Council of the District of Columbia
COMMITTEE ON THE JUDICIARY
MEMORANDUM
1350 Pennsylvania Avenue, NW, Washington, DC 20004

TO: Nyasha Smith, Secretary of the Council
FROM: Kenyan R. McDuffie, Chairperson of the Committee on the Judiciary
RE: Closing Hearing Record
DATE: October 30, 2015

Dear Ms. Smith,

Please find attached copies of the Hearing Notice, Agenda and Witness List, and testimony for the Committee on the Judiciary’s October 1, 2015, hearing on B21-243, the “Cardiopulmonary Resuscitation and Automated External Defibrillator Requirements Amendment Act of 2015”

The following witnesses testified at the roundtable or submitted written testimony to the Committee:

i. Public Witnesses

1. Michael Musante, Director of Government Relations, FOCUS
2. Richard Benson, MD/PhD, Associate Medical Director, Comprehensive Stroke Program, Medstar Washington Hospital Center/Associate Professor of Clinical Neurology, Medstar Georgetown University Medical Center/Board Member, Greater Washington Region, American Heart Association
3. Dr. Charles Berul, M.D., FACC, Division Chief of Pediatric Cardiology, Children’s National Medical Center
4. Dr. Ankoor Shah, District of Columbia Chapter of the American Academy of Pediatrics
5. Cynthiana Lightfoot, Chair, Emergency Medical Services Advisory Committee
6. Dr. Harvey Sloane, Former Public Health Commissioner for the District of Columbia/Former Mayor of Louisville
7. Dr. Dave Milzman, Emergency Medical Services Advisory Committee, Mayor’s Advisory Committee on Emergency Health/Georgetown University School of Medicine
8. Anne Renshaw, Emergency Medical Services Advisory Committee
9. Stuart Berlow, Director, Government Relations – D.C., American Heart Association
10. Jennifer Griffin, American Heart Association
11. Michael Augustus Lee, Public Witness
12. Brandon Ferell, Heroes for Hearts
13. Victoria Nance, Public Witness

ii. Government Witnesses

1. John Davis, Chief of Schools, District of Columbia Public Schools
COUNCILMEMBER KENYAN R. MCDUFFIE, CHAIRPERSON
COMMITTEE ON THE JUDICIARY

AND

COUNCILMEMBER DAVID GROSSO, CHAIRPERSON
COMMITTEE ON EDUCATION

ANNOUNCE A PUBLIC HEARING ON

BILL 21-0243, THE “CARDIOPULMONARY RESUSCITATION AND AUTOMATED EXTERNAL DEFIBRILLATOR REQUIREMENTS AMENDMENT ACT OF 2015”

Thursday, October 1, 2015, 2:00 p.m.
Room 412, John A. Wilson Building
1350 Pennsylvania Avenue, N.W.
Washington, D.C. 20004

On Thursday, October 1, 2015, Councilmember Kenyan R. McDuffie, Chairperson of the Committee on the Judiciary, and Councilmember David Grosso, Chairperson of the Committee on Education, will hold a public hearing on Bill 21-0243, the “Cardiopulmonary Resuscitation and Automated External Defibrillator Requirements Amendment Act of 2015”. The hearing will be held in Room 412 of the John A. Wilson Building, 1350 Pennsylvania Avenue, N.W., at 2:00 p.m. The hearing will be immediately followed by a related hearing on the State of Emergency Medical Services in the District of Columbia and Bill 21-0290, the “Office of Unified Communications Training, CPR, and Modernization Amendment Act of 2015”.

The stated purpose of Bill 21-0243 is to amend the Public Access to Automated External Defibrillator Act of 2000 to require each school to have a certain number of automated external defibrillators that can be used on both children and adults in the school; to require specific employees of each school to complete a training program on cardiopulmonary resuscitation and the operation and use of an automated external defibrillator; to require the Mayor to establish guidelines for these training programs; and to require the Mayor to approve all training programs offered pursuant to the act.
The Committee invites the public to testify or to submit written testimony. Anyone wishing to testify at the hearing should contact Kate Mitchell, Judiciary Committee Director, at (202) 727-8275, or via e-mail at kmitchell@dccouncil.us, and provide their name, telephone number, organizational affiliation, and title (if any) by close of business, September 28, 2015. Representatives of organizations will be allowed a maximum of five minutes for oral testimony, and individuals will be allowed a maximum of three minutes. Witnesses should bring fifteen copies of their written testimony and, if possible, also submit a copy of their testimony electronically to kmitchell@dccouncil.us.

For witnesses who are unable to testify at the hearing, written statements will be made part of the official record. Copies of written statements should be submitted either to the Committee or to Nyasha Smith, Secretary to the Council, 1350 Pennsylvania Avenue, N.W., Suite 5, Washington, D.C. 20004. The record will close at the end of the business day on October 15, 2015.
COUNCILMEMBER KENYAN R. MCDUFFIE, CHAIRPERSON
COMMITTEE ON THE JUDICIARY

AND

COUNCILMEMBER DAVID GROSSO, CHAIRPERSON
COMMITTEE ON EDUCATION

ANNOUNCE A PUBLIC HEARING ON

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AGENDA AND WITNESS LIST

I. CALL TO ORDER

II. OPENING REMARKS

III. WITNESS TESTIMONY

i. Public Witnesses

1. Michael Musante, Director of Government Relations, FOCUS

2. Richard Benson, MD/PhD, Associate Medical Director, Comprehensive Stroke Program, Medstar Washington Hospital Center/Associate Professor of Clinical
Neurology, Medstar Georgetown University Medical Center/Board Member, Greater Washington Region, American Heart Association

3. Dr. Charles Berul, M.D., FACC, Division Chief of Pediatric Cardiology, Children’s National Medical Center

4. Dr. Ankoor Shah, District of Columbia Chapter of the American Academy of Pediatrics

5. Cynthiana Lightfoot, Chair, Emergency Medical Services Advisory Committee

6. Dr. Harvey Sloane, Former Public Health Commissioner for the District of Columbia/Former Mayor of Louisville

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8. Anne Renshaw, Emergency Medical Services Advisory Committee

9. Stuart Berlow, Director, Government Relations – D.C., American Heart Association

10. Jennifer Griffin, American Heart Association

11. Michael Augustus Lee, Public Witness

12. Brandon Ferell, Heroes for Hearts

13. Victoria Nance, Public Witness


ii. Government Witnesses

1. John Davis, Chief of Schools, District of Columbia Public Schools

IV. ADJOURNMENT
Good afternoon. My name is Michael Musante, and I am the Senior Director for Government Relations of Friends of Choice in Urban Schools. FOCUS is a 19 year-old D.C. non-profit that provides advocacy, communications, and other support for D.C.‘s public charter schools. Thank you for the opportunity to testify before you today. According to the Sudden Cardiac Arrest Foundation, out-of-hospital cardiac arrest affects over 300,000 adults annually. Reducing deaths related to these incidents is an admirable goal. However, requiring public schools to have AEDs may not make meaningful progress towards this goal, and may divert scarce public school resources that are better used on other initiatives.
First, the actual impact of provisioning AEDs to public schools is questionable. While the American Heart Association’s 2015 statistical update suggests that up to 6,328 children experience sudden cardiac arrest annually, even advocacy organizations like the Sudden Cardiac Arrest Awareness Foundation acknowledge that very few occur in a school setting, and that targeted deployment mandates for schools actually offer a very limited health benefit.

There are several ways that Council could legislate that would appear to have a greater impact on actual sudden cardiac arrest mortality rates. First, Council could consider a widespread public access mandate. The widespread presence of AEDs in a variety of public spaces would benefit more D.C. citizens than a school mandate. Second, the Council could direct the revision of the school physicals that are required of all students annually to include the American Heart Association’s 14-step screening process to reduce the risk of cardiac arrest in youth.

Third, Council could focus its legislative efforts on ensuring that AED Good Samaritan liability protection meets the four pronged test described by SCA Aware – that it covers all program constituents, covers a broad scope of operational activities, provides protection
for ordinary negligence, and does not condition immunity protection upon compliance with any statutory operational conditions.

Operationally, schools are ill-prepared to implement this legislation. First and foremost, the creation and execution of a well-designed AED program is currently outside the expertise of most schools. Regarding the requirement that each program be managed by a physician, it is exceedingly difficult for most schools to get a physician to engage on behalf of their own patients in the school setting, let alone to manage a school-wide AED program. In addition, there is significant variability in both the quality and availability of school nurses under the current school nurse program, and it is unreasonable to expect them to take on additional responsibilities when so many schools report underperformance at their current workload. The 120-day timeline for schools to train personnel may also be unreasonable given the expected uptick in training requests due to new requirements. Also, unless the Council were willing to fund and coordinate bulk purchases of AED equipment for all public and public charter schools, it is cost prohibitive for most of the charter LEAs.
In lieu of this legislation that is expensive, difficult to implement, and would appear to have limited, if any, impact on sudden cardiac arrest mortality rates in the District of Columbia, we would urge Council to look to increasing CPR capacity at the school level through the Office of Unified Communications Training, CPR and Modernization Amendment Act of 2015. FEMS already provides free CPR training to the community at large. This could easily be extended to include the public charter schools through a targeted campaign working in conjunction with FOCUS, the PCSB and the new charter school emergency response planner that is being selected by the PCSB. Once this individual/entity is in place we could all work together to ensure maximum saturation of CPR classes in all public charter schools. Thank you and I am available to answer any questions.
Richard Benson, MD/PhD  
Medstar Washington Hospital Center  
Stroke Center  
Associate Medical Director  
Committees on Education and the Judiciary  
B21-243, the CPR and AED Requirements Act of 2015  
October 1, 2015

Good afternoon members of the committee. My name is Dr. Richard T. Benson. I am the Associate Medical Director for the Stroke Program at Medstar Washington Hospital Center, board member for the American Heart Association of the Greater Washington Region (GWR) and chair of its Mission Committee. More importantly, I am also a resident of the District of Columbia.

I am here today to show my support of the placement of automated external defibrillators (AEDs) in every school in the District of Columbia. I applaud you for your appreciation of the devastating health impact of cardiac disease in this region. However, AEDs alone are insufficient to protect the citizens of our great region. The training of each and every student, staff member, and teacher of all schools in The District of Columbia is required to improve the outcome of any person in the world experiencing a cardiac arrest in the Greater Washington Region.

As a practicing neurologist specializing in the treatment of stroke and vascular disease, I have had, all too often, the firsthand experience of examining citizens of this region who have suffered serious and life altering brain damage due to cardiac arrest outside of the hospital setting. I am usually one of the physicians who is consulted to declare some of these patients as brain dead. It is estimated that over 326,000 sudden cardiac arrests occur annually, including over 9,500 young people. Approximately 88% of these occur at home. Many of these victims appear healthy with no known heart disease prior to that initial heart attack. Failure to act in a cardiac emergency can lead to unnecessary deaths. Effective bystander CPR provided immediately after a sudden cardiac arrest can double or triple a victim’s chance of survival. Unfortunately, only 32% of cardiac arrest victims get CPR from a bystander. Therefore, only approximately 10% of out of hospital cardiac arrest victims survive. We can change this.

The bill before this committee is a strong start. AEDs save lives, and putting one in every school in Washington, DC is an important component in the chain of survival. But without immediate care, such as bystander CPR, the brain can begin to die in 4-6 minutes following a cardiac arrest. When sudden cardiac arrest occurs, your brain is the first part of your body to suffer, because, it does not have a reserve of oxygen-rich blood like other organs. The brain is completely dependent on an uninterrupted blood supply. If your heart rhythm does not rapidly return to its normal rhythm, brain damage occurs and either severe neurological impairment, a chronic vegetative state, or death occurs.

Our research tells us that using CPR immediately can double or even triple survival rates. And that is why we need to train as many community members in this lifesaving skill as we can. I also want to note that we’re talking about hands-only CPR here, and that’s an important
distinction. We are not talking about mouth-to-mouth, because of the obvious concerns that go along with that form of resuscitation.

As a practicing physician here in the national capital region, I strongly believe that all students should be required to learn CPR before graduation. More than 5,000 students graduate from DC public schools each year. That means, if we require CPR for graduation, every year there will be thousands of potential lifesavers able to step in, in the event of a cardiac arrest anywhere in the District of Columbia, and possibly prevent the tragic outcomes I described earlier. It takes less than 30 minutes to learn hands only CPR – it’s fun to learn, and it’s a lifesaving skill that can last a lifetime.

The American Heart Association reports that 26 states have laws that require all students to learn CPR – this includes Maryland, Virginia, and most of the Mid-Atlantic region. Unfortunately, DC does not have this common sense law on the books. And we need to change this. As a physician, I more than most, understand the consequences of the lack of immediate care in a cardiac emergency. That is why I am so passionate about this. It is critical we create a culture of health and train our community to save lives. I urge this committee to amend this bill and to require all students in DC Public schools to learn CPR before they graduate. The next life that is saved may be mine or yours.

Thank you very much, and I am happy to answer your questions.
Testimony of Charles I. Berul, MD, FACC on B21-0243, Cardiopulmonary Resuscitation and Automated External Defibrillator Requirements Amendment Act of 2015

Good afternoon. My name is Dr. Charles Berul. I am Division Chief of Pediatric Cardiology at Children’s National Medical Center. I also serve on the American College of Cardiology’s Board of Governors representing cardiovascular specialists in the District of Columbia. I am pleased to be with you this afternoon to comment upon B21-0243. I testify on behalf of the American College of Cardiology which strongly supports measures to reduce mortality from sudden cardiac arrest.

The ACC is a 49,000-member medical society that is the professional home for the entire cardiovascular care team. The mission of the College is to transform cardiovascular care and to improve heart health. The ACC leads in the formation of health policy, standards, and guidelines. The College operates national registries to measure and improve care, provides professional medical education, disseminates cardiovascular research and bestows credentials upon cardiovascular specialists who meet stringent qualifications. The ACC also produces the Journal of the American College of Cardiology (JACC), top-ranked among cardiovascular journals worldwide for its scientific impact.

An important strategic objective embraced by the College is improving population health with reference to cardiovascular disease everywhere but especially in the District of Columbia, the location of our worldwide headquarters. If I may digress briefly, I thank the Council and especially Councilperson Yvette Alexander for its fine work in helping fulfill a long standing ACC objective within the population health sector by its enactment of legislation requiring newborn screening to detect critical congenital heart defects (CCHD) in DC birthing centers. We look forward to working with the Council to craft solutions to other population health initiatives including those included in B21-0243.

Sudden cardiac arrest (SCA) is one of the most difficult problems facing the cardiology community. SCA is the sudden, unexpected loss of heart function, breathing and consciousness. Sudden cardiac arrest usually results from an electrical disturbance in the heart that disrupts the pumping action, stopping blood flow to the rest of the body. SCA differs from a heart attack which occurs when blood flow to a portion of the heart is blocked. However, a heart attack can sometimes trigger an electrical disturbance that leads to sudden cardiac arrest.
Sudden cardiac arrest constitutes a medical emergency. If not treated immediately, it causes sudden death. With fast appropriate medical care, survival is possible. Administering cardiopulmonary resuscitation (CPR) – or even just compressions to the chest – can improve the chances of survival until emergency personnel arrive.

Sudden cardiac arrest is a leading cause of death in the United States. Approximately 424,000 people of all ages experience out-of-hospital non-traumatic SCA each year (more than 1,000 per day) and nine out of ten victims die. In 2013 the American Heart Association reported 9,500 cases of out-of-hospital cardiac arrest in young persons under the age of 18.

Early bystander intervention with cardiopulmonary resuscitation (CPR) before emergency help arrives results in survival of approximately four out of ten victims. Even the best emergency medical services may not be able to reach a victim within the first three to five minutes. Immediate bystander CPR and the use of automated external defibrillators (AEDs) is a crucial element in enhancing a victim’s chances for survival.

The ACC supports B21-0243 which would place AEDs in ALL schools in the District of Columbia and require training of personnel in each school in the proper use and maintenance of AEDS. I urge prompt passage of this bill without weakening amendments. Enactment of this measure would constitute a major step forward in promoting population health in the city.

The measure before the Council is a strong bill. I am particularly pleased with the following provisions in B21-0243: (1) its applicability to ALL schools in the city – public, charter, parochial or private; (2) the extensive list of individuals who must complete a CPR/AED program – athletic coaches, coaching assistants, athletic trainers, athletic directors, the team or game physician, each school nurse, anticipated AED users designated by the school principal; and (3) the requirement “that at least one individual trained in a CPR and AED program be present during the school’s hours of operation and during any athletic event.”

In urging the Council’s prompt passage of B21-0243 without weakening amendments, I must elaborate on the College’s broader objectives regarding the AED/CPR issue. The College supports B21-0243 as an important incremental building block upon the 2000 AED law. Enactment of this bill will promote the ACC’s population health objectives in the District of Columbia. It will save lives!

B21-0243 is a building block. It is by no means the ACC’s final objective on this issue. The College supports requiring all DC high school students to receive AED and CPR training as a graduation requirement from DC schools. We want to work with all stakeholders to achieve this objective in the near future. Twenty-six states including Maryland and Virginia have enacted legislation requiring high school CPR training as a graduation requirement. Today you will hear testimony from persons instrumental in enactment of this legislation in Virginia. We commend their story to you, and we hope the District of Columbia will join its neighbors soon.
Good afternoon. My name is Ankoor Shah, and I am a pediatric doctor and represent the District of Columbia Chapter of the American Academy of Pediatrics (DC AAP).

DC AAP is the Washington, D.C. chapter of the national organization of 60,000 pediatricians. The D.C. chapter has over 400 members, including pediatricians, residents and medical students from all of the District’s hospitals, community clinics and school based health centers.

This bill will save lives, pure and simple. I remember when I was a training pediatrician, and I was working the Emergency Department when a 16 year old was rushed in on a stretcher unconscious. He was at a school basketball game when he suddenly collapsed. Not breathing, with no heartbeat. At that point, every minute — every second counts. Luckily paramedics were at the game. With CPR and quick Defibrillator use, his heart started to beat again. So he came in to our ER unconscious, but with a pulse — and that is what made all the difference. It’s why he is alive today. But I often wonder what would have happened if the paramedics were not there already?

The hope is that there would be a Defibrillator and staff trained in CPR nearby. The Cardiopulmonary Resuscitation and Automated External Defibrillator Requirements Act of 2015 can make that hope into a reality.

Thinking back about my patient, he had no medical problems and definitely no history of any heart issues. I think that is what scares me the most. As a general pediatrician, I hope I am catching these kids by picking up suspicious heart murmurs and family history of young cardiac problems. But with syndromes like ALCAPA (Anomalous Left Coronary Artery from the Pulmonary Artery) will not have a murmur, but it is a part of coronary artery abnormalities that
are the second leading cause of sudden death in athletes. Long QT syndrome, in which the heart
beats irregularly, can cause sudden cardiac arrest. Since this syndrome is genetic, there should be
some family members that have it. But often times it is never known – seemingly accidental
deaths like drowning and unexplained car accidents may be the clue that there is a fatal heart
disease running in the family.

As the District becomes ever more globalized & international, the risk of undiagnosed
critical heart disease in kids coming from other countries is high. Also, because of the incredible
life saving measures we can do surgically for infants with severe heart disease, more and more
children are having a significant cardiac medical history. So I only see this bill and intervention
needed more as time goes on.

Keeping all of this in mind, I believe there is still one huge gap in this bill. We at the DC
Chapter of the American Academy of Pediatrics truly believe that required CPR & AED training
is needed for all students before high school graduation. By adding this provision, you would not
only join 27 states that include it already, but dramatically increase the number of first
responders at schools and in the community. Because most students stay in the District or
surrounding area after high school, this measure is an enormous public health triumph for
District residents. Essentially thousands and thousands of citizens will be armed with how to
save a life.

Even beyond the obvious life-saving impact, this requirement will benefit the
development of our teenagers becoming young adults. During the teenage years, adolescents
move from concrete thinking to more abstract thinking. They start to identify themselves and
their relationship with the world. By having our students learn CPR & AED skills, we our
ingraining a sense of social responsibility that they will carry well beyond high school.

I remember my first CPR and First Responder training during my freshman year of
college. Trust me, I did not do it for some noble reason, but instead for course credit. But it was
that experience – the notion that I could actually save a life – which changed my career trajectory
to medicine. As we crave for more students to pursue science and medicine, learning CPR can be
their trigger as it was for me.

I would like to thank this moment to just thank you for presenting such a game changing
bill and for considering making it even stronger by requiring CPR training for high school
students and thus creating a sea of student life savers.
COMMITTEE ON THE JUDICIARY
Councilmember KENYAN R. McDUFFIE, Chairperson
Council of the District of Columbia

PUBLIC HEARING

THE STATE OF EMERGENCY MEDICAL SERVICES IN
THE DISTRICT OF COLUMBIA

Testimony of

Anne Mohnkern Renshaw
Vice-Chair,
Mayor’s Emergency Medical Services Advisory Committee
and
Immediate Past President
DC Federation of Citizens Associations

October 1, 2015
I’m Anne Renshaw, vice chair of the Mayor’s Emergency Medical Services Advisory Committee (EMSAC) and immediate past president and current board member of the D.C. Citizens Federation.

By outsourcing to private ambulance services to handle many of its calls, FEMS has admitted that it cannot do the job it is meant to do or cannot do it well enough. **This is a good thing.** That admission has been a long time coming. And it represents a change in a healthy and honest direction. However, what happens next will determine whether that healthy direction can mature into a better-functioning EMS system or simply turn out to be another ritual dance to impress the public. In the past, when FEMS has come under enough criticism, it does “something” and says, “See, I’m doing something,” which makes the criticism go away for a while. Often that “something” has consisted of hiring a new fire chief or Medical Director. Or setting up a new program [civilianization (mid 1970s), Rapid Response Units (mid 1980s) Paramedic Engine Companies (late 1990s), de-civilianization, or Dual-Role/Cross-Trained (early 2000s) All Hazard Workforce (2007), etc.].

To avoid more dancing and crisis stop-gap measures, FEMS must state (**in detail, this time and within the next 90 days**) what it plans to do after it has **bought** some breathing room with this privatization proposal. If this is indeed a short-term pilot project (aka, experiment), one designed to provide a hiatus to allow time for FEMS to pull itself together, it must quickly transition to a comprehensive EMS plan that will result in a solid, well-functioning EMS system.

The essence of one major problem faced by EMS – and the one which this pilot ambulance project will possibly help solve - is the steadily increasing volume of calls to which FEMS is required to respond. The volume is not
exclusively the result of a significant increase in the city’s population. It is possibly more a result of the population’s aging (i.e., need for more frequent service) and its increased dependency on EMS instead of other services, like conveniently-located urgent care centers and alternative transport modes.

FEMS tends to use the overused term “response time” as the primary, if not sole, measure of quality performance. It’s quantifiable; it’s easy to measure. If you toss out response time, however, a huge problem of abuse/misuse of the system remains. EMS is supposed to exist to handle emergencies, not sub-acute injuries and illnesses. By putting forward this pilot project, it looks as though FEMS is suggesting that it can better manage overuse of the system by farming out the cases which are most likely to be the sub-acute, actually non-emergency use of the system. Since the private ambulance services can only be compensated for transporting patients, does that mean that the privates will be transporting all/most these sub-acute cases thus diverting many millions from our General Fund? Keep in mind that “private services” are necessarily good or bad, but always ‘profit-driven enterprises’.

*If an enormous portion of the volume problem is non-emergency use of an emergency system, then why not empower our own first-responders to turn away non-emergency users of the system. Perhaps FEMS does not trust enough of its workforce to allow them that responsibility and/or fears that it will be sued if turning away someone who indeed had a life-threatening illness or injury. This is a more salient aspect of the problem faced by FEMS – the fact that they cannot trust their dispatches and/or pre-hospital medical care providers to make decisions about the need to transport. Outsourcing the problem to private ambulance services can a very, very expensive solution to this particular problem.*
In order to allow FEMS providers to render timely service to severely ill or injured people, the privatization plan calls for a first responder to reach the scene, assess the patient, decide whether or not to call in an outsource private unit, and make the call. This seems like an extremely cumbersome, slow approach to a job which must ideally works quickly. Why can’t a dispatcher decide, based upon the available sophisticated software and information obtained by OUC call-takers whether to call a D.C. EMS unit (for an apparently true emergency) or a private unit (for an apparent non-emergency)? The answer is either that FEMS does not trust the dispatchers to make this decision and/or it does not trust the private units to make a decision of this magnitude once they arrive on the scene.

In summary, the heart of this problem of too great a magnitude of calls seems not to be so much a problem of too little staff, or too few units, but FEMS’ mistrust of its firefighter, EMSer and dispatcher workforces. Perhaps the mistrust is justified, maybe not. But is the answer to the problem a $15,000,000 experiment? Indeed, the money is being diverted from the General Fund to pay for the outsourcing, which means that those funds will not be available for FEMS’ valuable ongoing work, new apparatus, advance training programs and/or modernization or, for that matter, other worthy city services.

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Testimony of the American Heart Association
Stuart Berlow, Director of Government Relations
DC Council Committees on Education and the Judiciary
October 1, 2015

Chairmen McDuffie and Grosso, and members of both committees: thank you for the opportunity to testify in support of this lifesaving measure. Today we have the opportunity to legislate an entire generation of lifesavers here in the District of Columbia. My name is Stuart Berlow, Director of Government Relations at the American Heart Association, and I’m happy to be here to share our views on CPR training in the District.

AHA supports this bill and the admirable goal of placing an AED in every school in Washington, DC. However, we are concerned that without including language that adds a required CPR and AED training regimen for teachers and students, the measure’s intent will not be realized. 27 states, including our neighbors in Maryland and Virginia require CPR training for all students prior to high school graduation. We encourage the Council to ensure that DC joins more than half of the country by making compulsory this critical component of high school health education. I have included suggested amendment language with my written testimony.

In a cardiac arrest, when the heart stops beating and a victim is unconscious, immediate medical care is essential. For every minute that passes without CPR, the victim’s chance of survival drops 10% every minute. Bystander CPR saves lives. If no CPR is provided or no defibrillation occurs within 3 to 5 minutes of collapse, the chances of survival drop.

326,000 people experience cardiac arrest outside of a hospital each year, including 9,500 youth and over 500 in the District. 90 percent of those victims die, often because bystanders don’t know how to start CPR or are afraid they’ll do something wrong.

Less than 30% of victims receive CPR from a bystander, and again, more than 90% die. However, bystander CPR, especially if performed immediately, can double or triple a cardiac arrest victim’s chance of survival. Teaching students CPR could save thousands of lives by filling our community with more lifesavers — those trained to give cardiac arrest victims the immediate help they need to survive until EMTs arrive.
The American Heart Association was pleased to learn that as part of its new Cornerstones program, all DCPS 7th grade and high school health students will learn CPR. This is an essential life skill, and DCPS’s commitment to teach all students, and to purchase CPR in Schools kits for all middle and high schools is a testament to DCPS’s community leadership and forward thinking.

However, we call on this Committee to formalize this voluntary curriculum addition by amending this bill to require in statute that all students will learn CPR before they graduate. Again, more than half of the country already has this common sense law in place, and it’s time for the District to do the same. Suggested language is attached.

What we’re requesting is simple, and DCPS is already doing it! Hands-only CPR can be taught in less than 30 minutes – less time than it takes to watch a TV sitcom. In fact, I had the pleasure of observing a recent CPR class at HD Woodson High School in Ward 7. The students had fun, were engaged, and learned a skill that will last a lifetime.

The bill before us, as written, is a good start: AEDs save lives. But again, AEDs are just one piece – an important piece – of the chain of survival. Without a cadre of trained bystanders, critical time and lives can be lost. And this extends far beyond the school building. Teaching CPR to all students creates a community of lifesavers, who can jump into action if they witness a cardiac arrest at home, on the sports field, or anywhere in the community. CPR saves lives, and this Committee has the opportunity to ensure that over 5,000 Washingtonians learn CPR every year in our schools.

We thank both the Judiciary and Education committees for hearing this important piece of legislation, and we strongly encourage you to amend the bill to ensure CPR training for all DCPS students prior to graduation. Thank you for your consideration, and I’m happy to answer any questions.
CPR in Schools

Suggested Amendment language to require CPR instruction as a requirement for graduation

Summary: This bill will require operators of schools grades 7-12, including school boards, operators of independent charter schools, and the governing bodies of private schools, to provide enrolled students instruction in cardiopulmonary resuscitation (CPR) and awareness in the use of an automated external defibrillator (AED) as a requirement for graduation from high school. The instruction must be based on an instructional program established by the American Heart Association or the American Red Cross or another program which is nationally recognized and uses the most current American Heart Association Guidelines for CPR and Emergency Cardiovascular Care and incorporates psychomotor skills development into the instruction.

(1) “Psychomotor skills” is defined as the use of hands-on practicing to support cognitive learning (cognitive-only training does not qualify).

(2) Beginning in the 20xx–20xx school year, each school board operating school grades 7-12, the operator of each charter school that operates school grades 7-12, and the governing body of each private school that operates school grades 7-12 shall provide instruction in cardiopulmonary resuscitation and the use of an automated external defibrillator to pupils enrolled in the school district, charter school, or private school as a requirement for graduation from high school. The school board, operator of the charter school, or governing body of the private school shall use either of the following, and shall incorporate into the instruction the psychomotor skills necessary to perform cardiopulmonary resuscitation (CPR) and awareness in the use of an automated external defibrillator (AED):

(a) An instructional program developed by the American Heart Association or the American Red Cross.

(b) An instructional program which is nationally recognized and is based on the most current American Heart Association Guidelines for CPR and Emergency Cardiovascular Care.

(3) A licensed teacher shall not be required to be an authorized CPR/AED instructor to facilitate, provide, or oversee instruction for training that does not result in a course completion card being earned.

(4) Courses which result in a course completion card being earned are required to be taught by an authorized CPR/AED instructor.

(5) The state Department of Education shall establish a procedure for monitoring adherence by school boards, operators of independent charter schools, and the governing bodies of private schools to the requirements set forth in subdivision (2) of this section and may adjust state grant/shared revenue amounts based on failure to comply with the requirements set forth in subdivision (2) of this section.
CPR in Schools
27 states | 54% of public high school graduates

Annual Public High School Graduates*

<table>
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<th>State</th>
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Total 1,639,920

2015 HANDS-ONLY™ CPR FACT SHEET

WHY LEARN HANDS-ONLY CPR?
Cardiac arrest – an electrical malfunction in the heart that causes an irregular heartbeat (arrhythmia) and disrupts the flow of blood to the brain, lungs and other organs - is a leading cause of death. Each year, over 326,000 out-of-hospital cardiac arrests occur in the United States.
- When a person has a cardiac arrest, survival depends on immediately getting CPR from someone nearby.
- According to the American Heart Association, 90 percent of people who suffer out-of-hospital cardiac arrests die. CPR, especially if performed immediately, can double or triple a cardiac arrest victim’s chance of survival.
- Most Americans (70 percent) feel helpless to act during a cardiac emergency because they don’t know how to administer CPR or they’re afraid of hurting the victim.

BE THE DIFFERENCE FOR SOMEONE YOU LOVE
If you are called on to give CPR in an emergency, you will most likely be trying to save the life of someone you love: a child, a spouse, a parent or a friend.
- 70 percent of out-of-hospital cardiac arrests happen in homes and residential settings.
- Unfortunately, only about 39% of people who experience an out-of-hospital cardiac arrest get the immediate help that they need before professional help arrives.
- Hands-Only CPR has been shown to be as effective as conventional CPR for cardiac arrest at home, at work or in public. It can double or even triple a victim’s chance of survival.

MUSIC CAN SAVE LIVES
- Hands-Only CPR has just two easy steps: If you see a teen or adult suddenly collapse, (1) Call 9-1-1; and (2) Push hard and fast in the center of the chest to the beat of the disco song “Stayin’ Alive.”
- People feel more confident performing Hands-Only CPR and are more likely to remember the correct rate when trained to the beat of a familiar song.
- During CPR, you should push on the chest at a rate of at least 100 compressions per minute. The beat of “Stayin’ Alive” is a perfect match for this.

TAKE A MINUTE TO LEARN HOW TO SAVE A LIFE
- Watch the short demo video. Visit heart.org/handsonlycpr to watch the Hands-Only CPR instructional video and share it with the important people in your life. You can also find a CPR class near you.

NOTE: The AHA still recommends CPR with compressions and breaths for infants and children and victims of drowning, drug overdose, or people who collapse due to breathing problems.
CPR in Schools

Frequently Asked Questions (FAQ)

Q: How much time does it take to train students in CPR?

A: Effective CPR training takes less than the amount of time to watch a typical 30 minute TV sitcom.

Q: How much will CPR training in school cost?

A: Costs can vary depending on the type of training utilized but estimates show the per student cost being approximately $1.00. In fact, some schools have been able to provide training at no cost using community volunteers and donated equipment. Training all middle and high school students will add one million trained rescuers across the United States every few years. Those students will be ready, willing and able to act and save lives for years to come, if they witness an emergency within their community.

Q: How will CPR in Schools be funded?

A: School districts have developed various models for providing and paying for the training and equipment, including using volunteer instructors or video-based programs, and drawing support from businesses, foundations, civic organizations and public agencies. If schools paid for their own CPR training program, average per student cost can be as low as approximately $1.00.

Q: Why should the government tell our schools what they should be teaching? Why do we have to legislate this?

A: One of the responsibilities of state government is to protect its citizens. Ensuring that school districts universally conduct CPR training fits within that responsibility.

Q: Won't CPR in Schools take time away from other more important learning?

A: No. CPR training is effectively completed in less time than it takes to watch a 30 minute TV sitcom. Students need only be trained once so we are really only talking about 30 minutes within 4 years of high school. Many schools have incorporated CPR training into existing health and physical education classes and have found it to be an excellent complement to current curriculum.

Q: Are kids really capable of administering CPR?
A: Yes. The American Heart Association does not have a minimum age requirement for people to learn CPR. The ability to perform CPR is based more on body strength rather than age. Studies have shown that middle school aged children can effectively learn and perform CPR.

Q: If someone performs CPR, aren't they liable if the person who needs CPR dies anyway?

A: Good Samaritan laws are designed to protect those who choose to serve and tend to others who are injured, ill, or otherwise incapacitated. They are intended to reduce a bystander’s hesitation to assist for fear of being sued or prosecuted for unintentional injury or wrongful death, and generally protect individuals who are acting in a volunteer capacity.

Q: Is it really true that students could be prevented from graduating if they aren't trained in CPR?

A: The goal is to ensure that students are all trained in CPR, not to create barriers to high school graduation. Students will have all 4 years of high school to complete the requirement — that’s 30 minutes of class time within 4 years. This should be achievable for all students and should not prevent anyone from graduating. However, the only way to ensure that all students receive CPR training is to make it a requirement for graduation.

Q: How are students trained in CPR?

A: Contemporary Hands-Only CPR training is much easier than training of the old days. Now CPR training includes a video and practice on a mannequin that can easily be learned in approximately 30 minutes and does not need to be taught by a certified instructor. Physical education and health teachers can teach students to perform CPR.

Q: Don't you have to be certified to perform CPR on someone?

A: No. Basic CPR training gives you the skills needed to save someone’s life and does not require certification.
About Cardiopulmonary Resuscitation (CPR)

CPR has origins dating back to the 1700's. In 1741, The Paris Academy of Sciences officially recommended mouth-to-mouth resuscitation for drowning victims. More than 100 years later in 1891, Dr. Friedrich Maass performed the first equivocally documented chest compression in humans. In 1960, a group of resuscitation pioneers, Drs Peter Safar, James Jude, and William Bennett Kouwenhoven, combined mouth-to-mouth breathing with chest compressions to create Cardiopulmonary Resuscitation, the lifesaving action we now call “CPR.”

In the 1960s, with the formal endorsement of CPR and the start of a program to acquaint physicians with closed-chest cardiac resuscitation, the American Heart Association became the forerunner of CPR training for the general public. Today, through its global Training Network of close to 300,000 Instructors and more than 3500 authorized Training Centers, the AHA trains more than 12 million people annually in CPR, first aid and advanced cardiovascular life support.

Throughout the years, CPR has evolved from a technique performed almost exclusively by physicians and healthcare professionals. Today it's a lifesaving skill that is simple enough for anyone to learn. However, research has shown that several factors prevent bystanders from taking action, including fear that they will perform CPR incorrectly, fear of legal liability, and fear of infection from performing mouth-to-mouth.

Recommendations outlined in the 2010 AHA Guidelines for CPR & ECC (Emergency Cardiovascular Care) continue to simplify CPR for rescuers, so that more people can and will act in the event of an emergency. However, to get CPR and first aid training into the hands of every person, from healthcare providers to bystanders, the way that the AHA delivers training and information also has evolved.

Through scientific research, the AHA has been able not only to create specialized training for professionals, but to lead the way in developments like Hands-Only™ CPR for bystanders, so that more victims have a chance at survival. It was 2008 when AHA first endorsed Hands-Only CPR – the two-step technique of calling 9-1-1 and pushing hard and fast in the center of the chest until help arrives. Through the AHA's Hands-Only CPR Ad Council campaign and other exciting initiatives, AHA is spreading the message that anyone can and should learn the simple skills that can save a life.

With its Alliance partner, Laerdal Medical, in 2005, AHA launched the revolutionary CPR Anytime® personal learning program, developed to increase CPR knowledge among the general public. CPR Anytime and Infant CPR Anytime kits contain everything needed to learn basic CPR skills in about 20 minutes. You can learn skills from the comfort of your home or in a group setting, and then share the kit with close family members and friends to pass on skills to others.
About Cardiopulmonary Resuscitation (CPR) (continued)

To help deliver training to busy healthcare professionals and employees with a duty to respond to emergencies in the workplace, in 2007 AHA created OnlineAHA.org, which today offers a variety of online courses in basic and advanced life support, CPR and first aid, stroke education, rhythm recognition and more. To date, more than 1.25 million people have completed courses through OnlineAHA.org!

The AHA also has been able to create tools for the general public that deliver real-time lifesaving information. The AHA Pocket First Aid & CPR Smartphone Application – AHA’s first app — amazingly helped Dan Woolley, a U.S. filmmaker trapped for more than 60 hours in rubble from the massive January 12, 2010, Haiti earthquake survive. He was able to treat his injuries using information found on the app, which features hundreds of pages of illustrations covering CPR and first aid procedures, and more than 40 detailed videos.

Sudden Cardiac Arrest (SCA) & CPR Fast Facts

- Every year in the US, EMS treats almost 393,000 out-of-hospital sudden cardiac arrests — that’s more than 1,000 a day.
- Almost 80 percent of sudden cardiac arrests happen at home and are witnessed by a loved one. Put very simply: The life you save with CPR is mostly likely to be the life of someone you love.
- Currently, less than 12 percent of victims survive sudden cardiac arrest. Effective bystander CPR provided immediately after sudden cardiac arrest can double or triple a victim’s chance of survival, but only 41 percent of cardiac arrest victims get CPR from a bystander.
- Sudden cardiac arrest can happen to anyone at any time. Many victims appear healthy with no known heart disease or other risk factors.
- Sudden cardiac arrest is not the same as a heart attack. Sudden cardiac arrest occurs when electrical impulses in the heart become rapid or chaotic, which causes the heart to suddenly stop beating. A heart attack occurs when the blood supply to part of the heart muscle is blocked. A heart attack may cause cardiac arrest.
- African-Americans are almost twice as likely to experience cardiac arrest at home, work or in another public location than Caucasians, and their survival rates are twice as poor as for Caucasians.
- The AHA trains 13 million people in CPR annually, to equip Americans with the skills they need to perform bystander CPR.
- The most effective rate for chest compressions is greater than 100 compressions per minute — the same rhythm as the beat of the BeeGee's song, "Staying Alive."
Chairman McDuffie, Chairman Grosso and other distinguished Council-members, my name is Jennifer Griffin and I am here today to testify in support of amending Bill 243.

As the legislation currently stands, I applaud your efforts to put AED’s in all schools. However, an AED is merely a tool used in the process to save a life. Without someone to operate the AED it is simply a machine and without the majority of the population being aware of how and when to use the AED, it could very well go unnoticed and unused in an emergency situation. This was proven most recently in this very building when an employee collapsed.

A more comprehensive bill would include at least the training of students if not the training of all faculty. I am here today to share the story of my daughter Gwyneth.

Gwyneth was a happy, active and compassionate 12 year old. She had recently been inducted into the National Junior Honor Society and had won the school and regional science fairs. Although born with a heart murmur she was an avid dancer. Gwyneth always had a smile to share whether she had just met you or had known you her entire life.

On the morning of June 8, 2012, she went to school early for a day of activities focused around healthy eating and exercise. Her father joined her that morning then went to the adjoining school for our younger daughter’s field day. Around ten o’clock several students ran to get my husband saying Gwyneth had passed out on the track and he needed to check on her. As he got closer he saw her laid flat, in a ditch and no one by her side, no one doing anything. Upon reaching Gwyneth he began CPR. Seconds later he was joined by a substitute teacher with an EMT background. Together they worked to regain a pulse. It must be noted that it was Gwyneth’s friends that took the initiative to seek help and locate the AED.

When emergency services arrived she was transported to the local hospital then flown to Richmond. We spent seven weeks repairing the organs and systems affected by this event. However, the one organ we were unable to repair was her brain. She suffered a devastating and unrecoverable anoxic brain injury. For us it was seven weeks of one heart wrenching decision after another.

On July 30th Gwyneth passed away all because the time between her collapse and the arrival of my husband no one did anything. Had CPR and defibrillation been available faster – the outcome may have been different.

It was during our time in the hospital that we decided to ensure no other parent ever had to arrive at school to save their own child and we began to write what would be known as Gwyneth’s Law. Gwyneth’s Law was passed in Virginia in March 2013.
Since the passage of Gwyneth’s Law, the lives of at least four individuals in Virginia have been saved. It is our hope that this becomes a national standard for all schools, students and teachers and with amendments to Bill 243 our nation’s capital could join us in this endeavor.

CPR has been written into the DC Public School Cornerstone Program as seventh grade and high school health objectives. By amending Bill 243 to include student training, you are ensuring that CPR training remains a requirement across the District in perpetuity. By joining Virginia and Maryland, DC’s 5,000 graduating seniors, will create approximately 145,000 life savers across our national capital region.

Before I conclude my remarks today I would like to leave you with three things to consider.

First, CPR training is already written into the DC curriculum. The only new requirement would be for health teachers to annotate in student’s records that they completed the training. This does not affect graduation rates.

Second, Gwyneth’s friends repeatedly told us that had they known CPR they would have acted. It was her friends that took it upon themselves to become CPR certified in those seven weeks we were in the hospital. Not only did they become certified themselves, but took other friends, family and neighbors with them. Students ARE very capable of learning and administering CPR.

Finally, the brain begins to die within 4-6 minutes and the national average response time for EMS is 6-8 minutes. Without properly trained individuals, people suffering an out-of-hospital cardiac arrest have little to no chance of recovering a productive quality of life. If amended, Bill 243 can ensure that time is NOT lost especially since the individual with the patient is the true “first responder.”

The requested amendment to this bill is not only the right thing for DC Public Schools, but the right thing for the overall health of individuals suffering cardiac arrests across the District of Columbia. I respectfully ask your support in creating a new generation of life savers by writing a more comprehensive bill to include training the students and teachers of DC Public Schools.

Thank you for your attention to this important issue and your commitment to the health of all DC residents.
Gwyneth Griffin
6/26/99 - 7/30/12

Student
- National Junior Honor Society Member
- School Science Fair, Grade Level Winner (2 times)
- Regional Science Fair, 2nd Place (Biology)
- Technology Student Association (1 Year)
- Mural Club (2 years)
- Student Council Classroom Representative (1 year)
- Patrick McGrath School of Irish Dance (5 years)
- Barton & Williams Dance Academy (8 years)
- Stafford Area Soccer Association (SASA) (1 year)
- Girl Scouts (2 years)

Patient
- Virginia Commonwealth University (VCU) Hospital
  (06/08/12 - 07/30/12)
  - Initial collapse from a cardiac event possibly
    related to an underlying congenital heart defect
  - Death was a result of complications from an anoxic
    brain injury

Friend
- 14,752 “hits” on Caring bridge during hospital stay
  and immediately thereafter
- 400+ attendees at Gwyneth’s funeral
- Over $5000 in donations made by individuals to the
  Ronald McDonald House, American Heart
  Association, American Red Cross, Brain Injury
  Association of American, VCU Child Life
  Department

“Gwyneth was the most amazing friend, she never was into
drama, or rumors...she was beautiful, kind, strong hearted,
open minded, and smart. She was there for you when you
needed her. Gwyneth was there from the beginning, she would
never give up on you. That’s why I love her.”
- Stafford County Public School Student

Be it enacted by the General Assembly of Virginia:

1. That §§ 22.1-178, 22.1-253.13:1, 22.1-253.13:4, 22.1-274, 22.1-298.1, and 22.1-299.3 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 22.1-274.4 as follows:

§ 22.1-178. Requirements for persons employed to drive school buses.
A. No school board shall hire, employ, or enter into any agreement with any person for the purposes of operating a school bus transporting pupils unless the person proposed to so operate such school bus shall:
   1. Have a physical examination of a scope prescribed by the Board of Education with the advice of the Medical Society of Virginia and furnish a form prescribed by the Board of Education showing the results of such examination.
   2. Furnish a statement or copy of records from the Department of Motor Vehicles showing that the records of such Department do not disclose that the person, within the preceding five years, has been convicted upon a charge of driving under the influence of alcohol or drugs, convicted of a felony or assigned to any alcohol safety action program or driver alcohol rehabilitation program pursuant to § 18.2-271.1 or, within the preceding twelve 12 months, has been convicted of two or more moving traffic violations or required to attend a driver improvement clinic by the Commissioner of the Department of Motor Vehicles pursuant to § 46.2-498.
   3. Furnish a statement signed by two reputable persons who reside in the school division or in the applicant's community that the person is of good moral character.
   4. Exhibit a license showing the person has successfully undertaken the examination prescribed by § 46.2-339.
   5. Have reached the age of eighteen 18 on the first day of the school year.
B. Any school board may require successful completion of the American National Red Cross first-aid course or its equivalent proof of current certification or training in emergency first aid, cardiopulmonary resuscitation, and the use of an automated external defibrillator as a condition to employment to operate a school bus transporting pupils.
C. School boards may require persons accepting employment after July 1, 1994, as a driver of a school bus transporting pupils to agree, as a condition of employment, to submit to alcohol and controlled substance testing. Any such tests shall be conducted in compliance with Board of Education regulations.
D. The documents required pursuant to subdivisions A 1 and A 2 of this section shall be furnished annually prior to the anniversary date of the employment agreement as a condition to continuing employment to operate a school bus.
E. The documents required pursuant to this section shall be filed with, and made a part of, the records of the school board employing such person as a school bus operator.
F. The State Department of Education shall furnish to the several division superintendents the necessary forms to be used by applicants in furnishing the information required by this section. Insofar as practicable, such forms shall be designed to limit paperwork, avoid the possibility of mistake, and furnish all parties involved with a complete and accurate record of the information required.
G. The physical examination required by subsection A may be performed and the report of the results signed by a licensed nurse practitioner or physician assistant.

A. The General Assembly and the Board of Education believe that the fundamental goal of the public schools of the Commonwealth must be to enable each student to develop the skills that are necessary for success in school, preparation for life, and reaching their full potential. The General Assembly and the Board of Education find that the quality of education is dependent upon the provision of (i) the appropriate working environment, benefits, and salaries necessary to ensure the availability of
high-quality instructional personnel; (ii) the appropriate learning environment designed to promote student achievement; (iii) quality instruction that enables each student to become a productive and educated citizen of Virginia and the United States of America; and (iv) the adequate commitment of other resources. In keeping with this goal, the General Assembly shall provide for the support of public education as set forth in Article VIII, Section 1 of the Constitution of Virginia.

B. The Board of Education shall establish educational objectives known as the Standards of Learning, which shall form the core of Virginia's educational program, and other educational objectives, which together are designed to ensure the development of the skills that are necessary for success in school and for preparation for life in the years beyond. At a minimum, the Board shall establish Standards of Learning for English, mathematics, science, and history and social science. The Standards of Learning shall not be construed to be regulations as defined in § 2.2-4001.

The Board shall seek to ensure that the Standards of Learning are consistent with a high-quality foundation educational program. The Standards of Learning shall include, but not be limited to, the basic skills of communication (listening, speaking, reading, and writing); computation and critical reasoning, including problem solving and decision making; proficiency in the use of computers and related technology; and the skills to manage personal finances and to make sound financial decisions.

The English Standards of Learning for reading in kindergarten through grade three shall be based on components of effective reading instruction, to include, at a minimum, phonemic awareness, phonics, fluency, vocabulary development, and text comprehension.

The Standards of Learning in all subject areas shall be subject to regular review and revision to maintain rigor and to reflect a balance between content knowledge and the application of knowledge in preparation for eventual employment and lifelong learning. The Board of Education shall establish a regular schedule, in a manner it deems appropriate, for the review, and revision as may be necessary, of the Standards of Learning in all subject areas. Such review of each subject area shall occur at least once every seven years. Nothing in this section shall be construed to prohibit the Board from conducting such review and revision on a more frequent basis.

To provide appropriate opportunity for input from the general public, teachers, and local school boards, the Board of Education shall conduct public hearings prior to establishing revised Standards of Learning. Thirty days prior to conducting such hearings, the Board shall give notice of the date, time, and place of the hearings to all local school boards and any other persons requesting to be notified of the hearings and publish notice of its intention to revise the Standards of Learning in the Virginia Register of Regulations. Interested parties shall be given reasonable opportunity to be heard and present information prior to final adoption of any revisions of the Standards of Learning.

In addition, the Department of Education shall make available and maintain a website, either separately or through an existing website utilized by the Department of Education, enabling public elementary, middle, and high school educators to submit recommendations for improvements relating to the Standards of Learning, when under review by the Board according to its established schedule, and related assessments required by the Standards of Quality pursuant to this chapter. Such website shall facilitate the submission of recommendations by educators.

School boards shall implement the Standards of Learning or objectives specifically designed for their school divisions that are equivalent to or exceed the Board's requirements. Students shall be expected to achieve the educational objectives established by the school division at appropriate age or grade levels. The curriculum adopted by the local school division shall be aligned to the Standards of Learning.

The Board of Education shall include in the Standards of Learning for history and social science the study of contributions to society of diverse people. For the purposes of this subsection, "diverse" shall include consideration of disability, ethnicity, race, and gender.

The Board of Education shall include in the Standards of Learning for health instruction in emergency first aid, cardiopulmonary resuscitation, and the use of an automated external defibrillator, including hands-on practice of the skills necessary to perform cardiopulmonary resuscitation. Such instruction shall be based on the current national evidence-based emergency cardiovascular care guidelines for cardiopulmonary resuscitation and the use of an automated external defibrillator, such as a program developed by the American Heart Association or the American Red Cross. No teacher who is in compliance with subdivision D 4 of § 22.1-298.1 shall be required to be certified as a trainer of cardiopulmonary resuscitation to provide instruction for non-certification.

With such funds as are made available for this purpose, the Board shall regularly review and revise the competencies for career and technical education programs to require the full integration of English, mathematics, science, and history and social science Standards of Learning. Career and technical education programs shall be aligned with industry and professional standard certifications, where they exist.

C. Local school boards shall develop and implement a program of instruction for grades K through 12 that is aligned to the Standards of Learning and meets or exceeds the requirements of the Board of
Education. The program of instruction shall emphasize reading, writing, speaking, mathematical concepts and computations, proficiency in the use of computers and related technology, and scientific concepts and processes; essential skills and concepts of citizenship, including knowledge of Virginia history and world and United States history, economics, government, foreign languages, international cultures, health and physical education, environmental issues, and geography necessary for responsible participation in American society and in the international community; fine arts, which may include, but need not be limited to, music and art, and practical arts; knowledge and skills needed to qualify for further education, gainful employment, or training in a career or technical field; and development of the ability to apply such skills and knowledge in preparation for eventual employment and lifelong learning and to achieve economic self-sufficiency.

Local school boards shall also develop and implement programs of prevention, intervention, or remediation for students who are educationally at risk including, but not limited to, those who fail to achieve a passing score on any Standards of Learning assessment in grades three through eight or who fail an end-of-course test required for the award of a verified unit of credit. Such programs shall include components that are research-based.

Any student who achieves a passing score on one or more, but not all, of the Standards of Learning assessments for the relevant grade level in grades three through eight may be required to attend a remediation program.

Any student who fails to achieve a passing score on all of the Standards of Learning assessments for the relevant grade level in grades three through eight or who fails an end-of-course test required for the award of a verified unit of credit shall be required to attend a remediation program or to participate in another form of remediation. Division superintendents shall require such students to take special programs of prevention, intervention, or remediation, which may include attendance in public summer school programs, in accordance with clause (ii) of subsection A of § 22.1-254 and § 22.1-254.01.

Remediation programs shall include, when applicable, a procedure for early identification of students who are at risk of failing the Standards of Learning assessments in grades three through eight or who fail an end-of-course test required for the award of a verified unit of credit. Such programs may also include summer school for all elementary and middle school grades and for all high school academic courses, as defined by regulations promulgated by the Board of Education, or other forms of remediation. Summer school remediation programs or other forms of remediation shall be chosen by the division superintendent to be appropriate to the academic needs of the student. Students who are required to attend such summer school programs or to participate in another form of remediation shall not be charged tuition by the school division.

The requirement for remediation may, however, be satisfied by the student's attendance in a program of prevention, intervention or remediation that has been selected by his parent, in consultation with the division superintendent or his designee, and is either (i) conducted by an accredited private school or (ii) a special program that has been determined to be comparable to the required public school remediation program by the division superintendent. The costs of such private school remediation program or other special remediation program shall be borne by the student's parent.

The Board of Education shall establish standards for full funding of summer remedial programs that shall include, but not be limited to, the minimum number of instructional hours or the equivalent thereof required for full funding and an assessment system designed to evaluate program effectiveness. Based on the number of students attending and the Commonwealth's share of the per pupil instructional costs, state funds shall be provided for the full cost of summer and other remediation programs as set forth in the appropriation act, provided such programs comply with such standards as shall be established by the Board, pursuant to § 22.1-199.2.

D. Local school boards shall also implement the following:

1. Programs in grades K through three that emphasize developmentally appropriate learning to enhance success.

2. Programs based on prevention, intervention, or remediation designed to increase the number of students who earn a high school diploma and to prevent students from dropping out of school. Such programs shall include components that are research-based.

3. Career and technical education programs incorporated into the K through 12 curricula that include:
   a. Knowledge of careers and all types of employment opportunities, including, but not limited to, apprenticeships, entrepreneurship and small business ownership, the military, and the teaching profession, and emphasize the advantages of completing school with marketable skills;
   b. Career exploration opportunities in the middle school grades; and
   c. Competency-based career and technical education programs that integrate academic outcomes, career guidance, and job-seeking skills for all secondary students. Programs must be based upon labor market needs and student interest. Career guidance shall include counseling about available employment opportunities and placement services for students exiting school. Each school board shall
develop and implement a plan to ensure compliance with the provisions of this subdivision. Such plan
shall be developed with the input of area business and industry representatives and local community
colleges and shall be submitted to the Superintendent of Public Instruction in accordance with the
timelines established by federal law.
4. Educational objectives in middle and high school that emphasize economic education and financial
literacy pursuant to § 22.1-200.03.
5. Early identification of students with disabilities and enrollment of such students in appropriate
instructional programs consistent with state and federal law.
6. Early identification of gifted students and enrollment of such students in appropriately
differentiated instructional programs.
7. Educational alternatives for students whose needs are not met in programs prescribed elsewhere in
these standards. Such students shall be counted in average daily membership (ADM) in accordance with
the regulations of the Board of Education.
8. Adult education programs for individuals functioning below the high school completion level.
Such programs may be conducted by the school board as the primary agency or through a collaborative
arrangement between the school board and other agencies.
9. A plan to make achievements for students who are educationally at risk a divisionwide priority
that shall include procedures for measuring the progress of such students.
10. An agreement for postsecondary degree attainment with a community college in the
Commonwealth specifying the options for students to complete an associate's degree or a one-year
Uniform Certificate of General Studies from a community college concurrent with a high school
diploma. Such agreement shall specify the credit available for dual enrollment courses and Advanced
Placement courses with qualifying exam scores of three or higher.
11. A plan to notify students and their parents of the availability of dual enrollment and advanced
placement classes, the International Baccalaureate Program, and Academic Year Governor's School
Programs, the qualifications for enrolling in such classes and programs, and the availability of financial
assistance to low-income and needy students to take the advanced placement and International
Baccalaureate examinations. This plan shall include notification to students and parents of the agreement
with a community college in the Commonwealth to enable students to complete an associate's degree or
a one-year Uniform Certificate of General Studies concurrent with a high school diploma.
12. Identification of students with limited English proficiency and enrollment of such students in
appropriate instructional programs.
13. Early identification, diagnosis, and assistance for students with reading and mathematics problems
and provision of instructional strategies and reading and mathematics practices that benefit the
development of reading and mathematics skills for all students.
Local school divisions shall provide reading intervention services to students in grade three who
demonstrate deficiencies based on their individual performance on the Standards of Learning reading test
or any reading diagnostic test that meets criteria established by the Department of Education. The local
school division, in its discretion, shall provide such reading intervention services prior to promoting a
student from grade three to grade four. Reading intervention services may include the use of: special
reading teachers; trained aides; volunteer tutors under the supervision of a certified teacher;
computer-based reading tutorial programs; aides to instruct in-class groups while the teacher provides
direct instruction to the students who need extra assistance; and extended instructional time in the school
day or school year for these students. Funds appropriated for prevention, intervention, and remediation;
summer school remediation; at-risk; or early intervention reading may be used to meet the requirements
of this subdivision.
14. Incorporation of art, music, and physical education as a part of the instructional program at the
elementary school level.
15. A program of physical fitness available to all students with a goal of at least 150 minutes per
week on average during the regular school year. Such program may include any combination of (i)
physical education classes, (ii) extracurricular athletics, or (iii) other programs and physical activities
deemed appropriate by the local school board. Each local school board shall incorporate into its local
wellness policy a goal for the implementation of such program during the regular school year.
16. A program of student services for grades kindergarten through grade 12 that shall be designed to
aid students in their educational, social, and career development.
17. The collection and analysis of data and the use of the results to evaluate and make decisions
about the instructional program.
E. From such funds as may be appropriated or otherwise received for such purpose, there shall be
established within the Department of Education a unit to (i) conduct evaluative studies; (ii) provide the
resources and technical assistance to increase the capacity for school divisions to deliver quality
instruction; and (iii) assist school divisions in implementing those programs and practices that will
enhance pupil academic performance and improve family and community involvement in the public schools. Such unit shall identify and analyze effective instructional programs and practices and professional development initiatives; evaluate the success of programs encouraging parental and family involvement; assess changes in student outcomes prompted by family involvement; and collect and disseminate among school divisions information regarding effective instructional programs and practices, initiatives promoting family and community involvement, and potential funding and support sources. Such unit may also provide resources supporting professional development for administrators and teachers. In providing such information, resources, and other services to school divisions, the unit shall give priority to those divisions demonstrating a less than 70 percent passing rate on the Standards of Learning assessments.


A. Each local school board shall award diplomas to all secondary school students, including students who transfer from nonpublic schools or from home instruction, who earn the units of credit prescribed by the Board of Education, pass the prescribed tests, and meet such other requirements as may be prescribed by the local school board and approved by the Board of Education. Provisions shall be made to facilitate the transfer and appropriate grade placement of students from other public secondary schools, from nonpublic schools, or from home instruction as outlined in the standards for accreditation. Course credits earned for online courses taken in the Department of Education's Virginia Virtual program shall transfer to Virginia public schools in accordance with provisions of the standards for accreditation. Further, reasonable accommodation to meet the requirements for diplomas shall be provided for otherwise qualified students with disabilities as needed.

In addition, each local school board may devise, vis-a-vis the award of diplomas to secondary school students, a mechanism for calculating class rankings that takes into consideration whether the student has taken a required class more than one time and has had any prior earned grade for such required class expunged.

Each local school board shall notify the parents of rising eleventh and twelfth grade students of (i) the number and subject area requirements of standard and verified units of credit required for graduation pursuant to the standards for accreditation and (ii) the remaining number and subject area requirements of such units of credit the individual student requires for graduation.

B. Students identified as disabled who complete the requirements of their individualized education programs shall be awarded special diplomas by local school boards.

Each local school board shall notify the parent of such students with disabilities who have an individualized education program and who fail to meet the requirements for a standard or advanced studies diploma of the student's right to a free and appropriate education to age 21, inclusive, pursuant to Article 2 (§ 22.1-213 et seq.) of Chapter 13.

C. Students who have completed a prescribed course of study as defined by the local school board shall be awarded certificates of program completion by local school boards if they are not eligible to receive a Board of Education-approved diploma.

Each local school board shall provide notification of the right to a free public education for students who have not reached 20 years of age on or before August 1 of the school year, pursuant to Chapter 1 (§ 22.1-1 et seq.), to the parent of students who fail to graduate or who have failed to achieve the number of verified units of credit required for graduation as provided in the standards for accreditation. If such student who does not graduate or achieve such verified units of credit is a student for whom English is a second language, the local school board shall notify the parent of the student's opportunity for a free public education in accordance with § 22.1-5.

D. In establishing course and credit requirements for a high school diploma, the Board shall:

1. Provide for the selection of integrated learning courses meeting the Standards of Learning and approved by the Board to satisfy graduation credit requirements, which shall include Standards of Learning testing, as necessary.

2. Establish the requirements for a standard and an advanced studies high school diploma, which shall each include at least one credit in fine or performing arts or career and technical education and one credit in United States and Virginia history. The requirements for a standard high school diploma shall, however, include at least two sequential electives chosen from a concentration of courses selected from a variety of options that may be planned to ensure the completion of a focused sequence of elective courses. Such focused sequence of elective courses shall provide a foundation for further education or training or preparation for employment. The advanced studies diploma shall be the recommended diploma for students pursuing baccalaureate study. Both the standard and the advanced studies diploma shall prepare students for post-secondary education and the career readiness required by the Commonwealth's economy.

Beginning with first-time ninth grade students in the 2013-2014 school year, requirements for the standard diploma shall include a requirement to earn a career and technical education credential that has
been approved by the Board, that could include, but not be limited to, the successful completion of an
industry certification, a state licensure examination, a national occupational competency assessment, or
the Virginia workplace readiness skills assessment.

Beginning with first-time ninth grade students in the 2016-2017 school year, requirements for the
standard and advanced diplomas shall include a requirement to be trained in emergency first aid,
cardiopulmonary resuscitation, and the use of automated external defibrillators, including hands-on
practice of the skills necessary to perform cardiopulmonary resuscitation.

The Board shall make provision in its regulations for students with disabilities to earn a standard
diploma.

3. Provide, in the requirements to earn a standard or advanced studies diploma, the successful
completion of one virtual course. The virtual course may be a noncredit-bearing course.

4. Provide, in the requirements for the verified units of credit stipulated for obtaining the standard or
advanced studies diploma, that students completing elective classes into which the Standards of Learning
for any required course have been integrated may take the relevant Standards of Learning test for the
relevant required course and receive, upon achieving a satisfactory score on the specific Standards of
Learning assessment, a verified unit of credit for such elective class that shall be deemed to satisfy the
Board’s requirement for verified credit for the required course.

5. Establish a procedure to facilitate the acceleration of students that allows qualified students, with
the recommendation of the division superintendent, without completing the 140-hour class, to obtain
credit for such class upon demonstration of mastery of the course content and objectives. Having
received credit for the course, the student shall be permitted to sit for the relevant Standards of Learning
assessment and, upon receiving a passing score, shall earn a verified credit. Nothing in this section shall
preclude relevant school division personnel from enforcing compulsory attendance in public schools.

6. Provide for the award of verified units of credit for passing scores on industry certifications, state
licensure examinations, and national occupational competency assessments approved by the Board of
Education.

School boards shall report annually to the Board of Education the number of Board-approved
industry certifications obtained, state licensure examinations passed, national occupational competency
assessments passed, Virginia workplace readiness skills assessments passed, and the number of career
and technical education completers who graduated. These numbers shall be reported as separate
categories on the School Performance Report Card.

For the purposes of this subdivision, a "career and technical education completer" is means a student
who has met the requirements for a career and technical concentration or specialization and all
requirements for high school graduation or an approved alternative education program.

In addition, the Board may:

a. For the purpose of awarding verified units of credit, approve the use of additional or substitute
tests for the correlated Standards of Learning assessment, such as academic achievement tests, industry
certifications or state licensure examinations; and

b. Permit students completing career and technical education programs designed to enable such
students to pass such industry certification examinations or state licensure examinations to be awarded,
upon obtaining satisfactory scores on such industry certification or licensure examinations, the
appropriate verified units of credit for one or more career and technical education classes into which
relevant Standards of Learning for various classes taught at the same level have been integrated. Such
industry certification and state licensure examinations may cover relevant Standards of Learning for
various required classes and may, at the discretion of the Board, address some Standards of Learning for
several required classes.

7. Provide for the waiver of certain graduation requirements (i) upon the Board’s initiative or (ii) at
the request of a local school board. Such waivers shall be granted only for good cause and shall be
considered on a case-by-case basis.

E. In the exercise of its authority to recognize exemplary academic performance by providing for
diploma seals, the Board of Education shall develop criteria for recognizing exemplary performance in
career and technical education programs by students who have completed the requirements for a Board
of Education-approved diploma and shall award seals on the diplomas of students meeting such criteria.
In addition, the Board shall establish criteria for awarding a diploma seal for advanced mathematics
and technology for the Board of Education-approved diplomas. The Board shall consider including
criteria for (i) technology courses, (ii) technical writing, reading, and oral communication skills; (iii)
technology-related training; and (iv) industry, professional, and trade association national certifications.

The Board shall also establish criteria for awarding a diploma seal for excellence in civics education
and understanding of our state and federal constitutions and the democratic model of government for the
Board of Education-approved diplomas. The Board shall consider including criteria for (i) successful
completion of history, government, and civics courses, including courses that incorporate character
education; (ii) voluntary participation in community service or extracurricular activities that includes the
types of activities that shall qualify as community service and the number of hours required; and (iii)
related requirements as it deems appropriate.
F. The Board shall establish, by regulation, requirements for the award of a general achievement
adult high school diploma for those persons who are not subject to the compulsory school attendance
requirements of § 22.1-254 and have (i) achieved a passing score on the GED examination; (ii)
successfully completed an education and training program designated by the Board of Education; (iii)
earned a Board of Education-approved career and technical education credential such as the successful
completion of an industry certification, a state licensure examination, a national occupational competency
assessment, or the Virginia workplace readiness skills assessment; and (iv) satisfied other requirements
as may be established by the Board for the award of such diploma.
G. To ensure the uniform assessment of high school graduation rates, the Board shall collect,
analyze, and report high school graduation and dropout data using a formula prescribed by the Board.
The Board may promulgate such regulations as may be necessary and appropriate for the collection,
analysis, and reporting of such data.
§ 22.1-274. School health services.
A. A school board shall provide pupil personnel and support services, in compliance with
§ 22.1-253.13:2. A school board may employ school nurses, physicians, physical therapists, occupational
therapists, and speech therapists. No such personnel shall be employed unless they meet such standards
as may be determined by the Board of Education. Subject to the approval of the appropriate local
governing body, a local health department may provide personnel for health services for the school
division.
B. In implementing subsection O of § 22.1-253.13:2, relating to providing support services which
that are necessary for the efficient and cost-effective operation and maintenance of its public schools,
each school board may strive to employ, or contract with local health departments for, nursing services
consistent with a ratio of at least one nurse (i) per 2,500 students by July 1, 1996; (ii) per 2,000
students by July 1, 1997; (iii) per 1,500 students by July 1, 1998; and (iv) per 1,000 students by July 1,
1999. In those school divisions in which there are more than 1,000 students in average daily
membership in school buildings, this section shall not be construed to encourage the employment of
more than one nurse per school building. Further, this section shall not be construed to mandate the
aspired-to ratios.
C. The Board of Education shall monitor the progress in achieving the ratios set forth in subsection
B of this section and any subsequent increase in prevailing statewide costs, and the mechanism for
funding health services, pursuant to subsection O of § 22.1-253.13:2 and the appropriation act. The
Board shall also determine how school health funds are used and school health services are delivered in
each locality and shall provide, by December 1, 1994, a detailed analysis of school health expenditures
to the House Committee on Education, the House Committee on Appropriations, the Senate Committee
on Education and Health, and the Senate Committee on Finance.
D. With the exception of school administrative personnel and persons employed by school boards
who have the specific duty to deliver health-related services, no licensed instructional employee,
instructional aide, or clerical employee shall be disciplined, placed on probation, or dismissed on the
basis of such employee's refusal to (i) perform nonemergency health-related services for students or (ii)
obtain training in the administration of insulin and glucagon. However, instructional aides and clerical
employees may not refuse to dispense oral medications.
For the purposes of this subsection, "health-related services" means those activities which that, when
performed in a health care facility, must be delivered by or under the supervision of a licensed or
certified professional.
E. Each school board shall ensure that, in school buildings with an instructional and administrative
staff of ten 10 or more, (i) at least two three employees have current certification or training in
emergency first aid, cardiopulmonary resuscitation, or have received training, within the last two years,
in emergency first aid and cardiopulmonary resuscitation and the use of an automated external
defibrillator and (ii) if one or more students diagnosed as having diabetes attend such school, at least
two employees have been trained in the administration of insulin and glucagon. In school buildings with
an instructional and administrative staff of fewer than ten 10, school boards shall ensure that (i) (a) at
least one employee has two employees have current certification or training in emergency first aid,
cardiopulmonary resuscitation, or have received training, within the last two years, in emergency first aid
and cardiopulmonary resuscitation and the use of an automated external defibrillator and (ii) (b) if one
or more students diagnosed as having diabetes attend such school, at least one employee has been
trained in the administration of insulin and glucagon. "Employee" shall include includes any person
employed by a local health department who is assigned to the public school pursuant to an agreement
between the local health department and the school board. When a registered nurse, nurse practitioner,
physician, or physician assistant is present, no employee who is not a registered nurse, nurse practitioner, physician, or physician assistant shall assist with the administration of insulin or administer glucagon. Prescriber authorization and parental consent shall be obtained for any employee who is not a registered nurse, nurse practitioner, physician, or physician assistant to assist with the administration of insulin and administer glucagon.

§ 22.1-274.4. Automated external defibrillators.
Each local school board may develop a plan to allow for the placement, care, and use, and funding of an automated external defibrillator in every school.

§ 22.1-298.1. Regulations governing licensure.
A. As used in this section:
"Alternate route to licensure" means a nontraditional route to teacher licensure available to individuals who meet the criteria specified in the regulations issued by the Board of Education.
"Licensure by reciprocity" means a process used to issue a license to an individual coming into Virginia from another state when that individual meets certain conditions specified in the Board of Education's regulations.
"Professional teacher's assessment" means those tests mandated for licensure as prescribed by the Board of Education.
"Provisional license" means a nonrenewable license issued by the Board of Education for a specified period of time, not to exceed three years, to an individual who may be employed by a school division in Virginia and who generally meets the requirements specified in the Board of Education's regulations for licensure, but who may need to take additional coursework or pass additional assessments to be fully licensed with a renewable license. 
"Renewable license" means a license issued by the Board of Education for five years to an individual who meets the requirements specified in the Board of Education's regulations.
B. The Board of Education shall prescribe, by regulation, the requirements for the licensure of teachers and other school personnel required to hold a license. Such regulations shall include requirements for the denial, suspension, cancellation, revocation, and reinstatement of licensure. The Board of Education shall revoke the license of any person for whom it has received a notice of dismissal or resignation pursuant to subsection F of § 22.1-313 and, in the case of a person who is the subject of a founded complaint of child abuse or neglect, after all rights to any appeal provided by § 63.2-1526 have been exhausted. Regardless of the authority of any other agency of the Commonwealth to approve educational programs, only the Board of Education shall have the authority to license teachers to be regularly employed by school boards, including those employed to provide nursing education.

The Board of Education shall prescribe by regulation the licensure requirements for teachers who teach only online courses, as defined in § 22.1-212.23. Such license shall be valid only for teaching online courses. Teachers who hold a five-year renewable license issued by the Board of Education may teach online courses for which they are properly endorsed.

Notwithstanding the provisions of this section and the Board's authority to license teachers, local school boards shall be authorized to issue valid, three-year local eligibility licenses pursuant to § 22.1-299.3.

C. The Board of Education's regulations shall include requirements that a person seeking initial licensure:
1. Complete professional assessments as prescribed by the Board of Education;
2. Complete study in attention deficit disorder;
3. Complete study in gifted education, including the use of multiple criteria to identify gifted students; and
4. Complete study in methods of improving communication between schools and families and ways of increasing family involvement in student learning at home and at school.

D. In addition, such regulations shall include requirements that:
1. Every person seeking initial licensure or renewal of a license demonstrate proficiency in the use of educational technology for instruction;
2. Every person seeking initial licensure and persons seeking licensure renewal as teachers who have not completed such study shall complete study in child abuse recognition and intervention in accordance with curriculum guidelines developed by the Board of Education in consultation with the Department of Social Services that are relevant to the specific teacher licensure routes;
3. Every person seeking initial licensure or renewal of a license shall receive professional development in instructional methods tailored to promote student academic progress and effective preparation for the Standards of Learning end-of-course and end-of-grade assessments; and
4. Every person seeking initial licensure or renewal of a license shall provide evidence of completion of certification or training in emergency first aid, cardiopulmonary resuscitation, and the use of
automated external defibrillators. The certification or training program shall be based on the current national evidence-based emergency cardiovascular care guidelines for cardiopulmonary resuscitation and the use of an automated external defibrillator, such as a program developed by the American Heart Association or the American Red Cross. The Board shall provide a waiver for this requirement for any person with a disability whose disability prohibits such person from completing the certification or training; and

4.5. Every person seeking licensure with an endorsement as a teacher of the blind and visually impaired shall demonstrate proficiency in reading and writing Braille.

E. The Board's regulations shall require that initial licensure for principals and assistant principals be contingent upon passage of an assessment as prescribed by the Board.

F. The Board shall establish criteria in its regulations to effectuate the substitution of experiential learning for coursework for those persons seeking initial licensure through an alternate route as defined in Board regulations.

G. Notwithstanding any provision of law to the contrary, the Board may provide for the issuance of a provisional license, valid for a period not to exceed three years, to any person who does not meet the requirements of this section or any other requirement for licensure imposed by law.

H. The Board's licensure regulations shall also provide for licensure by reciprocity:

1. With comparable endorsement areas for those individuals holding a valid out-of-state teaching license and national certification from the National Board for Professional Teaching Standards or a nationally recognized certification program approved by the Board of Education. The application for such individuals shall require evidence of such valid license and national certification and shall not require official student transcripts.

2. For individuals who have obtained a valid out-of-state license, with full credentials and without deficiencies, that is in force at the time the application for a Virginia license is received by the Department of Education. The individual must establish a file in the Department of Education by submitting a complete application packet, which shall include official student transcripts. An assessment of basic skills as provided in § 22.1-298.2 and service requirements shall not be imposed for these licensed individuals; however, other licensing assessments, as prescribed by the Board of Education, shall be required; and

3. The Board may include other provisions for reciprocity in its regulations.

§ 22.1-299.3. Three-year local eligibility license.

A. Local school boards shall be authorized, upon recommendation of the local superintendent, to issue a valid three-year nonrenewable local eligibility license to classroom teacher candidates in accordance with the following criteria:

1. No such license shall be issued to teachers providing instruction in special education, and the issuance of such license shall be restricted to those teachers providing instruction in courses that do not represent core academic areas as defined by the federal No Child Left Behind Act, P.L. 107-110, as it may be amended.

2. No more than 10 percent of the classroom teachers employed by the relevant local school division shall hold such local licenses, based on the number of classroom teachers employed by such school division during the preceding school year.

3. The applicant for a three-year local eligibility license shall have earned a baccalaureate degree from an accredited institution of higher education and shall have such experience or training in a subject or content area as the local school board and superintendent may deem appropriate for the intended teaching assignment.

4. The applicant for a three-year local eligibility license shall provide evidence of completion of certification or training in emergency first aid, cardiopulmonary resuscitation, and the use of automated external defibrillators. The certification or training program shall be based on the current national evidence-based emergency cardiovascular care guidelines for cardiopulmonary resuscitation and the use of an automated external defibrillator, such as a program developed by the American Heart Association or the American Red Cross. The local school board shall provide a waiver for this requirement for any person with a disability whose disability prohibits such person from completing the certification or training.

4.5. The holder of a three-year local eligibility license shall be required to complete such training within the three-year licensure period as may be specified by the division superintendent, the school board, and standards prescribed by the Board of Education which shall include, but need not be limited to, curriculum and instruction, including educational technology, reading, and other specific course content relating to the Standards of Learning, differentiation of instruction, classroom/behavior management, and human growth and development.

5.6. The local eligibility license shall only be valid within the issuing school division.

6.7. No local eligibility license shall be issued if the teacher candidate/applicant is eligible for a
collegiate professional or postgraduate professional license issued by the Department of Education.

7. Teachers issued a three-year local eligibility license shall be considered probationary teachers, shall not be eligible for continuing contract status while employed under the authority of a local license, and shall be subject to the probationary terms of employment specified in § 22.1-303.

B. Except as specified in this section and § 22.1-303, a teacher employed while holding a local eligibility license shall be entitled and subject to all other requirements and rights provided by law or regulation.

C. Any teacher employed pursuant to a local eligibility license shall be issued a collegiate professional or postgraduate professional license upon the expiration of the local eligibility license upon satisfaction of the following conditions: (i) recommendation by the division superintendent and the school board for such licensure; (ii) the completion of three successful years of teaching experience while holding a valid three-year local eligibility license as certified by the division superintendent and the school board; (iii) achieving a satisfactory score on the professional teacher's examinations required by the Board; and (iv) such standards as may be prescribed by the Board of Education.

D. Local school boards shall provide to the Board of Education information about teachers receiving local eligibility licenses and other data related to the local school division's issuance of eligibility licenses as prescribed by the Board. The Board is authorized to revoke and reinstate a local school board's authority to issue local eligibility licenses upon a determination of any violation of this section.

2. That the Board of Education, in conjunction with the Department of Health, shall adopt regulations and establish guidelines to implement the provisions of this act.

[Signatures]
President of the Senate
Speaker of the House of Delegates
Governor
WEDNESDAY 30 SEPTEMBER 2015

THE HONORABLE MCDUFFIE AND GROSSO SIR, CHAIRPERSONS, COMMITTEE ON THE JUDICIARY, COMMITTEE ON EDUCATION, RESPECTFULLY GENTLEMEN., THANK YOU, FOR HAVING THIS CRITICALLY IMPORTANT HEARING., THE WORK THAT YOU DO., COULD POSSIBLY "SAVE SOME ONES LIFE"!!!

PUBLIC HEALTH AND SAFETY., PUBLIC SAFETY AND SECURITY.,

THE TRUTH, THE WHOLE TRUTH, AND NOTHING BUT THE TRUTH, SO HELP US GOD!!! "IN GOD WE TRUST"!!! ITS ON ALL THE MONEY!!

1. OUR WONDERFUL HEAVENLY FATHER....
2. HIS SON OUR SAVIOUR....
3. THE AMAZING HOLY GHOST....
4. ANGEL OF THE LORD....

5. THE HOUSE RULES COMMITTEE...
6. THE SENATE RULES COMMITTEE....
7. THE HOUSE JUDICIARY COMMITTEE....
8. THE SENATE JUDICIARY COMMITTEE....

9. THE DEPARTMENT OF JUSTICE....
10. ONE JUDICIARY SQUARE....

11. THE LAW OF EDUCATION....
12. THE BUSINESS OF EDUCATION....

COUNCILMEMBER MCDUFFIE SIR, RESPECTFULLY SIR, IN 2015, WITH THE DC PUBLIC SCHOOLS, 52% OF THE AFRICAN AMERICANS., AND 28% OF THE EUROPEAN AMERICANS "DID NOT GRADUATE"!! WE AS AFRICAN AMERICANS
SHOULD BE ASHAMED OF OURSELVES!! OVER HALF OF OUR YOUNG PEOPLE, ARE NOT EVEN FINISHING HIGH SCHOOL!! WHERE ARE THEY GONNA END UP!!

WE HAVE BECOME THE PRESIDENT OF THE UNITED STATES AND THE FIRST LADY., THE ATTORNEY GENERAL THE DEPT. OF JUSTICE., AND WHEN PRESIDENT OBAMA FIRST GOT ELECTED, JOHN CONYERS, WAS THE CHAIR OF THE HOUSE JUDICIARY COMMITTEE, THIS IS MONUMENTAL, CONSIDERING WHERE WE HAVE COME FROM!!

BUT WE HAVE NOT FIGURED OUT, HOW TO HELP, ALL OF OUR YOUNG PEOPLE, TO FINISH HIGH SCHOOL!! WHEN I THINK ABOUT THE NAACP, THE NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF COLORED PEOPLE.,., SOMETHING IS WRONG WITH THIS PICTURE!! MAYBE IT IS ME.,., MAYBE I AM WRONG., I AM NOT A ROLE MODEL.,., YOU ARE SIR!!

4,000 YOUNG PEOPLE, WITH THE PUBLIC SCHOOLS ARE HOMELESS, IF THE NUMBERS ARE RIGHT. WHERE ARE THESE YOUNG PEOPLE, GONNA END UP!! THEY TALK ABOUT THE PIPELINE TO PRISON., I DO NOT KNOW ABOUT THAT!! BUT IT COULD BE, "THE PIPELINE TO POVERTY"!! I COULD BE WRONG!!

I AM TRYING TO TELL THESE YOUNG PEOPLE, "DON'T BE LIKE ME"!! "DON'T END UP POOR"!!

1. LAW SCHOOL REFORM
2. MEDICAL SCHOOL REFORM
3. EDUCATION REFORM
4. GOVERNMENT REFORM

5. OFFICE OF THE INSPECTOR GENERAL  6. THE ATTORNEY GENERALS OFFICE DC GOVERNME  7. BOARD OF ETHICS AND GOVERNMENT ACCOUNTABILITY (BEGA)  8. THE UNITED STATES ATTORNEYS OFFICE

Michael (Matthew)
FOR THE SECOND HEARING, COUNCILMEMBER MCDUFFIE SIR...,

TO MUCH OFFICE CRIME!! SIR!! WITH ALL DUE RESPECT, SIR....

USING DEPT. OF HUMAN SERVICES AS AN EXAMPLE...,
CORRUPTION AT THE TOP., AND CORRUPTION AT THE BOTTOM!!...,
SOME OF THESE CASEMANAGERS ARE RIDICULOUS!!

PLEASE TAKE A CLOSE LOOK, AT THE DEPT. OF HUMAN SERVICES,
64 NEW YORK AVENUE!! ON TUESDAY 13 AUGUST 2013., AND FRIDAY
1 NOVEMBER 2013., I HAD A VERY DISGUSTING, DEGRADING, DEHUMANIZING
EXPERIENCE WITH DHS...,, AFRICAN AMERICANS SCHEMING AGAINST
AFRICAN AMERICANS...,, AFRICAN AMERICANS OPPRESSING AFRICAN
AMERICANS...,, VETERANS SCHEMING AGAINST VETERANS!!!! THIS IS
PITIFUL!!

PEOPLE WORKING FOR THE GOVERNMENT, THEY HAVE A GOVERNMENT JOB,
A GOVERNMENT PAYCHECK., A GOVERNMENT PHONE., AND THE PEOPLE
ARE AFRAID, TO USE THEIR GOVERNMENT PHONE...,, WON'T EVEN CHECK
THEIR VOICEMAIL...,, TRYING TO COVER UP ALL THESE CORRUPT
CONVERSATIONS!! I AM A VETERAN, OVER 8,000 SOLDIERS HAVE LOST
THEIR LIFE, IN IRAQ AND AFGHANISTAN., THEY SAY 10 TO 15 VETERANS,
COMMITT SUICIDE EACH DAY...,, AND CASEMANAGERS AT DHS ARE AFRAID
TO USE THEIR GOVERNMENT PHONE!! WON'T EVEN CHECK THEIR VOICEMAIL!!
MAY GOD AND JESUS, BE WITH ALL THESE VETERANS, WHO HAVE COMMITTED
SUICIDE!! MAY GOD AND JESUS BE WITH THEM AND THEIR FAMILIES!!
PLEASE TAKE A CLOSE LOOK AT DEPT. OF HUMAN SERVICES, 64 NEW YORK
AVE. PLEASE DO THIS SIR!! "TO MUCH OFFICE CRIME!!
Public Hearing
on
Cardiopulmonary Resuscitation and
Automated External Defibrillator Requirements Act of 2015

Testimony of
John Davis
Chief of Schools
District of Columbia Public Schools

Before the
Council of the District of Columbia
Committee on the Judiciary
And
Committee on Education

Thursday, October 1, 2015

John A. Wilson Building,
1350 Pennsylvania Avenue, NW
Room 412
Washington, D.C. 20004
Introduction

Good afternoon, Councilmember Grosso, Councilmember McDuffie and members of the Council. I am John Davis, the Chief of Schools for the District of Columbia Public Schools. I want to thank you on behalf of Mayor Bowser and Chancellor Henderson for the opportunity to discuss the Cardiopulmonary Resuscitation and Automated External Defibrillator Requirements Act of 2015 with you today.

Background

Student health and safety is of utmost importance to us at DC Public Schools (DCPS). In fact, many of the current practices at DCPS align to the requirements outlined in this bill. For example, our athletic trainers have carried AEDs with them for over 15 years, and we recently went through an equipment refresh. DCPS employs 12 Athletic Trainers - one in each HS with a football program. All of our trainers are CPR/AED-certified as a requirement to maintain their trainer certification. AED devices are with our trainers at all times. This year, we have four certified athletic trainers on staff that are now AED/CPR Instructors and can train additional personnel. There are also 334 coaches who are currently CPR/AED-certified, in addition to many of our physical education teachers. DCPS also requires CPR as a part of its high school health education curriculum.

Current Constraints

Based on our research, 15 states require some schools to have access to portable defibrillators and two additional states urge the use of them. Since DCPS has access to portable defibrillators through all of our athletic trainers, we are already in line with what other states are doing. However, there are several ways in which DCPS is not currently compliant with the proposed bill’s recommendations, nor do we think it would be practical to implement them. Beyond our trainers and coaches, there are few other AED devices in our buildings; the only stationary device in a school is located at Cardozo Education Campus. AEDs are not at all practices and practice sites. For example, all middle school sports practices do not have trainers present. Some high school sports such as tennis, bowling, golf and swimming (because trained lifeguards are present) do not require trainers to be present also. And some teams - such as cross-country
- practice off-site and away from school grounds. Our individual high schools have as many as eight athletic practices occurring at the same time. In order to comply with the bill's proposal, DCPS would need to purchase multiple devices per school. Needless to say, this would be expensive to implement.

The Chief Financial Officer for the District assessed the fiscal impact of a prior version of this legislation and found that it would cost approximately $1.2 million to implement in the first year and $2.4 million over the course of four years. This does not account for the additional staff that would be needed at LEAs and OSSE to monitor the compliance of implementation, which would be another several hundred thousand dollars.

And further, we have not seen or heard a demonstrated need to install AEDs in all of our schools, and have them present for all games, practices and PE classes. According to our records over the past ten years, DCPS has experienced only two cardiac arrests at a school and/or an athletic event. Both occurred at Cardozo Education Campus. In one case, someone not affiliated with the school passed away on the school property (parking lot). In the other case, a student who was not allowed to play sports because of a pre-existing heart condition went into the gym without permission during recess to play basketball and experienced a fatal cardiac event.

The reality is that sudden cardiac arrest occurs most frequently in adults in their mid-30s to mid-40s; this condition is rare in children, affecting only 1 to 2 per 100,000 children nationally each year.\(^1\) Closer to home, according to DC Fire and EMS, there were approximately 550 cases of cardiac arrest in the District in 2013 - and a majority of these cases were adults. It is a real concern that the additional requirements of the proposed legislation might inadvertently cause schools to have to scale back what they are able to offer to their students at a time when the district is working to expand athletic offerings for students. Implementing a full-fledged CPR/AED program in schools is a function outside the scope of our core business, which is to educate students. We believe that combatting childhood obesity and poor physical fitness through the curriculum and athletic offerings is a much higher priority for the district to address.
Additionally, the effectiveness and reliability of these devices have come into question in the past few years. In January 2015, the Food and Drug Administration (FDA) announced strengthened review protocols of AEDs to help improve the quality and reliability of the devices. This was due to over 72,000 reports of the devices failing or malfunctioning since 2005. There have been 111 manufacturer recalls since 2005 affecting more than two million AEDs.

Beyond our current AED and CPR capacity, DCPS staff and students can always call 911 in response to a cardiac event. In this way, we are able to rely on providers in our community who are far better trained to manage these situations and can transport people to hospitals for appropriate care.

Recommendations

To our knowledge, there is not a demonstrated need for the expansion of AEDs in schools in the District of Columbia. On the other hand, DCPS sees the value in the American Heart Association’s (AHA) recommendation to increase CPR training for our students. Expanded CPR training would create a “roving resource” in schools that would benefit both students and staff. Additionally, that capacity would extend into the community, when students and staff leave their school buildings. The cost of CPR training is significantly lower. Further, there are educational and lifelong benefits to CPR training, as it is a requirement for certain jobs, including day care centers, lifeguarding, babysitting, and certainly most health care careers. By providing increased access to CPR training, we would be supporting students’ interest and potential advancement in health professions.

Closing

We agree that student health and safety is incredibly important and we appreciate the Council’s efforts to ensure additional capacity for emergency response to potentially life-threatening events. However, we are concerned about an approach that places a higher responsibility for this response on schools where there is little or no demonstrated need. DCPS welcomes the opportunity to work with Council to address this concern in a way that is more closely aligned to the educational mission of the district and that would not compete with
established priorities. Thank you again for the opportunity to be here with you today. I would be happy to answer any questions.

1http://my.clevelandclinic.org/services/heart/disorders/arrhythmia/sudden-cardiac-death