-Flight program, while operating as a first-right-of-refusal service, is not always the closest due to legacy response protocols and differing billing practices. The Office of Emergency Medical Services (OEMS) allocates \$3.1 million annually to Med-Flight, with \$2.05 million from DMV funds and over \$1 million from

RSAF grants, which reduces available EMS agency grants. In FY 2026, an estimated \$1.3 million will be reallocated from trauma center funding to Chesterfield County for Med-Flight staffing as a result of language in the Appropriations Act signed.

Given the increase in helicopter EMS providers since Med-Flight's inception, the Virginia Department of Health (VDH) and stakeholders should reevaluate the funding structure. Specifically, the allocation of DMV, RSAF, and trauma center funds to Med-Flight warrants review to determine if it remains justified. Figures 9 and 10 illustrate the coverage areas of VSP Med-Flight helicopters and all licensed air medical helicopters, respectively, highlighting service distribution and geographical overlap.

Figure 9: Air Ambulance Locations

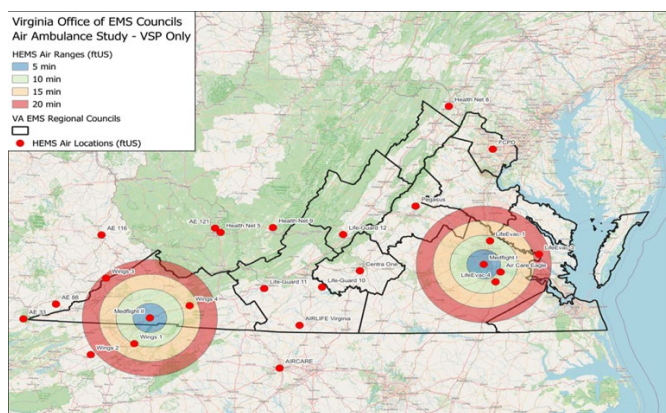
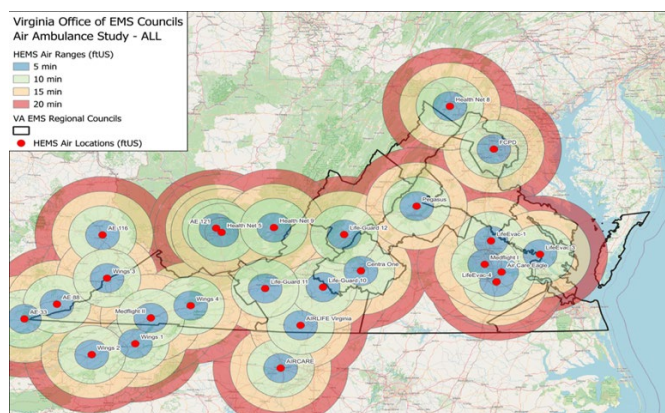


Figure 10: Air Ambulance Coverage



Review of Budgetary Actuals and Associated Expenditures

FITCH collaborated with both VDH and OEMS leadership to assess its financial performance and viability. The evaluation was hindered by insufficient documentation and policies. Additionally, OEMS had neglected accounts payable tasks for an unspecified period, complicating the financial assessment. This lack of information impeded FITCH's ability to fully grasp the financial challenges during their consultancy.

Complications also arose from how Regional EMS Councils managed expenditures, often categorizing purchases as "pass-throughs" rather than properly classifying them as OEMS expenses. This practice, combined with inadequate record-keeping, made it difficult for FITCH to accurately identify these transactions. Proper classification under "Cost to Run OEMS" would have provided a clearer picture of operational costs. The OEMS operates with an annual budget of \$56 million, with \$50.6 million allocated as pass-through funds for various programs. Total annual expenses, including salaries, amount to \$7.8



million, resulting in a \$2.4 million deficit. VDH and OEMS are projecting for Fiscal Year 2025 a deficit of \$6 million.

In clarifying the financial breakdown, FITCH divided the expenses further to outline how funds are allocated and for which specific programs. It was found that an annual expenditure of \$5.619 million within these pass-through dollars was allocated to Council funding but should be accounted for as a direct cost of running OEMS. Therefore, when considering both figures, the total annual operating cost of the OEMS is \$13.4 million, not \$7.8 million.

Revenues are Fixed and Inadequate

Analysis has shown that current revenues are insufficient to sustain the current OEMS operating mode. The primary revenue source for OEMS is based on Department of Motor Vehicles (DMV) vehicle registration fees. However, DMV revenue has remained flat for many years. This funding mechanism allows no annual adjustments for cost-of-living increases, additional mandates, or new programs.

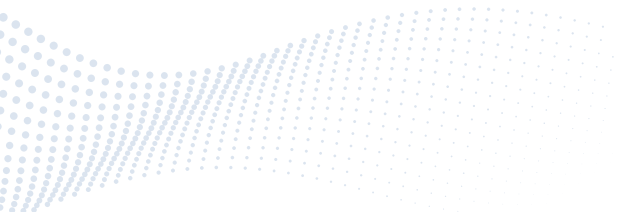
The growing gap between fixed funding and escalating costs throws into sharp relief the necessity for a more adaptive funding strategy. Future considerations for funding OEMS must consider the current dynamic economic environment. An ideal model would reflect the current inflation rate and accommodate the expanding needs of the EMS infrastructure.

Expand Funding for Agencies and Workforce Development of Providers

VDH and the Commonwealth must develop a more robust financial strategy for distributing OEMS funds, ensuring precise and sufficient allocation to EMS agencies and regions. This strategy should address key concerns such as the need for more providers and the replacement of aging equipment.

Nationwide, EMS services face financial strain as operating costs exceed revenues from Medicare, Medicaid, and private insurance. This has forced local agencies to consider cutting coverage, reducing services, or even shutting down, placing the financial burden on municipalities and healthcare institutions. In Virginia, this has led to a 12% decrease in private EMS agencies and an 18% decrease in community and non-profit agencies, while hospital-based EMS agencies have increased by 50%.

Investing in workforce development and assets could greatly benefit the Commonwealth by expanding EMS coverage and addressing the critical shortage of EMTs, notably in the Southwestern region with a 27% reduction. Expanding the RSAF (Rescue Squad Assistance Fund) to include private and for-profit entities would ensure equitable access to funding and enhance service availability across all EMS services. Additionally, the program should ensure funds are distributed across diverse communities to provide equitable opportunities. This inclusive approach is crucial for sustaining and growing the EMS system, leading to a more resilient infrastructure.



Recent Interventions

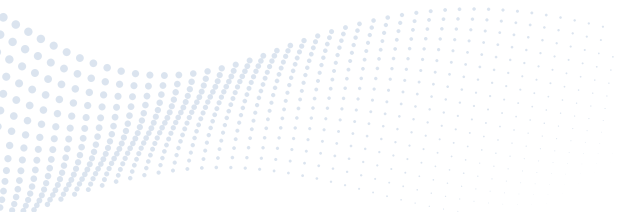
Recent Interventions by VDH and FITCH Regarding OEMS Financial Oversight

Following the discovery of financial issues by VDH and in partnership with FITCH, several corrective measures are being implemented to improve fiscal oversight. Daily and monthly financial reviews have been introduced to ensure continuous monitoring and accountability, providing greater transparency and early detection of discrepancies. Additionally, contracts previously managed by Regional EMS Councils are being transferred back to OEMS or discontinued, centralizing control and streamlining operations.

The previous OEMS Director had 11 direct reports, leading to an unsustainable span of control and disorganized Council reporting. To improve oversight, communication, and accountability, VDH and FITCH restructured the reporting system, adding three Deputy Directors under the OEMS Director, creating a more manageable span of control.

To strengthen financial integrity, comprehensive policies, workflows, and control systems have been established, supported by the appointment of a dedicated Business Manager to help with the fiscal analysis to address irregularities and support ongoing financial operations. VDH and OEMS have also appointed a new Business Manager to oversee financial operations and implement best practices. The OEMS structure has been reorganized, with a Deputy Director now overseeing the Business Manager and optimizing grant funding processes, ensuring a strategic focus on financial management.

A key contractual adjustment includes the renegotiation of the \$9 million ESO contract, which will now be managed directly by OEMS for better alignment with organizational goals. The appointment of the Business Manager in April 2024 further reinforces OEMS's commitment to sustainable financial practices, setting a foundation for transparency, efficiency, and effective resource management.



Pathway Forward

Overview

The pathway forward for the Commonwealth of Virginia, as outlined by FITCH, includes several crucial decision categories that are summarized by:

1. Improve EMS governance, including best practices
2. Immediate and midterm actions for consideration
3. Long-term strategies for improved operations and sustainability
4. Ensuring Continuity in Political Transitions

FITCH recommends options that address potential legislation, regulatory, structural, employee, and funding implications to tackle identified challenges. Given the stakeholders and system complexities, a broad, incremental strategy is essential to facilitate necessary adjustments. Complex issues are best addressed through careful, planned solutions that allow for execution and performance assessment.

Improve EMS Governance

The governance of the OEMS involves the leadership and oversight ensuring the efficient operation of Virginia's statewide EMS system. The OEMS sets the system's direction, establishes goals, and collaborates with regional councils to coordinate efforts. It is responsible for developing and enforcing standards for EMS personnel, training, and equipment to maintain consistent care quality, as well as managing funding and resource allocation for EMS agencies.

The Pillars of Effective EMS Governance

A well-functioning EMS system relies heavily on a robust governance framework. This framework should be built upon several key pillars including:

- Transparency and Accountability
- Strong Leadership and Oversight
- Collaboration and Stakeholder Engagement
- Legal and Regulatory Framework



Transparency and Accountability

Transparency and accountability are critical to a trustworthy EMS system. Key practices include publishing detailed budgets, reporting performance variances, and sharing expenditure reports. Open communication with stakeholders, such as through public meetings, websites, and social media, ensures clarity and accessibility. Independent audits further demonstrate fiscal responsibility.

Data sharing enhances transparency by providing performance metrics, including response times, survival rates, and protocol adherence. This promotes public trust, encourages engagement, and supports informed oversight.

Accountability is achieved through clear decision-making processes, published protocols, and performance monitoring against benchmarks. A system for reporting concerns ensures ethical standards and continuous improvement. Accountability fosters consistent care delivery, responsible resource use, and system enhancements.

Together, transparency and accountability build trust, engage stakeholders, and ensure high-quality EMS services through responsible governance and effective resource management.

Strong Leadership and Oversight

Effective OEMS governance relies on strong leadership and robust oversight mechanisms. Leaders must combine EMS expertise with management skills, including operations, clinical care, logistics, and system administration. They must also demonstrate the ability to lead and motivate a diverse team, communicate a long-term vision, and address emerging challenges.

High ethical standards are essential, with leaders promoting transparency, accountability, and responsible resource use. Effective oversight, such as through the Virginia State EMS Advisory Board, is crucial. The board should include independent stakeholders with expertise in EMS operations, finance, legislation, and regulation, providing objective policy advice and performance reviews.

Additional oversight mechanisms, including internal controls, clear spending procedures, and regular internal and external audits, help prevent mismanagement. Strong leadership and oversight ensure the EMS system is aligned with the needs of the Commonwealth, prioritizes high-quality care, and fosters public trust through evidence-based practices and resource efficiency.

This pillar of strong leadership and oversight provide clear direction, operational efficiency, and a focus on continuous improvement in EMS governance.



Collaboration and Stakeholder Engagement

Collaboration and stakeholder engagement are vital to effective EMS governance, promoting shared responsibility and informed decision-making. Within the EMS system, collaboration among public, private, and volunteer agencies ensures unified protocols and efficient resource use. Cooperation between EMTs, paramedics, dispatchers, and medical facilities enhances seamless patient care and communication.

Beyond the EMS system, partnerships with public health departments align EMS with broader health goals, while collaboration with emergency management agencies integrates EMS into preparedness and response plans. Stakeholder engagement, involving EMS personnel, community leaders, and citizen advocacy groups, ensures the system is responsive and accountable to diverse community needs.

The benefits of collaboration include a shared vision, coordinated efforts, and data-driven resource allocation. Open communication fosters trust, promotes best practices, and enhances public confidence in the EMS system.

Legal and Regulatory Framework

A robust legal and regulatory framework is essential for effective EMS governance, ensuring public safety and consistent high-quality care. State laws provide clear guidelines on licensing requirements for EMS agencies, personnel, and vehicles, defining scope of practice for various EMS roles and establishing equipment standards. Data reporting requirements mandate tracking performance metrics like response times and patient outcomes for continuous improvement.

Federal oversight, including National Highway Traffic Safety Administration (NHTSA) standards for ambulance design and Centers for Medicare & Medicaid Services (CMS) regulations for services under Medicare and Medicaid within the U.S. Department of Health and Human Services (HHS), complements state laws. Effective enforcement mechanisms include regular inspections, investigations of misconduct, and sanctions such as fines or license suspensions.

This framework ensures qualified personnel, uniform care standards, and accountability across EMS agencies. Balancing regulatory requirements with affordability and allowing for innovation ensures the framework remains adaptable and cost-effective while maintaining safety and care standards. A comprehensive legal structure supported by enforcement promotes a reliable and high-quality EMS system.



Other Governance Considerations

Quality Improvement and Innovation: Implement systems for continuous data collection and analysis of EMS performance metrics to identify improvement areas. Adopt new technologies, training methods, and operational strategies to enhance EMS effectiveness and efficiency.

Workforce Development and Training: Set clear training standards for EMS personnel and support ongoing professional development to ensure high-quality care and up-to-date skills.

Sustainability and Resource Management: Develop a sustainable funding model and optimize resource allocation, including personnel support and assets, to effectively meet community needs.

Integrating these focus areas with transparency, accountability, leadership, collaboration, and legal frameworks will strengthen EMS governance, ensuring high-quality, adaptable care and continuous improvement.

Immediate and Midterm Actions for Consideration

To enhance efficiency and effectiveness within OEMS, the following immediate and midterm interventions are recommended:

Organizational and Staffing Adjustments:

- Eliminate OEMS staff from non-essential committees
- Consider eliminating non-essential committees
- Refocus regulation and compliance on customer service
- Reduce EMSAB size and hold virtual meetings

Operational and Financial Revisions:

- Cut unnecessary expenses for EMSAB services and accommodations
- Move from spot to scheduled inspections
- Suspend strategic plan work until execution clarity is achieved
- Deploy updated financial software for improved financial management.

Structural and Functional Reviews:

- Assess communication technology roles in Emergency Operations Plans (EOP) and potential duplication with other state agencies

- Explore transferring EOP functions to entities like VDEM or VDH's Office of Emergency Preparedness
- Evaluate potential downsizing of the CHaTR Program
- Consider American College of Surgeons (ACS) designation rather than in-house designation

Contractual and Cost Evaluations:

- Review and renegotiate Council contracts to reduce costs and specify performance outputs
- Assess and potentially renegotiate or terminate vendor contracts, including the ESO ePCR contract
- Evaluate the feasibility of relocating the epidemiological team within VDH
- Determine the legality of Hybrid Councils and renegotiate traditional Councils if necessary

Long-term Strategies for Improved Operations and Sustainability

FITCH has identified five primary decision points for the Commonwealth to consider improving operations and ensuring long-term sustainability. These points offer options and action items for enhancing service delivery from OEMS to EMS agencies and providers, aiming to better serve residents and visitors. The decision points include:

1. OEMS Positioning for Strong Oversight
2. Regional Structure and Support
3. Policy and Regulatory Process Review
4. Community Input and EMS Oversight Enhancement
5. Education, EMS Portal, and Department Functions

Decision Point 1: OEMS Positioning for Strong Oversight

The Office of Emergency Medical Services (OEMS) currently operates under the Virginia Department of Health (VDH). However, with the evolving EMS landscape—marked by increased involvement of fire departments in EMS transport, hospitals managing patient transport, and emerging community paramedicine and public health roles—the optimal placement of the OEMS within the state government warrants reevaluation.

The EMS Agenda 2050 envisions a transformative future where EMS is a people-centered, community-based health management system, seamlessly integrated with the broader healthcare infrastructure. This future EMS model will not only manage acute care and chronic conditions, but also enhance community health and optimize resource use, reinforcing EMS as a vital safety net.

Figure 11: EMS Agenda 2050 Framework



Given these developments and the framework outlined by EMS Agenda 2050, there is a critical need to evaluate whether the OEMS's alignment with VDH is still appropriate or if reorganization under the Public Safety Secretariat might be more beneficial. Four potential options for restructuring the OEMS are presented for consideration, each with implications for legislative action and future operational effectiveness.

Option 1: Remain within the Virginia Department of Health

The Virginia Department of Health (VDH) oversees a broad range of healthcare entities across the Commonwealth, including the Office of Emergency Medical Services (OEMS). VDH's existing advisory board, which includes numerous subcommittees, supports both the department and OEMS, facilitating valuable feedback and collaboration.

VDH's alignment with various healthcare partners positions it well for addressing public health emergencies, emergency preparedness, and mass casualty situations. Given this integration, it would be advantageous for OEMS to remain within VDH. Enhancing stakeholder alignment by incorporating more public safety representatives on the EMS Advisory Board (EMSAB) could further improve coordination with community partners.

VDH has made considerable progress toward financial accountability and transparency within the OEMS with the full support and buy-in from VDH senior leadership. Adjusting the reporting structure of OEMS at this time may upset further progress towards those goals.



Considering the findings from recent surveys and the goals outlined in EMS Agenda 2050, FITCH recommends maintaining OEMS within VDH to support the evolving role of EMS within the broader healthcare continuum.

Legislative Action Required: None.

Option 2: Establish a Department within the Public Safety Branch of the Government

The Emergency Medical Services (EMS) industry plays a crucial role in public safety, handling over 1.3 million emergency responses annually within the Commonwealth. In addition to emergency responses, EMS manages hospital transfers and over 350,000 non-emergency requests each year.

Reorganizing the Office of Emergency Medical Services (OEMS) under the Department of Public Safety could enhance synergy with existing public safety agencies such as the Virginia Department of Fire Programs, Virginia Department of Emergency Management, and the Virginia State Police. This realignment could streamline coordination and oversight, potentially improving operational efficiency.

However, challenges include ensuring adequate engagement from the Public Safety Branch, which is already heavily involved in various activities. There would be a need to establish appropriate administrative codes, regulations, and policies to ensure consistency and effectiveness with changes in leadership.

Legislative Action Required: Yes, to transition OEMS from VDH and establish it as a new Department of EMS within the Public Safety Branch of government.

Option 3: Merge with the Virginia Department of Fire Programs (VDFP), creating a new Virginia Department of EMS & Fire Programs

In recent years, Fire Departments have significantly expanded their role in providing EMS transport services, surpassing fire-related activities in volume. Fire Departments now manage the majority of emergency 9-1-1 responses, highlighting their critical role in EMS.

Currently, the Virginia Department of Fire Programs (VDFP) primarily functions as a funding mechanism for fire education and certification but does not handle regulatory or compliance activities. Merging the Office of Emergency Medical Services (OEMS) with VDFP could streamline and consolidate services, particularly in education and training, reducing duplication and enhancing consistency for providers.

However, this merger would require VDFP to expand its scope to include regulatory and compliance functions, a significant shift from its current role. Additionally, merging the two entities could impact



funding management and necessitate a comprehensive review of legal and financial implications. Implementing this option would likely be complex and time-consuming.

Legislative Action Required: Yes, to consolidate OEMS with VDFP and establish a new Virginia Department of EMS and Fire Programs within the Public Safety Branch of government.

Option 4: Dissolve the OEMS completely, parsing the various regulatory requirements to other agencies.

This option is the most complex and involves redistributing the responsibilities of the Office of Emergency Medical Services (OEMS) to various existing agencies. Functions currently managed by OEMS overlap with several other entities within the Commonwealth of Virginia (COV), including:

- **Department of Health Professions (DHP):** Since DHP certifies nearly all medical practitioners in the state, transferring EMS certification responsibilities to DHP would be logical.
- **Virginia Department of Fire Programs (VDFP):** VDFP, which manages funding and education for fire services, could assume financial processing responsibilities for RSAF and RTL, aligning with its existing functions.
- **Virginia Department of Health (VDH):** VDH's Office of Licensure and Certification, which oversees hospital licensing, could be extended to handle trauma center designations. Additionally, VDH's other funding departments could manage trauma fund distribution.

While this option might streamline operations by integrating EMS functions with related agencies, it has significant drawbacks. EMS may lose visibility at higher government levels, which could affect future funding opportunities and impede growth. Moreover, the reorganization could cause confusion among EMS providers and agencies regarding which state entity to approach for various issues.

Legislative Action Required: Yes, to dissolve OEMS and reallocate its functions to other departments.

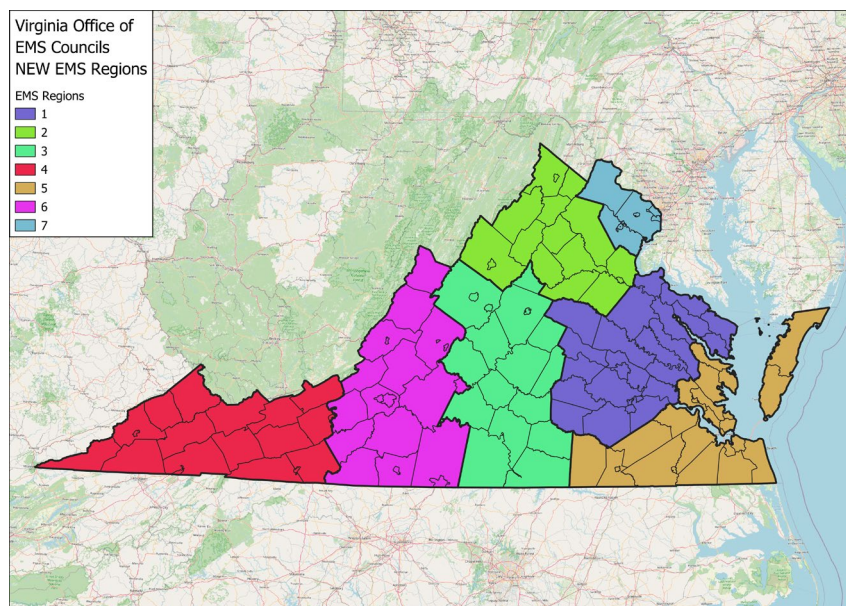
Decision Point 2: Regional Structure and Support

Virginia's EMS landscape is diverse, encompassing various community types and organizations, including volunteer, municipal, non-profit, for-profit, and federal entities. The centralized location in Richmond may not fully address the unique needs of different regions.

Currently, the Department of Emergency Management, State Police, and Virginia Department of Fire Programs operate across seven regions. However, more regions exist for Regional EMS Councils, as defined by legislation and budgetary documents. To improve efficiency and coordination, it is

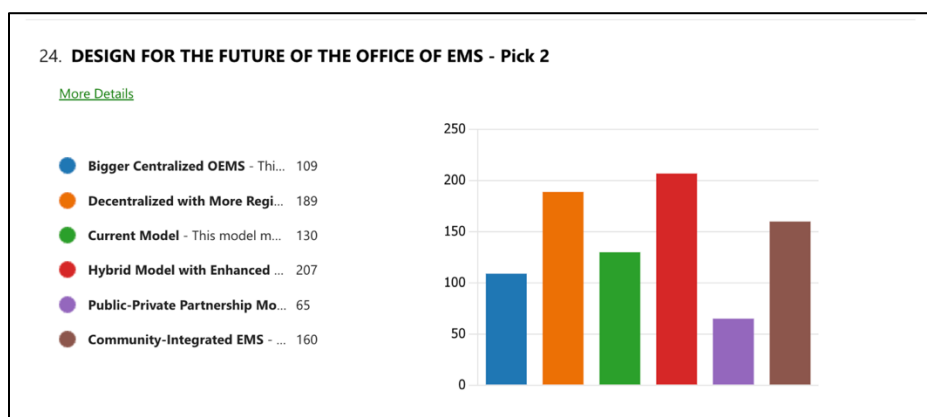
recommended to restructure Virginia's EMS system into seven regions. This alignment with existing state departments and regions aims to enhance strategic planning, streamline funding, and improve service coordination. The reorganization is expected to ensure consistent interactions with EMS agencies, achieve cost savings through shared staffing, and enhance overall service delivery.

Figure 12: Proposed EMS Regions



Legislative Action Required: Budget language must be struck 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.

Figure 13: Survey Question 24 “Design for the Future of the OEMS”





FITCH has outlined two main options to improve the OEMS and Regional EMS Councils based on stakeholder feedback, which favors increased regional support and reduced central oversight.

Option 1 proposes a Decentralized structure, which emphasizes increased regional support by utilizing all state staff members within the regions. Option 2 suggests an integrated model, granting enhanced local autonomy by involving non-state staff. Both models shift responsibilities and resources to regional entities. Additionally, the Community-Integrated EMS Model advocates for deeper collaboration with public health, healthcare, and public safety partners to better integrate EMS into the broader community.

These three models—Decentralized, Integrated, and Community-Integrated—account for 65% of stakeholder preferences, underscoring the need for a flexible structure to adapt to evolving EMS requirements.

Option 1: Decentralized Structure, More Regional Support, All State Staff

The decentralized model enhances regional support by allocating more authority and decision-making to local regions while keeping staff as state employees. This approach leverages local expertise to address community-specific challenges, ensuring that those closest to the issues are involved in the solutions. The arrangement maintains state employment standards and benefits while allowing for tailored regional service management.

Under this model, FITCH proposes restructuring OEMS to align with its core mission by positioning necessary resources in seven distinct regions. Each region will be staffed with both an Education officer and a Compliance and Regulation officer, who will serve as the primary contact for EMS agencies. These staff members will collaborate with local advisory boards and medical directors' councils to coordinate support and address service needs.

The Regional Medical Director will have representation on the States Medical Advisory Committee, to ensure regional representation that is led by the State Medical Director. This representation will facilitate informed policy decisions on education, protocols, funding, and other local needs. There may be local Regional Boards or Councils that would be representative of the local agencies and work with the EMSAB to enhance the system.

While Regional EMS Councils may continue, they would no longer receive state funding. Instead, the state will assume the responsibilities for the new regional structure. State staff operating within the regions will be co-located with other state agencies, promoting coordination and cost efficiency through shared resources.



The responsibilities will be distributed as follows:

State Office:

- Support for the Medical Director and Regional Board or Council
- Development and maintenance of statewide protocols
- Oversight of data reporting and quality assurance
- Standardization of regulations and compliance
- Support for state-level education programs

Regions:

- Coordination and support for local education and training programs
- Assistance with regulation, compliance, inspections, and support for EMS agencies
- Support for local Medical Directors and regional boards or councils

Option 2: Integrated Model, Enhanced Local Autonomy, Non-State Staff

This model 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. Mixed staffing, with both state and local hires, would facilitate regional adaptability.

Under this structure, the state would establish an office focused on core mission areas, while collaborating with the Regional EMS Councils. The state would provide grants to these councils for specific activities, including staffing and service expectations. Each grant would outline positions, costs, expectations, and communication protocols.

Regional EMS Councils, which must operate as 501(c)(3) nonprofits or EMS agencies, would apply for these grants. The state would retain the right to audit funded entities to ensure compliance like the regulation in the agreement with the VCU health system. Each region would have an EMS Director, Education staff, and additional support staff, serving as local points of contact and extensions of the OEMS.

This model eliminates state employees within Regional EMS Councils, establishing clear lines of responsibility. Councils would be financially responsible for any activities beyond the grant's scope. Regional EMS Councils would have a Medical Director and advisory board, with representatives on the state's Medical Director and Regional Board to inform policy decisions on education and funding.



Responsibilities are allocated as follows:

State Office (State-funded):

- Support for the Medical Director and advisory board
- Development and maintenance of statewide protocols
- Oversight of data reporting and quality assurance
- Standardization of regulations and compliance
- Education program support

Regional EMS Councils (Grant-funded):

- Local education coordination and training
- Support for the local Medical Director and advisory board

Additional Considerations for Options 1 or 2: Community-Integrated EMS

The Commonwealth of Virginia should enhance the integration of EMS into local public health systems, moving beyond traditional emergency response roles to encompass broader health promotion and preventive care. This integration involves collaboration with public health, social services, and community organizations to provide a holistic approach to community wellness. According to the EMS Agenda 2050, EMS should be deeply embedded within the healthcare and public safety ecosystems, reflecting a shift towards proactive health management.

EMS personnel are increasingly involved in preventive measures, chronic disease management, and health education, reducing hospital admissions and supporting patient recovery through hospital-to-home programs. Their participation in public health initiatives, such as vaccine clinics, also enhances community health and trust. Despite these advancements, challenges remain due to historical barriers between the VDH and the OEMS, which have hindered seamless collaboration.

Addressing these challenges requires dismantling existing barriers and fostering continuous dialogue among stakeholders. An evolving EMS infrastructure must adapt to trends like community paramedicine and hospital-to-home care, ensuring adequate regulation, protocol adjustments, education, and funding to maintain high standards of care across the Commonwealth.

Legislative Action Required: Yes, redesign the OEMS to include only seven (7) regions and a decentralized office with either option presented.

Financial Considerations

FITCH conducted an extensive analysis to address the overspending issues faced by OEMS and identified potential cost-saving measures. The analysis involved a detailed review of current personnel costs and other expenses, with the goal of finding effective ways to reduce expenditures.

FITCH's review revealed a total expenditure of \$5,784,204 for 49 positions, encompassing both salary and fringe benefits. Based on this review, FITCH proposed three distinct staffing options to help 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.

FITCH reviewed current and projected personnel costs by analyzing a list of all OEMS compensated positions. Each existing role was compared to those in the proposed staffing models. Assumptions were made to assess the needs for each future option. The figure below outlines the future staffing options.

Figure 14: Options Staffing Details

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

FITCH estimates an annual personnel cost savings of \$1.89 to \$2.28 million from staffing reductions and reallocations. Key changes include:

- Trauma Program: Trauma program costs including staff, contractors for inspection teams, and another administrative burden, could be covered by the Trauma Fund. This would require legislative allowance.
- Epidemiology: Staff would be integrated into the VDH epidemiology team, eliminating costs for OEMS.
- Regional Educators: Seven regional educators would enhance the education department and local training efforts.
- Data/IT & Analytics: Ensure there are two IT staff assigned to OEMS to manage the EMS portal, departmental reports, and analytics.
- Regional Planning: Local and regional planners would support EMS system development and management.
- Program Representatives: Each regional office would have a representative for compliance and regulation duties.
- Regional Office Directors: Seven directors would serve as primary contacts for agencies and OEMS.

Figure 15: Estimated Personnel Cost Reductions

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)

FITCH conducted a budget review of OEMS to identify cost-saving opportunities. Although precise expenditure details were challenging to isolate due to invoice management issues, FITCH identified several areas for potential savings:

1. Regional EMS Councils: Reducing the number of Councils to seven could cut expenditures by approximately \$1.5 million annually.
2. Office Relocation: Moving OEMS from its oversized Glen Allen office to the VDH office in Richmond at the Madison Building and reducing lease and maintenance payments to regional councils could save approximately \$500,000 annually in lease and maintenance costs.
3. Staff Co-location: Regional staff could be co-located with VDEM, VDFP, or local health districts. If not feasible, placement with regional Councils or other agencies is a consideration.
4. Trauma System Costs: Covering site visit honorariums of approximately \$50,000 annually through the Trauma Fund or other sources could lead to direct savings.

5. ESO Contract Adjustment: Transitioning from a statewide ePCR to a NEMSIS data repository could reduce costs by up to \$4 million annually.
6. Med-Flight Program: Discontinuing or restructuring the Med-Flight program, which costs about \$3.07 million annually, could yield additional savings of \$2,052,723 and \$1,021,539 from the RSAF grant process.

Considering overlaps with private programs and the potential to eliminate the service, overall savings could range between \$6 million and \$9.17 million annually. These adjustments could collectively reduce OEMS expenditures significantly.

Figure 16: Estimated Other Expenses Cost Reductions

Item	Amount
Reduction to Seven Councils	\$ 1,517,873
Med-Flight Reduction (Med-Flight and RSAF 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

Depending on which of the three OEM staffing options are chosen and decisions regarding other identified expense items, FITCH estimates potential annual cost savings can range from \$7.99 million to \$11.45 million, as highlighted in the figure below.

Figure 17: Summary of Savings for Options

	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)		

Decision Point 3: Policy and Regulatory Process Review

Divisions within the Office of Emergency Medical Services (OEMS) manage multiple policy manuals. These have been updated without undergoing any formal review or public comment process. Two main issues were identified: 1) Policy changes are not consistently formalized through a documented process



involving the EMS Advisory Board (EMSAB), and 2) The OEMS does not always elevate EMSAB recommendations to the Board of Health or to VDH.

The lack of formalization and clear documentation for policy and guidance adoption can lead to inconsistent application and potential harm to individuals and agencies. A more structured approach with formal procedures and communication is needed to ensure that OEMS policy changes are well-documented, communicated, and effectively managed. The following option should be considered:

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 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

The EMS Advisory Board (EMSAB) provides advice and counsel to the OEMS and VDH on planning, developing, and maintaining the statewide EMS system. Appointed by the Governor, the board comprises 28 members from various community sectors and operates through 21 sub-committees. The EMSAB's responsibilities include:

- Advising on the administration of Title 32.1, Chapter 4, Article 2.1 of the Code of Virginia.
- Reviewing and recommending changes to the statewide emergency medical services plan.
- Evaluating reports on the EMS system's status, including the Financial Assistance and Review Committee, the Rescue Squad Assistance Fund, and regional EMS Councils.
- Reviewing the annual report of the Virginia Association of Volunteer Rescue Squad
- Providing information to the Governor, state legislators, and local officials
- Managing the nomination process for the EMS Representative to the State Board of Health

- Performing additional duties as requested by the Governor, State Board of Health, State Commissioner of Health, or OEMS

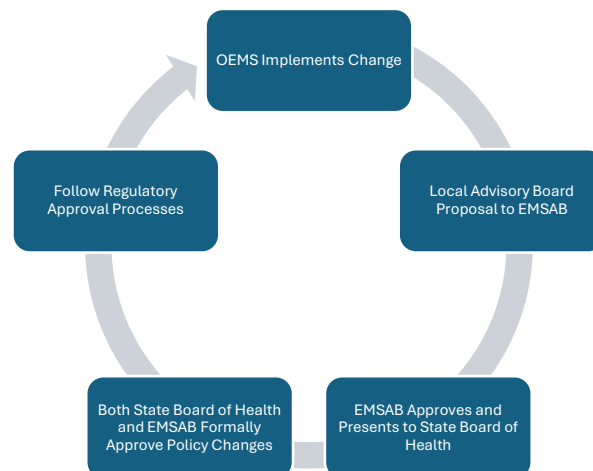
Additionally, each of the 11 Regional EMS Councils has its own advisory board, which varies in oversight and support depending on its type.

A key concern identified by FITCH is that the EMSAB is not fully utilized. As an advisory body, it lacks the authority to enforce regulatory or code changes. Previous leadership often bypassed the EMSAB, making independent decisions on system modifications, leading to a lack of collaboration and utilization of the board's expertise.

Considerations for the Future

The Commonwealth of Virginia should consider granting the EMS Advisory Board (EMSAB) the authority to propose regulations and code changes for consideration by the State Board of Health. This adjustment would enable local advisory boards and Councils to collaborate with the EMSAB. If approved, these changes could be implemented by the OEMS, providing a structured process for regulatory updates and ensuring clear expectations and cost estimates for modifications.

Figure 18: Proposed EMSAB Process



Additionally, the EMSAB should independently manage its own administrative functions, such as minutes, agendas, and logistical coordination, rather than relying on OEMS staff. The board's size and subcommittees, having grown over time, might require reassessment for better representation and cost efficiency.

For better alignment, the Virginia Department of Health (VDH) should integrate regional OEMS personnel into local health department offices. This would streamline coordination, enhance operational

efficiency, and unify command structures. Such integration would improve communication, resource allocation, and the overall quality of emergency and health services.

Decision Point 5: Education, EMS Portal, and Department Functions

Education

Council representatives raised concerns to FITCH regarding rising EMT candidate failure rates. FITCH's research indicates that Virginia's pass rates have remained near the national average, but a significant issue persists: a growing number of students either did not take or failed the exam. Since 2013, the lowest combined rate of failure and non-testing occurred in 2017, with 732 students (23%). By 2023, this figure increased to 1,209 (32%). Overall, 10,575 individuals have either failed or never tested since 2013, representing a missed opportunity for increasing the EMS workforce. See the figures below:

Figure 19: NREMT EMT: Rates of Success, Not Tested and Failed

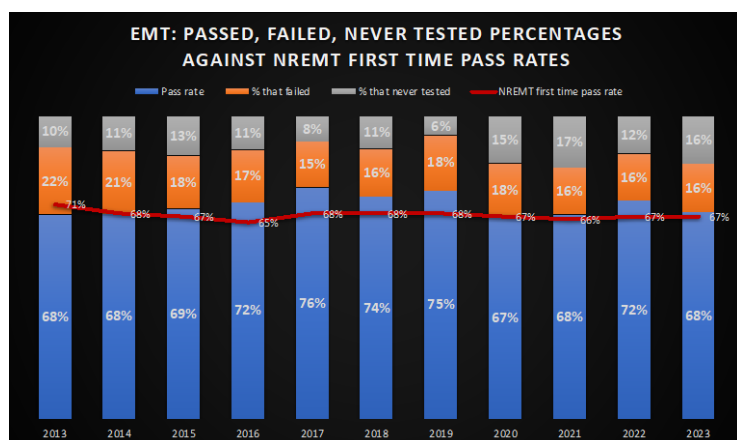
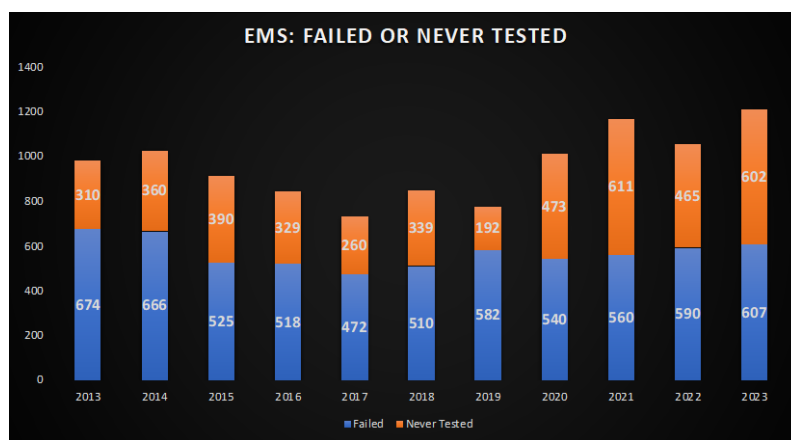


Figure 20: NREMT EMT: Number of Not Tested and Failed



Discussions with EMS representatives highlighted two main issues behind declining EMT numbers and increased non-testing students: the challenging NREMT exam misaligned with the curriculum and problems with the OEMS Education Coordinator process. The Director of ACE links these trends to the COVID-19 pandemic, which disrupted EMS education, while stakeholders cite inadequate OEMS regional support.

The Education Coordinator process, intended to raise the standard for EMS educators, is seen as cumbersome and inconsistent with national norms. Most states require EMS instructors to complete a 40-hour Instructor Methodology course and hold an EMS certification to ensure they possess necessary

teaching skills. Some states waive this requirement for candidates with prior teaching experience, advanced degrees (e.g., nursing, physician assistant, physician), or EMS Instructor credentials from another state. However, Virginia's Education Coordinator credential provides no concessions for previously credentialed instructors, with many requirements tied to the candidate's education level. Comparatively, states like Kentucky, Tennessee, and North Carolina follow more standardized practices aligned with the National Association of EMS Educators (NAEMSE).⁷⁸

The 2022 EMS Training Program Administration Manual (TPAM), published by OEMS, is the primary document for EMS education, certification, and credentialing. It covers certification levels, accreditation, continuing education, and training funds. However, many users find it overly long, difficult to navigate, and prone to changes without input, negatively impacting agencies. System-wide changes affecting policy or process should include a dedicated procedure for provider input and approval, as outlined in Decision Point 3. An example of process changes negatively impacting the system was evident in Southwest Virginia, where EMS provider numbers dropped 27% from 2004 to 2024 due to changes in the education and Education Coordinator processes. Additionally, applying out-of-state continuing education (CE) credits requires subjective approval from Education Coordinators, discouraging participation in external conferences. A more streamlined and transparent process for accepting out-of-state CEs is needed.

Per TPAM policy 1561, the EMS Training Fund supports the Virginia EMS Scholarship Program, managed by OEMS. It provides scholarships for current and aspiring EMS providers enrolled in approved Virginia certification programs for EMR, EMT, Advanced EMT, and Paramedic levels, designed to offset National Registry of EMTs (NREMT) testing costs. The program awarded about \$2.7 million annually but has been suspended since December 2023. VDH is working on a process to resume funding without routing funds through a Regional Council.

To qualify for funding, EMS programs must maintain NREMT pass rates above the 16th percentile, assessed twice yearly. High school EMT programs often fall below this benchmark due to low student and school motivation, limiting the entry of new EMTs into the workforce. Currently, 24 programs are

⁷ **Kentucky** - <https://kbems.ky.gov/Education/Pages/Educator-Evaluator.aspx>

Tennessee - <https://www.tn.gov/content/dam/tn/health/healthprofboards/Instructor%20Application%20Packet%20EMS.pdf>

West Virginia -

[https://www.wvoems.org/media/446555/educational%20institute%20instructor%20endorsement%20and%20education%20approval%20policy%20and%20procedures%20v1%2011082021%20\(1\)%20%2011.9.21.pdf](https://www.wvoems.org/media/446555/educational%20institute%20instructor%20endorsement%20and%20education%20approval%20policy%20and%20procedures%20v1%2011082021%20(1)%20%2011.9.21.pdf)

North Carolina - <https://info.ncdhhs.gov/dhsr/EMS/pdf/cred/instructorapp.pdf>

Maryland - <https://www.law.cornell.edu/regulations/maryland/title-30/subtitle-04>

⁸ <https://www.vdh.virginia.gov/emergency-medical-services/education-certification/documents-forms-downloads/ems-training-program-administration-manual/>



ineligible for funding, and no support is provided for underperforming programs, which could benefit from a more supportive approach. The latest 16th percentile report is available on the OEMS website.⁹

The OEMS uses both state competency tests and NREMT cognitive exams for EMT certification in Virginia. Pre-pandemic, the EMT pass rate averaged 71%, but between 2020 and 2023, it fell to 69%, with an annual average 40.87% (228) increase in candidates who never tested and a 4.42% (25) rise in failures, contributing to the EMT shortage. In contrast, Advanced EMT and Paramedic levels saw less dramatic shifts, though Paramedic failures rose by 67% post-pandemic, requiring further investigation. Limited access to testing centers may explain these trends. Implementing Regional Councils as Pearson Vue testing centers, as done in other states, could improve testing access, address failure rates, and generate additional revenue through other certification exams.

EMS Portal

The OEMS has made significant progress with its EMS portal, intended as a comprehensive repository for EMS accreditation, certification, and education. However, recent staff reductions have exacerbated management issues. The portal, which contains all EMS-related information vital to the ACE Division, has become increasingly challenging to manage due to the reduced staff.

Site visits revealed difficulties in generating basic data, such as geographic and demographic details about EMS providers in the Commonwealth. Additionally, there is limited data on active versus inactive staff. The staff's ability to produce these reports is hampered by both their small numbers and the labor-intensive nature of the task. The portal's complexity and user-unfriendly design further complicate navigation and data retrieval, as reported by many users.

To resolve these issues, immediate updates to the EMS portal are necessary. Improvements should focus on enhancing usability and accessibility, including streamlining data extraction processes, improving the user interface, and developing dashboards for key performance indicators. Ensuring frequent updates to data repositories and effective communication with users will be crucial for making the portal a functional and supportive tool for its users.

Regulation and Compliance Enforcement Considerations

The Division Director has highlighted that two program representatives are scheduled to retire this year and emphasized the critical need to fill these positions. Given the central role these positions play in OEMS's field operations, FITCH recommends that VDH prioritize hiring individuals who excel in customer

⁹ <https://www.vdh.virginia.gov/content/uploads/sites/23/2018/07/EMT-Published.pdf>.



service and communication. Additionally, it is essential to ensure that the new hires are adaptable and align with the evolving pathway forward model.

This role is unique in requiring a balance between customer focus and regulatory duties. Current challenges highlight the need for a review, as this division must remain customer-focused while also fulfilling its regulatory responsibilities.

Emergency Operations Division Considerations

The EMD program aligns with the VDEM as part of the state 9-1-1 board's jurisdiction. This integration consolidates all Public Safety Answering Point (PSAP) topics, including protocols and operational matters, under the 9-1-1 board and VDEM's oversight, potentially enhancing the coordination of emergency dispatch services statewide.

Regional planning initiatives could be integrated into VDEM's existing regional offices, which are already central to various planning activities. This approach could streamline operations and leverage current resources and expertise. However, this integration risks diminishing the specialized focus on EMS by combining it with broader emergency management activities. On the positive side, this alignment may improve collaboration and communication with local emergency response agencies, fostering more responsive and practical planning. This could enhance the effectiveness of emergency response plans and ensure a more coordinated and efficient emergency response infrastructure for communities.

Community Health and Technical Resources Division Considerations (CHaTR)

The division's focus prompts several questions regarding its alignment with mobile-integrated health and the broader EMS Agenda 2050 goals. The division, which has traditionally managed Councils, continues to prioritize this role despite recent reorganization. Additionally, its telehealth initiative, operating under the CHaTR scheme, directs funds to the state telehealth board, raising concerns about the efficiency of this resource allocation.

Furthermore, CHaTR's efforts to develop curricula for EMS Officers I, II, and the new EMS Safety Officer appear redundant, as NEMSMA has already established training programs for these roles. There may be merit in redirecting the division's focus towards community initiatives and aligning more closely with the objectives outlined in EMS Agenda 2050. This refocusing could enhance the division's contribution to advancing the overarching goals of mobile-integrated health and community-centered emergency medical services.



Accreditation, Certification, and Education Division Considerations

The absence of a succession plan within the ACE Division poses a critical risk to the EMS system, particularly regarding certification processes. With only two full-time staff members, the division's operations could be severely impacted if either were to leave, especially given that one holds extensive, specialized knowledge crucial to the division's functions. Such a loss could lead to

immediate operational challenges and hinder the division's ability to maintain effective service delivery.

To address this vulnerability, the development of a comprehensive succession plan is essential. This plan should encompass several key elements:

1. **Identification of Successors:** Determine potential internal candidates who could step into critical roles or outline a clear strategy for external recruitment if necessary.
2. **Knowledge Transfer:** Implement structured processes for transferring specialized knowledge. This could involve mentoring programs, detailed documentation of processes, and systematic cross-training initiatives to ensure that key information is shared and retained within the division.
3. **Operational Continuity:** The plan must ensure smooth operations during transitions by preparing for temporary coverage and managing critical functions without disruption. It should include realignment to the updated regional model to distribute workload efficiently among staff and create processes that enhance division continuity. This approach will maintain operational stability while improving efficiency during changes.
4. **Resilience and Morale:** Developing a succession plan will bolster the EMS system's resilience by ensuring continuity of essential services. It also demonstrates a commitment to employee development and organizational stability, which can positively impact morale within the ACE Division and the wider OEMS.

Overall, creating and implementing a succession plan is a strategic necessity. It safeguards the certification processes and the integrity of the EMS system against potential disruptions from personnel changes. Immediate action is required to prepare for unforeseen staff departures and to uphold the EMS system's reliability and efficiency.

Trauma and Critical Care Division Considerations

The potential transfer of the Trauma and Critical Care division within VDH, rather than relocating the trauma designation process to an external body, offers an opportunity to address long-standing resource allocation issues. OEMS previously secured the trauma designation to increase funding, but none of the additional funds reached EMS to manage the program, revealing inefficiencies in the current



setup. Moving this responsibility to another division within VDH could better align resources with the needs of trauma care systems, encouraging collaboration across departments, streamlining processes, and improving patient outcomes through a more integrated approach.

This shift also provides a chance to reassess and modernize the trauma designation criteria and processes, making them more adaptable to the evolving healthcare landscape. By transferring these responsibilities and considering use of the ACS verification instead of in-house verification, VDH could align with current best practices but also prepared to meet future challenges. This reorganization could lead to a more dynamic, responsive trauma care system that optimizes resource distribution and maintains high standards of care across the state.

Administration and Fiscal Division Considerations

The Administration and Fiscal Division is at a critical point where a thorough review and update of its policies and procedures is essential. This process is more than just a refinement; it aims to align the division's operations with proper standards and regulatory demands. By addressing any gaps in the existing policy framework, the division ensures compliance with legal requirements and positions itself to tackle future challenges effectively. This comprehensive review is key to enhancing operational resilience and adapting to the evolving landscape.

In addition to updating current policies, developing new ones is crucial to address emerging needs and trends. These policies should focus on modern challenges, including technological advancements and regulatory shifts, to future-proof the division. Moreover, the clear segregation of work duties and responsibilities is necessary to prevent task overlap, reduce inefficiencies, and enhance communication. By defining roles and expectations, the division can streamline operations, promote accountability, and foster a more productive, collaborative environment that ultimately boosts overall work performance and efficiency.

EMS System Funding Division Considerations

EMS agencies have expressed distrust toward OEMS regarding the allocation of DMV revenue to the grant program, as the total amount returned to localities is often less than expected. This discrepancy arises because agencies such as the DMV, Treasury Department, and others deduct small percentages as transaction fees before disbursement. As a result, localities may receive less funding than they calculate based on vehicle registrations in their area. To address this concern, the division should develop a transparent process that tracks and shows each financial transaction, detailing how much was received and how much was deducted along the way. This approach will foster transparency and help rebuild trust between OEMS and EMS agencies.

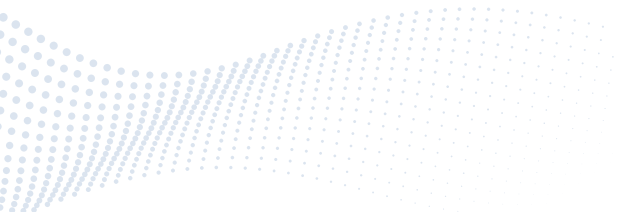


Additionally, the division should explore the possibility of expanding the RSAF grant program to better meet the needs of all EMS agencies. An equitable distribution of funding is critical, especially when considering demographic differences across localities. By ensuring that funding decisions are fair and data-driven, the division can support a more balanced allocation of resources that adequately addresses the diverse needs of EMS agencies statewide. This would not only promote fairness but also enhance the efficiency and effectiveness of emergency medical services delivery.

Patient Care Informatics and Epidemiology Division Considerations

OEMS plays a crucial role in emergency medical services and response, but its involvement in epidemiological functions overlaps with the core responsibilities of other VDH departments. To enhance operational efficiency and prevent redundancy, it is advisable to reassign the epidemiologist from OEMS to a department within VDH where epidemiology is a primary focus. This shift would consolidate expertise in disease surveillance and epidemiological research, leading to a more cohesive and effective public health strategy.

FITCH recommends that this reassignment be accompanied by replacing the epidemiologist with an analyst with OEMS. This change is not merely administrative but aims to streamline services and eliminate overlapping functions. By placing the epidemiologist in a department that specializes in epidemiology, VDH can optimize its resources and strengthen its capacity for disease monitoring and research. Meanwhile, OEMS can benefit from an analyst who is better suited to support its specific needs, ensuring both OEMS and VDH can concentrate on their distinct yet complementary responsibilities effectively.



Ensuring Continuity in Political Transitions

Maintaining the positive momentum of OEMS during political transitions and changes in executive leadership requires proactive strategies and the development of an annual strategic plan. Below are some best practices to consider while crafting such a strategic plan to help ensure continuity.

Building a Strong Foundation

To secure the implemented changes, they should be embedded within existing Virginia codes, regulations, or OEMS policies. This formalizes the improvements and makes them less susceptible to reversal due to political shifts. Detailed documentation is crucial. Creating comprehensive reports outlining the implemented changes, their rationale, and the positive impact on OEMS performance, supported by data and metrics is imperative.

Building Consensus and Advocacy

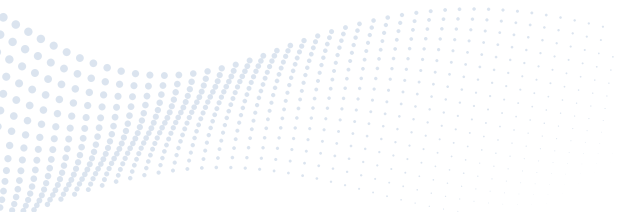
Seek buy-in from stakeholders, such as the Virginia Association of Volunteer Rescue Squads (VAVRS), legislators, and emergency medical professionals who can advocate for continued implementation of the changes. Identify individuals within OEMS who understand and value the changes to serve as champions during the transition.

Effective Communication During Transitions

Proactively brief the incoming administration on the implemented changes, emphasizing their positive impact on Virginia EMS performance. Highlight the improved performance and standing of OEMS due to the changes, aligning them with broader government priorities. Present these as a success story to build upon.

Long-Term Strategies for Sustainability

Establish a culture of continuous improvement within the organization to prevent changes from being tied solely to a specific administration. Ensure transparency by making data on OEMS performance publicly available. Design changes with sustainability in mind, aiming for seamless integration into existing workflows to reduce disruption.



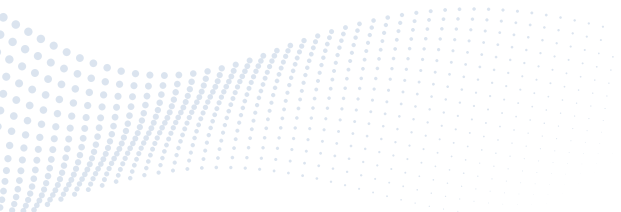
Conclusion

FITCH has 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 recommendation includes a range of options for legislative, regulatory, structural, employee, and funding changes, highlighting the need for a flexible and adaptive strategy. This approach allows for continuous evaluation and adjustment to meet the Commonwealth's evolving needs effectively.

The focus on industry best practices and the recommendation for immediate and midterm strategic actions ensure that the plan is both robust and forward-thinking. By implementing a carefully phased strategy, the Commonwealth can navigate its challenges with agility and achieve positive outcomes in governance and community services. This methodology promotes ongoing improvement and responsiveness, positioning the Commonwealth for sustained success and enhanced service delivery.

APPENDIX A

Agency Survey Review



Agency Survey Review

To grasp EMS agencies' perspectives on the current OEMS and Regional EMS Councils, as well as their anticipated needs from the OEMS, FITCH created a survey that was distributed state-wide among EMS agencies. Given the number of EMS agencies and the project's limited timeframe, FITCH and the VDH determined that this survey would efficiently collect extensive feedback. The aim was to reach a 95% confidence level with a margin of error below 5%, ensuring state-wide representation and inclusion of various types of EMS agencies. This approach was chosen to understand the system's requirements thoroughly and to enable the development of statistically meaningful future system models.

FITCH sent out 940 requests for responses to 567 agencies. However, because the OEMS did not have a consolidated distribution list, FITCH used other channels, such as the Regional EMS Councils and the VDFP, to ensure reaching the widest audience. Out of the 567 licensed agencies in the state, FITCH received 355 unique agency responses, which exceeded the required 230 to achieve a 95% confidence level with a 3.2% margin of error. Additionally, out of the 940 survey recipients, 441 responses were received, which surpassed the 273 needed to achieve a 95% confidence level with a 3.41% margin of error.

To ensure responses were evenly distributed, FITCH mapped them across the state. It's important to note that some came from beyond the state boundaries. These are from agencies licensed to operate within Virginia.

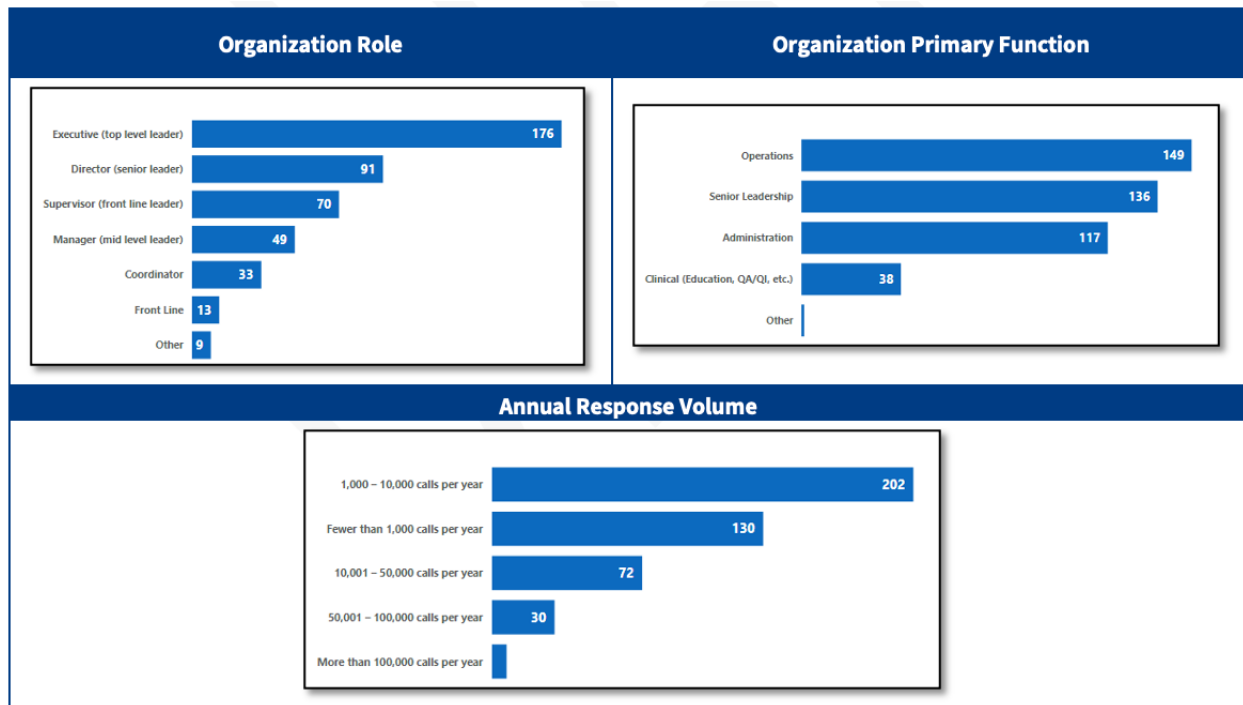
FITCH conducted an analysis of the types of agencies represented by the respondents to ensure a diverse representation. The table below displays the kind of agency alongside the total number of respondents.

Figure 1: Survey Respondent Agency Type

Agency Type	Number of Responses
Volunteer Organization	147
Locality (City or County) Fire Department Based - Career/Paid and Volunteer	83
Locality (City or County) Fire Department Based - Career/Paid	59
Non-governmental For Profit	39
Non-governmental Not For Profit	29
Locality (City or County) Operated Third Service (non-Fire Department based) - Career/Paid	23
Locality (City or County) Operated Third Service (non-Fire Department based) - Career/Paid and Volunteer	20
Locality (City or County) Fire Department Based - Volunteer	10
Quasi-Governmental	9
Hospital	7
Locality (City or County) Emergency Services Department Based- Career/Paid and Volunteer	6
Other	5
Federal	4
Total Responses	441

An analysis was conducted to understand the roles of respondents and the volume of EMS responses managed by their agencies. It was found that most respondents held leadership positions. Their annual EMS response volume was also collected to guarantee that FITCH's data set was adequately represented. The findings are detailed below.

Figure 2: Individual Respondent Analysis



When analyzing the responses, FITCH used cross-tabulation tables to compare the responses with the types of agencies. Through discussions with providers, FITCH found that different types of agencies had different needs based on their size and resources. This approach helped FITCH rank the systems' needs based on the survey responses. FITCH evaluated responses from five key areas, including:

- Essential Functions of OEMS
- Role of the EMS Regional Councils
- Essential Qualities of the OEMS
- Priorities of the OEMS
- Design of the Future of the OEMS

The complete analysis of the 25 questions is provided in Appendix A. It is worth mentioning that FITCH removed the question related to strengths within the OEMS. The question was designed in a way that required respondents to provide five answers. However, feedback overwhelmingly indicated that there were not five strengths to mention. Respondents had to mark something to submit, so this question and its responses were removed from the analysis.



Essential Functions of the OEMS

Question: What are the top five functions you believe are essential for the Office of EMS to effectively support and manage EMS services?

The purpose of this question was to identify the core functions that agencies require from the OEMS currently and in the future. There were 19 possible responses, and FITCH asked agencies to provide their top 5 choices.

Respondents ranked their needs from the office as follows:

1. Certify personnel
2. License and Inspect Ambulance Service
3. Facilitate State Funding Programs
4. Continue Education
5. Investigate Regulator Complaints

Role of the Regional Councils

Question: What do you see as the top 5 roles that the Regional Council fill?

The purpose of this question was to understand the functions that agencies expect from the Regional EMS Councils. Given the current system design and to better inform the role of any future regional system, FITCH believed it was best to hear from respondents about their needs. Respondents were asked to provide their top 5 out of 15 possible responses.

Respondents ranked their needs from the Regional EMS Councils as follows:

1. Develop and Maintain Regional EMS Protocols
2. Provide Continuing Education
3. Function as an Extension of the OEMS
4. Coordinate Regional Planning
5. Support Regional EMS Supply and Exchange Programs

Essential Qualities of the OEMS

Question: What are the top 5 qualities you believe are essential for the Office of EMS to support and manage EMS services effectively?

This question was designed to understand the qualities that respondents felt were important to them when interacting with the OEMS. It focuses on the customer's needs and how best for the OEMS to



provide customer service. There were 12 possible responses, and FITCH asked the agencies to offer their top 5.

Respondents ranked the desired qualities as follows:

1. Accountability
2. Responsiveness
3. Collaboration
4. Competence
5. Leadership

Priorities of the OEMS

Question: What should be the top priorities for the Office of EMS over the next five years?

This question aimed to identify the top priorities identified by respondents in terms of the support they need from the State, VDH, and OEMS. The focus was on understanding the needs of the customers and how these agencies can best provide support. Respondents were asked to rank 10 possible responses in order of importance.

Respondents ranked the priorities as follows:

1. Expanding Training and Development Opportunities
2. Enhanced Statewide EMS Coordination
3. Identify and Supporting new Funding Mechanisms for EMS Funding
4. Advancing Legislative Support for EMS
5. Improving EMS Response to Under-served Areas

Design for the Future of the OEMS

This question was designed to gather insights on the preferred system design for the OEMS in the future. Fitch analyzed the responses based on agency type and the respondents' views on the potential future design. The survey presented six options; each agency was asked to rank its top 3 choices.

Respondents ranked the preferred system design as follows

1. Hybrid Model with Enhanced Local Autonomy
2. Decentralized with More Regional Involvement, All State Staff
3. Community/Integrated EMS Model

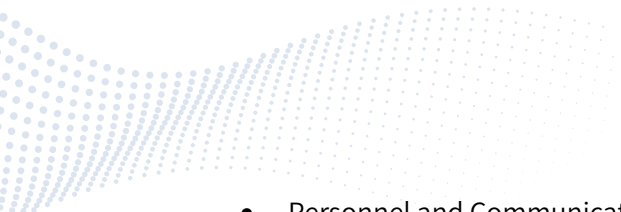


Respondent Comments

The survey included a section for comments. The aim was to gather more information and allow for detailed feedback. Here is a summary of the common themes and key points from the respondents' feedback.

Question: Do you have any other comments or suggestions that could help shape the strategic vision of the Office of EMS?

- Accountability and Support: Propose an "account manager" role within VAOEMS for streamlined communication and consistent agency support. Advocate for transparency and collaboration with EMS regions and field involvement.
- Basic Care and Training: Focus on basic care and training to ensure patient survival until hospital arrival.
- Disorganization and Leadership: Address disorganization within OEMS by introducing forward-thinking leaders and physicians for a redesigned prehospital care system and encouraging proactive legislative changes.
- Efficiency and Speed: Encourage OEMS to make quick, decisive actions recognizing the commitment of EMS providers.
- EMS Symposium: Highlight its role in networking, education, and collaboration, advocating for its return.
- Ethics and Integrity: Address past unethical certifications and the need for strict EMS regulations adherence.
- Future Vision and Relationships: Push for a clear understanding of EMS roles, closer agency relationships, customer service-oriented mindset, and strategic council alignment.
- Inter-Departmental Collaboration: Suggest enhanced partnership between the Secretary of Health and Human Services and the Secretary of Public Safety to support local fire-based EMS.
- Interfacility EMS Agencies: Point out the importance of interfacility EMS agencies in managing hospital transitions and reducing overload.
- Legislative Support: Call for legislative changes recognizing EMS as an essential service in Virginia, helping ensure funding pathways.
- Modernization and Fresh Approach: Shift from outdated symposium-focused training to a modernized, collaborative EMS system.
- Optimism and Challenges: Acknowledge current system failures while expressing hope for the future of OEMS, emphasizing support for volunteer agencies and what it will mean with/if volunteerism continues to reduce across the state.

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- Personnel and Communication: Underline the importance of solid hiring practices post-current educations leadership retirement and commend effective communication with inspectors and regulatory staff.
 - Regional Representation and Support: Stress the need for regional EMS Council support, particularly in rural areas, highlighting the importance of communication and collaboration.
 - Regulatory and Protocol Consistency: Advocate for a unified set of state-wide protocols and a system to track patient progress from pickup to discharge.
 - Technology and Training: Encourage the development of volunteer agencies offering EMT to paramedic courses while focusing on patient care.

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