MEDICAL DIRECTION COMMITTEE
1041 Technology Park Dr, Glen Allen, Virginia
Conference Rooms A and B
April 9, 2015
10:30 AM

Members Present:	Members Absent:	Staff:	Others:	
Marilyn McLeod, M. D. - Chair	Chief Eddie Ferguson	Gary Brown	Chad Blosser	Jeff Drylle
Charles Lane, M.D.	Christopher Turnbull, M.D.	Scott Winston	Michael Player	Wayne Harbour
Asher Brand, M.D.		Michael Berg	Marcia Pescitani	Daniel Green
E. Reed Smith, M.D.		Tim Perkins	Cathy Cockrell	Randy Breton
George Lindbeck, M.D.		Warren Short	Gary Morris	Joey King
Allen Yee, M.D.		Debbie Akers	Jack Cote	Neha Puppala
Forrest Calland, M.D.		Greg Neiman	Sharita Chapman Smith	Russell Blow
Cheryl Lawson, M.D.		Adam Harrell	Andy Southerland, MD	
Stewart Martin, M.D.			Rachel Dillon	
Paul Philips, D.O.			Ronald Passmore	
Scott Weir, M.D.			Stephen Skrip, MD	
Tania White, M.D.			Michael Bassham	
Theresa Guins, M.D.			Darren Clark	
Rob Lawrence, VAGEMSA			David Webb	

Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
1. Welcome	The meeting was called to order by Dr. McLeod at 10:32 AM	
2. Introductions	Introductions of Committee Members, Staff and Guests **Attachment 'A'**	**Meeting Sign-in Roster See Attachment 'A'**
3. Approval of Agenda		**Approved by consensus**
4. Approval of Minutes	Approval of minutes from the January 8, 2015 meeting.	**Approved by consensus**
5. Drug Enforcement Administration (DEA) & Board of Pharmacy (BOP) Compliance Issues	See Dr. Lindbeck's report.	
6. Old Business	No old business	

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Topic/Subject		Discussion	Recommendations, Action/Follow-up; Responsible Person
A			
7. New Business			
A	Uva iTREAT Pre-Hospital Stroke Study	PowerPoint presentation by Dr. Andrew Southerland on the iTREAT program. Questions entertained and appreciation expressed to Dr. Southerland and group for bringing the program to the attention of medical direction. PowerPoint Presentation – **Attachment 'B'** and iTREAT Brochure – **Attachment 'C'**	**See Attachment 'B'** **See Attachment 'C'**
B	IABP Paramedic Transport – Randolph Breton – VAA	Presentation by Mr. Breton addressing IABP transport of patients and how to facilitate the future transport of patients with an IABP by EMS and transport agencies in Virginia and the recognition of the Critical Care Paramedic in Virginia. Discussion by committee concerning issue, the role of the perfusionist, what role if any a RCIS could play, what needs to be done to recognize other professionals on a transport and questions posed to representatives from respective agencies present. A**ttachments 'D' and 'E'**	**Dr. McLeod established a workgroup to address future of IABP transport and other changes to SOP. See Attachment 'D' and 'E'.**
C	EMS use of MOLST/ POLST/POST – Dr. Yee	Dr. Yee distributed the Virginia POST form. Discussion by committee about future recognition of the POST form by prehospital providers in regard to patient and physician decisions about Scope of Treatment. Dr. Lindbeck stated that he has been involved with the POST group for a number of years. Committee agrees that recognition of the POST form should be addressed for prehospital providers. **Attachment 'F'**	**Dr. Yee and Dr. Lindbeck to review and bring back a recommendation to the committee. See Attachment 'F'**
D	Chesterfield MIHP pilot project – Dr. Yee	Firefighter David Webb gave a PowerPoint presentation about the Chesterfield MIHP pilot project. Provided information to the committee about the progress in Chesterfield. Questions entertained. **Attachment 'G'**	**Attachment 'G'**
E	Trauma Reporting – Dr. Calland	Dr. McLeod asked Dr. Calland to provide committee with insight about the trauma reporting. Dr. Calland provided information concerning data reporting and transport to the appropriate highest level of care facility. Stated that lack of required data has been discussed by the Trauma Committee. Goal is to provide the Regional Councils with reports concerning their agencies in approximately 90 days to see if data being report is useful, what is required, etc. Mike Berg said focus of OEMS would be in providing education to the EMS agencies to promote better reporting and adherence to the requirements.	**Dr. Calland to do presentation at next MDC meeting from the Trauma Committee.**
F	DOT Driving Rules – Dr. McLeod	Reporting to committee that there are no driving rules applicable to EMS transport crews in Virginia. Seeking input from the committee on their feelings about implementation of a policy to address this matter. Discussion by committee concerning how this might be implemented or addressed. Dr. McLeod to continue research on the matter. Michael Berg stated that this item will be addressed by the Health and Safety committee of the EMS Advisory Board.	
G	EMS Compact – Dr. McLeod	Requested that Gary Brown address the issue surrounding the Interstate Compact and what happened during the General Assembly. Gary provided the history surrounding the defeat of the REPLICA bill in the Virginia House this last legislative session. Stated that the bill would be re-introduced during the next legislative session and support needs from parties of interest will be required.	
H	Instructors and OMDs – Dr. McLeod	Discussed with committee the need to review and address prior pass/fail results with the instructors who are announcing classes and to ensure that the quality of education is adequate and meeting the needs of the EMS educational expectations.	

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Topic/Subject		Discussion	Recommendations, Action/Follow-up; Responsible Person
I	Spinal Immobilization Protocols – Dr. McLeod	Asked for insight from the committee concerning the transport of patients without having been placed on a backboard. Committee members provided information on procedures being followed in their region.	
8. Research Notes			
A	Research project discussion	Nothing reported	
9. State OMD – George Lindbeck, MD			
A	DNR orders	Requested that Dr. Weir address the issue of recognition of DNR in specific situations. Presented example of patient who had attempted to end their life and if the DNR was valid when implemented. Dr. Lindbeck stated that the Attorney General ruling was that the DNR could not be voided unless the individual or the power of attorney for the patient revokes the DNR. Lively discussion by committee concerning TDO's and ECO's.	
B	Pronouncing of Patients in the Field	Reported that the Code of Virginia does not address the ability for the patient to be pronounced in the field. State Code does describe that an MD, DO, NP, PA and RN's in a specific capacity are allowed to pronounce an individual as deceased in the field. Assistant AG's opinion was that if field resuscitation is implemented in the field it requires that they call for termination. Discussion by committee concerning the ability for the Paramedic to pronounce in the field.	
B	DEA Issues	FDA recently put out a notification on DuoDote auto-injectors and the extension of the expiration date. This does not apply to all DuoDote's, is specific to certain lots. **'Attachment H'** The drug box and drug signature implementation has been inconsistent across the commonwealth. The EMS regulation is very clear but if the hospital and pharmacist is requiring signature or further documentation, you will need to follow the requirements of that facility and pharmacy.	**Attachment 'H'**
Office of EMS Reports			
A	BLS Training Specialist – Greg Neiman	1. EC Institute a. Next Institute will be in June in Blacksburg. b. The next practical will be held in May here in Richmond. 2. Updates a. The DED Division will be conducting an update in CSEMS in April, Northern VA in May and Blacksburg in June. b. Added an additional update on Friday in Blacksburg to meet the needs of Education Coordinators who could not attend on Saturday due to either work or religious reasons. c. See the latest schedule on our Webpage: http://www.vdh.virginia.gov/OEMS/Training/EMS_InstructorSchedule.htm 3. TCC Report (provided by Dr. Lane) a. Presented the BLS and ALS requirements based on the National Registry requirements effective on	

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	Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
		April 1, 2016. **'Attachment I'** b. Provided the information concerning the NCCR/LCCR/ICCR. NCCR is defined by the National Registry requirements and is very prescriptive. c. TCC Committee decision is to allow the provider to take classes of choice for LCCR and ICCR. If the OMD or agencies have specific training they require of their providers it can be defined by LCCR/ICCR. d. Requested a motion to endorse the recommendation from the TCC committee on the new CE requirements effective April, 2016	**See Attachment 'I'** **Motion by Dr. Yee, 2nd by Dr. Martin. Motion passed unanimously.**
B	ALS Training Specialist – Debbie Akers	1. Please let ALS Coordinators know they must do their re-endorsement to recertify. a. 151 ALS-C's left 2. NR Stats **'Attachment J'** a. New breakdown to indicate Over 18 versus Under 18 statistics. Over 18 candidates are nearing the success rate of the national average of 75% within three attempts. b. Need to offer focused remediation to improve our retest numbers c. Higher percentage of failures in Intermediate and Paramedic than we have seen in the past.	**See Attachment 'J'**
C	Accreditation – Debbie Akers	1. Accreditation **'Attachment K'** a. Paramedic is the same b. American University has suspended their CoAEMSP accreditation for two year due to mass resignation of their staff c. Germanna CC/REMS has suspended their LOR and are not offering any ALS programs at this time. d. Intermediate i. Paul D. Camp CC site visit completed. Pending final report. ii. Henrico Fire app in iii. Roanoke Regional reaccreditation iv. CSEMS e. AEMT i. Frederick County Reaccreditation site visit completed for both AEMT and EMT. Report pending. f. EMT i. Chesterfield Fire and EMS site visit completed. Pending final report. Harrisonburg Rescue Squad site visit coming up	**See Attachment 'K'**
D	EMSTF – Adam Harrell	1. EMSTF **'Attachment L'** a. Report distributed. b. FY16 contracts are still being worked on with a few changes planned	**See Attachment 'L'**

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Topic/Subject		Discussion	Recommendations, Action/Follow-up; Responsible Person
		2. Scanner Update Required **'Attachment M'** a. If they are not updated they will not work after August b. Must be done in person so can be sent in or done at updates/institutes	**See Attachment 'M'**
E	Division of Educational Development – Warren Short	1. PowerPoint presentation on the 'New Options for EMS Course Delivery'. After presentation entertained questions concerning this new approach to EMS education. (available at: http://www.vdh.virginia.gov/OEMS/Training/EMSCourseDelivery.htm)	
F	Regulation and Compliance – Michael Berg	1. Fast track for FLAP is waiting review by AG Office 2. Fast Track Section 910 in the Governor's Office 3. General Assembly a. Working on final exempt packet to address items from the Technical clean-up Bill b. Legislation for EPI Pens was changed to create a workgroup to craft legislation. Warren represents OEMS c. HB1458 Naloxone i. Will allow providers to carry Narcan on their person and administer ii. Immunity to practitioner iii. Requires Board of Health to promulgate regulations for law enforcement and fire iv. Protocol from Board of Pharmacy on the use of Narcan d. HB1441 was left in committee 4. 2016 Governor's required periodic review of regulations will take place 5. Background checks a. Hiring a new wage person to help b. If a jurisdiction has an ordinance in place to require background checks on hire, they can use that in place of OEMS requirement. Only used for agencies in that jurisdiction.	
G	Other Office Staff	Nothing to report.	
PUBLIC COMMENT			
For The Good Of The Order		1. Dr. Weir raised question of the use of all online education for recertification purposes. Discussion by committee on value of online education.	
Future Meeting Dates for 2015		July 9, 2015; October 8, 2015	
Adjournment		2:47 P.M.	

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Attachment A

4/9/15 – Attendance Roster

MEDICAL DIRECTION COMMITTEE MEETING ROSTER
April 9, 2015

Please sign in next to your name.

Region	Representative	Signature
SWVEMS	PAUL PHILLIPS, D.O.	Paul A Phillips
WVEMS	CHARLES LANE, M.D.	
BREMS(CHAIR)	MARILYN MCLEOD, M. D.	Marilyn McLeod/dta
TJEMS (OEMS)	GEORGE LINDBECK, M. D.	
CSEMS	ASHER BRAND, M. D.	Asher Brand/dta
LFEMS	CHRISTOPHER TURNBULL, M.D.	
REMS	TANIA WHITE, M.D.	
NVEMS	E. REED SMITH, M.D.	
ODEMSA	ALLEN YEE, M. D.	
PEMS	CHERYL LAWSON, M. D.	Called in to work / NBB
TEMS	STEWART MARTIN, M. D.	
MAL	FORREST CALLAND, M.D.	
MAL	SCOTT WEIR, M.D.	Scott Weir/dta
EMS CHILDREN	THERESA GUINS, M.D.	Theresa Guins/dta
VAGEMSA	CHIEF EDDIE FERGUSON	Rob Lawrence for Eddie Ferguson

OEMS STAFF:

GARY BROWN	Gary Browne/dta	WARREN SHORT	
SCOTT WINSTON	Scott Winston	DEBBIE AKERS	
MIKE BERG		GREG NEIMAN	
TIM PERKINS	Tim Perkins/dta	ADAM HARRELL	

MEDICAL DIRECTION COMMITTEE MEETING ROSTER
April 9, 2015

OTHERS PRESENT: PLEASE PRINT YOUR NAME AND SIGN ON THE LINE NEXT TO YOUR NAME.

PRINT NAME	SIGNATURE
CHAD BUSSEN	
GARY MORRIS	
Jack Cole	
Sherita Chapman Smith	
Michael Player / PEMS	
ANDY SOUTHERLAND	
Rachel Dike	
RON PASSMORE	
Stephen Skryzio	
Marcia Pescitani	Marcia Pescitani
J.F. CALLAND	
Michael Bassham	
DARREN CLARK	
David Wells	
Jeff Doyle	
WAYNE HARBOUR	Wayne Harbour
Daniel Green	
RANDY BROWN	
Joey Ky	
Neha Puppala	
Russell Blow	
Cathy Cockrell	Cathy Cockrell

Attachment B

iTREAT presentation

Improving Treatment with Rapid Evaluation of Acute stroke via mobile Telemedicine (iTREAT)

Andrew M. Southerland, MD, MSc

Virginia Office of EMS Meeting

April 9, 2015

Prehospital Stroke Care – *No Time to Wait*

Numerous initiatives calling for innovative approaches to prehospital stroke care to improve time-to-treatment

- American Heart Association/American Stroke Association (AHA/ASA) *Target:Stroke*

Patients living in rural and underserved areas suffer a *geographic disparity* of distance to primary stroke centers and access to neurological expertise

In the acute stroke setting, this geographic disparity includes prolonged EMS transport times

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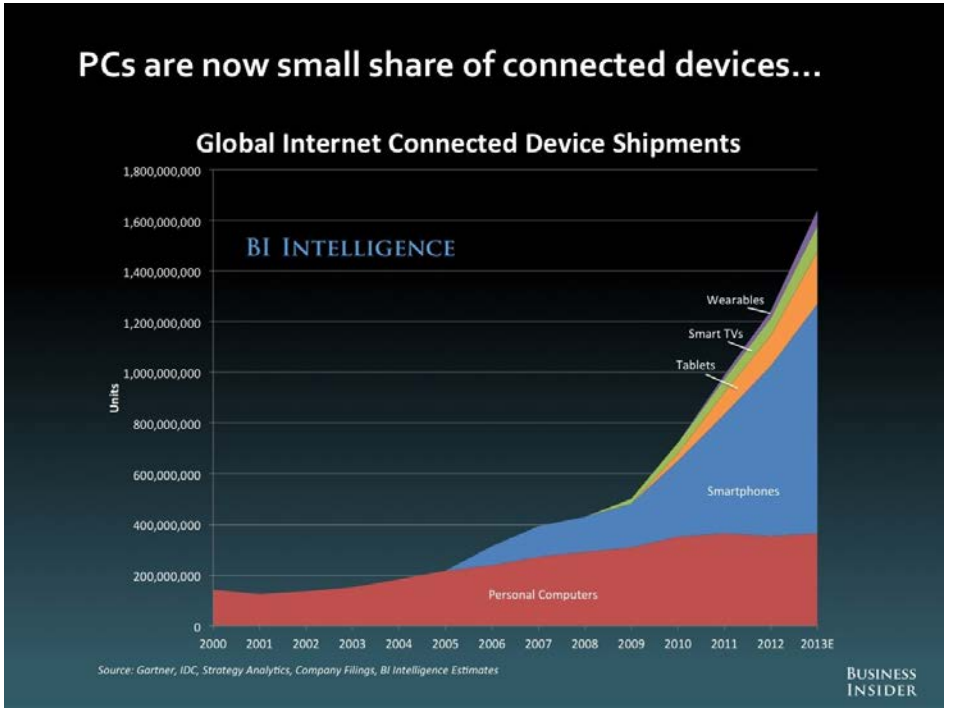
Mullen Stroke 2013, Lin Circulation 2012, Garnett Int J Stroke 2010

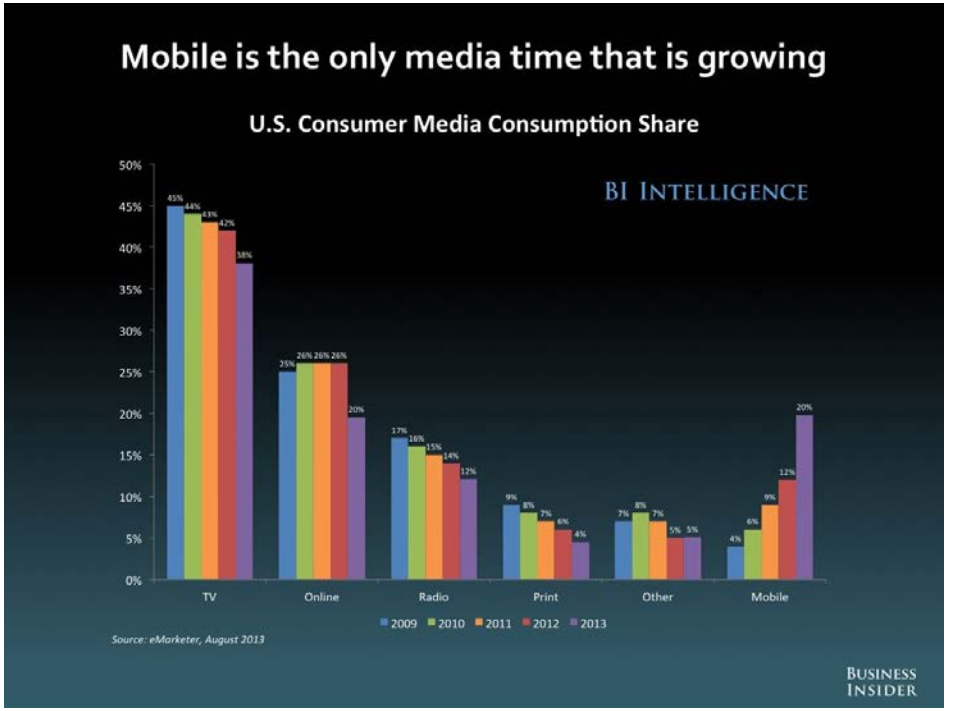
Going Mobile

Mobile devices have far surpassed desktop computers worldwide 2009-13

2014: 58% of the U.S. population own a smartphone and 42% own a tablet device

2009: 35% and 8% respectively





Blodget H www.businessinsider.com

Mobile Telestroke

- Integrating telestroke model with mHealth technology
- Purpose: facilitate mobile videoconferencing between a stroke physician, patient and transporting EMS provider:
  - Improve accuracy of prehospital stroke diagnosis
  - Facilitate appropriate patient triage (NEW endovascular therapy trials)
  - Reduce stroke onset-to-treatment time
  - Assist in prehospital stroke research (FAST MAG study)
- Mobile telestroke pilot studies
  - Telebat – LaMonte et al 2004
  - Europe - Aachen (Bergrath), Berlin (Liman), and Brussels (Van Hooff)
  - Wu et al. UT Houston 2014 (InTouch Health)

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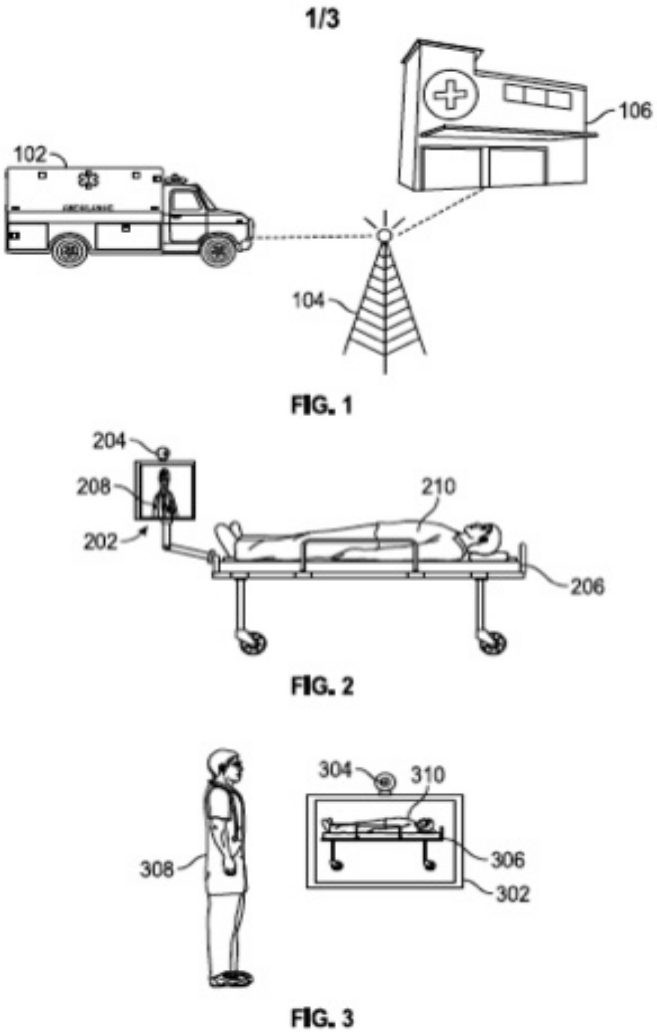
iTREAT

System

- Apple iPad® with retina display
- Cisco Jabber (Movi)™ video conferencing application (HIPAA compliant)
- 4G LTE CradlePoint© modem
- External magnetic-mount antennae
- Portable tablet mounting apparatus
- Verizon Wireless© 4G Mini SIM card
- Durable Pelican case



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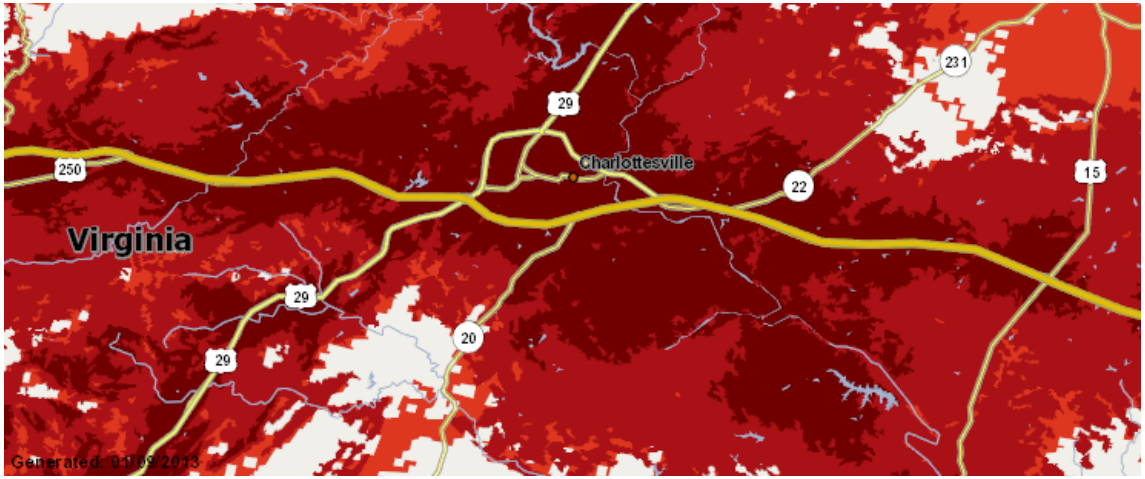
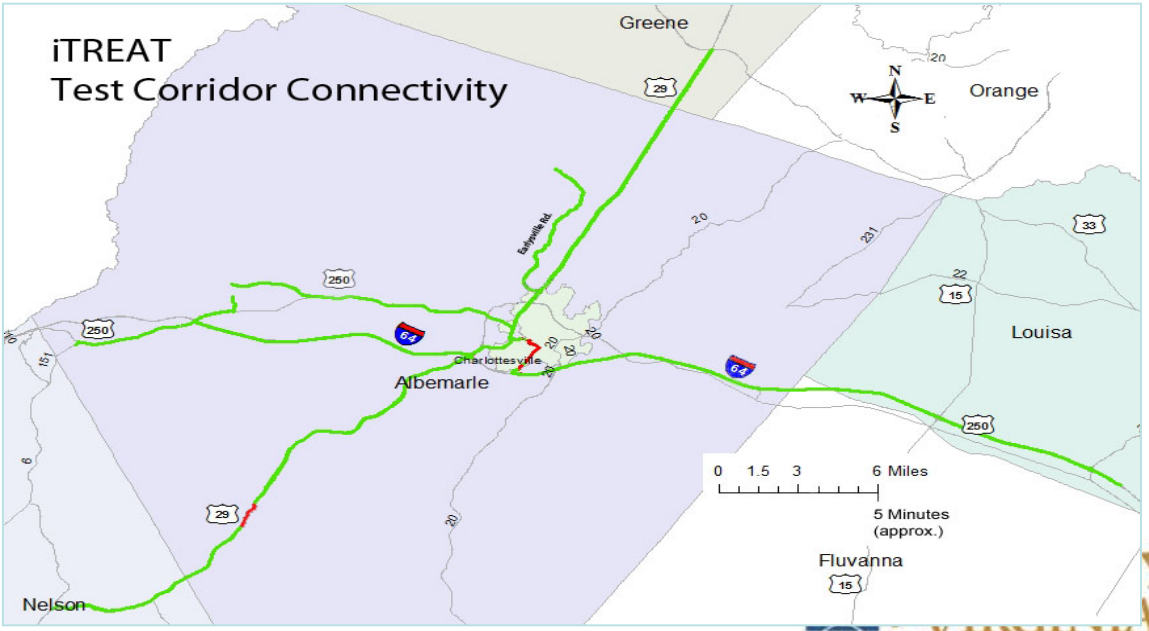
Connectivity Mapping – Feasibility Aim

Verizon© Map



Connectivity Map



Lippman, Chapman et al. ISC, AAN 2014

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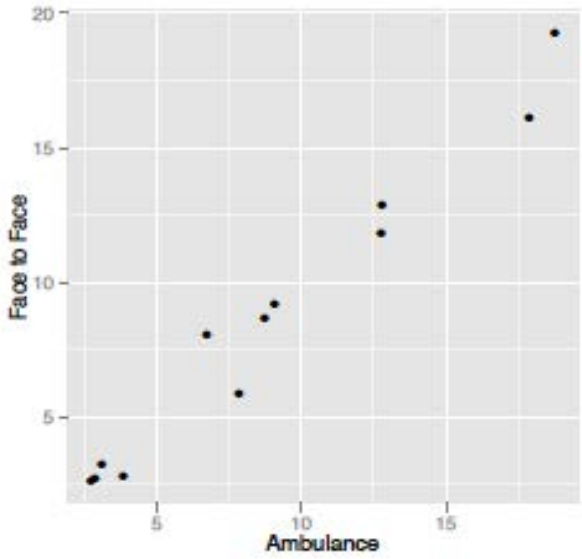
iTREAT – Feasibility Results

- 93% of all runs achieved at least 9 minutes of continuous connectivity between all raters
  - Mean: 18 minutes
- Good AV quality without technical interruption
- Excellent correlation of neurological examination compared to face to face encounters (0.98)



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Going forward

- Next steps
  - IRB approved for live patient encounters
  - Phase II feasibility trial (n=100)
  - Develop iTREAT system with national partners
    - Richmond/VCU (Chapman)
    - UCSF/Stanford (Govindarin)
    - St. Louis (Rempe)
  - Presenting at FCC in May
- Challenges
  - Refining the mounting apparatus
  - Becoming *more* wireless
  - Adapting to different settings
  - Developing a cohesive network

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What's next…
Mobile CT?

Median call-to-needle:
62 vs 98 min

http://www.youtube.com/watch?v=gIHJNBlwNXk

http://www.youtube.com/watch?v=OvXNUYBczhw

Audebert et al., Int J Stroke 2012, *Neurology* 2012

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What's next…
Handheld Diagnostics

http://infrascan.agencystudy.com

http://tricorder.xprize.org

Leon-Carrion Brain Inj 2010, Bressan Child Nerv Sys 2014

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What's next…
Wearable Platforms?

PRISTINE

NeuroEGG STUDY:

- **Neurology Resident Evaluation using Google Glass**

*Sponsored by the American Academy of Neurology and American Board of Psychiatry and Neurology

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THANK YOU

Contact:
Andy Southerland
as5ef@virginia.edu
@asouth01

Sponsors:
HRSA
NINDS CTMC
VAEMR
UVA Neuroscience CoE

Mid-Atlantic Telehealth Resource Center

UVA Stroke Team

Sherita Chapman Smith
Nina Solenski
Brad Worrall
Heather Turner
Timothy McMurry
Jack Cote
Max Padrick
Jason Lippman

UVA Emergency Medicine

- Debra Perina
- Donna Burns
- TJEMS Council

Business Partners

- Verizon Wireless©
- Cisco systems ©

UCSF

- Prasanthi Govindajaran

UVA Center for Telehealth

- Karen Rheuban
- David Cattell-Gordon
- Brian Gunnell
- Charles Lewis
- Richard Rose
- Virginia Burke
- Kathy Wibberly
- Lara Otkay
- Regina Carlson

Thomas Jefferson Emergency Medical Services Council

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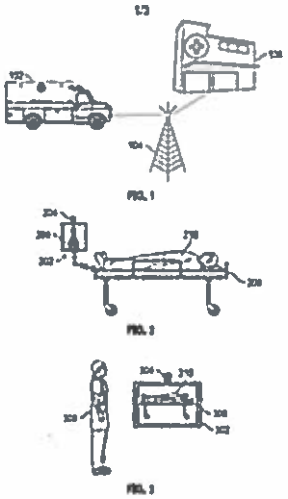
Attachment C

iTREAT Brochure

iTREAT

Improving Treatment with Rapid Evaluation of Acute stroke via mobile Telemedicine

- Apple iPad® with retina display
- Cisco Jabber (Movi)™ video conferencing application (HIPAA compliant)
- 4G LTE CradlePoint® modem
- External magnetic-mount antennae
- Portable tablet mounting apparatus
- Verizon Wireless® 4G Mini SIM card
- Durable Pelican case



It has always been the intention of the project to use "off the shelf" technology and equipment.

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Within the TJEMS region, our initial target/partner agencies are Greene County Rescue Squad and Western Albemarle Rescue Squad.

Prehospital Stroke Care – *No Time to Wait*

Numerous initiatives calling for innovative approaches to prehospital stroke care to improve time-to-treatment

American Heart Association/American Stroke Association (AHA/ASA) *Target:Stroke*

Patients living in rural and underserved areas suffer a *geographic disparity* of distance to primary stroke centers and access to neurological expertise

In the acute stroke setting, this geographic disparity include prolonged EMS transport times

- UVA Stroke onset-ED arrival 2012: 2 hr. 45 min

Mullen Stroke 2013, Lin Circulation 2012, Garnett Int J Stroke 2010

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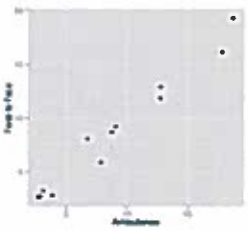
iTREAT – Feasibility Results

- 93% of all runs achieved at least 9 minutes of continuous connectivity between all raters
  - Mean: 18 minutes
- Good AV quality without technical interruption
- Excellent correlation of neurological examination compared to face to face encounters (0.98)
- IRB approved for a Phase II clinical trial to evaluate diagnostic accuracy and time-to-treatment in live patient encounters
  - Virginia, St. Louis, San Francisco



At this time we are pursuing the launch of the phase II trial.

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Attachment D

IABP Paramedic Transport Presentation Handout

"Use of medical devices not specified" and the need for OEMS recognition of Critical Care Transport Paramedics

A discussion of the Virginia OEMS regulations and interfacility transport.

Presented by Randolph T. Breton, VAA Vice President

April 9, 2015 VDH OEMS Medical Direction Committee

Current Virginia OEMS Regulations for Scope of Practice

- ***Practice Maximus***

There is no differentiation in the regulations…

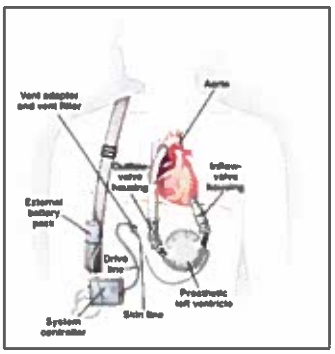
- All Virginia ground EMS agencies are treated alike – Career, Volunteer, Professional/Private
- There is no recognition of CCEMT-P or CCP-C level providers
- Air programs most often operate in the RN/Medic configuration. Many specialty transports do not require air transport due to their short distance/inter-urban/suburban nature. Air transport may not be available do to inclement weather or short distance for transport.

There is an inherent lag in regulation vs. equipment available – the Regs are silent on:

- External Compression Devices:
  - Lucas II
  - Michigan Equipment Thumper
  - Vest CPR
  - Auto Pulse

At current, as the Regulations are Practice Maximus, these tools should not be utilized

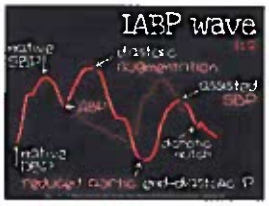
- External Transvenous Pacing
- Optiflow High Volume Oxygen
- Bair Hugger
- LVAD
- BiVad
- IABP



Intra Aortic Balloon Pumps

- **Hemodynamic Techniques**
  - Arterial Catheter Maintenance
  - EMT-P required
- **Hemodynamic Monitoring**
  - Invasive Hemodynamic Monitoring
  - EMT-P required

  IABP fits both of these categories



- All VAA Agencies agree that there needs to be a minimum of two ALS providers with the patient
- RNs are not always available
- The IABP devices of today are far more sophisticated than the first and second generation devices
- We specifically train EMT-Ps as CCEMT-P or CCP-C for these cases

No EMS requirement for non-EMS personnel*

- *There is no requirement, other than Neonatal Transport, that an RN, PA or MD attend specific patients in the regulations except for **12VAC5-31-1260. Supplemented transport requirements**
- Certain hospital based individuals (perfusionist, nurse practitioners) and certain training EMS providers are ***not*** recognized despite training along side RN/PA/MD on certain specialty equipment (IABP as an example). Our facilities actually prefer to send a perfusionist as they are the **Subject Matter Experts**
- There is ***no*** specific number of personnel required to attend any patient within the regulations for non-Neonatal transports so long as one Virginia certified provider that meets the drug and equipment skill set is in attendance

12VAC5-31-1260.
Supplemented transport requirements.

A. Supplemented transports require the following:

1. An ambulance equipped with an ALS intermediate/paramedic equipment package;

2. A determination by the sending physician that the patient's medically necessary care exceeds the scope of practice of available personnel certified at an advanced life support level or an equivalent approved by the Office of EMS; or

Supplemented Transports (cont.)

3. A. Determination by the sending physician that the specific equipment needed to care for the patient exceeds that required for a ground ambulance equipped with an ALS Advanced EMT/intermediate/paramedic equipment package[1].

B. An attendant-in-charge who must be a physician, registered nurse or physician assistant who is trained and experienced in the care and the equipment needed for the patient being transported.

[1] IV pumps are not part of the ALS package but are included in the Scope of Practice

Supplemented Transports (cont.)

C. An attendant who must be certified as an emergency medical technician or an equivalent approved by the Office of EMS in addition to the attendant-in-charge. The attendant must be a third person who is not the Operator.

Supplemented Transports (cont.)

D. An EMS agency requested to perform a supplemented transport, is responsible for the following:

1. Obtaining a written statement from the sending physician detailing the specific nature of the patient's medical condition and the *medical equipment* necessary for the transport. The written statement may be in the form of transport orders documented in the patient's medical record.

Supplemented Transports (cont.)

D. 2. Verifying that the individual acting as attendant-in-charge for the transport is experienced in the patient care required and the operation of all equipment to be used for the patient to be transported.

An EMS agency requested to perform a supplemented transport shall refuse to perform the transport if compliance with the requirements of this section cannot be satisfied. Refusal to provide the transport must be documented by the EMS agency.

Recognition of Critical Care Paramedics benefits to Virginia OEMS providers, agencies and Citizens

- Nationally recognized Programs available (CCEMT-P, CCP-C) as well as Community College Programs for Critical Care

- Similar standards to NR
- Didactic, Practical, Written components
- Recertification Required
- Aids with recruitment and retention of Paramedics
- Gives cream of the providers another outlet besides Air Transport
- A Virginia Critical Care EMS provider level would enable agencies doing interfacility transport to bill at the A0434 level for those truly Critical Care patients that can now only be billed as A0433.
- The additional, appropriate funding would offset losses the agencies currently experience training and equipping to the SCT level
- Better patient safety and interfaculty care for the Citizens and Visitors of the Commonwealth

Proposed Ways Forward

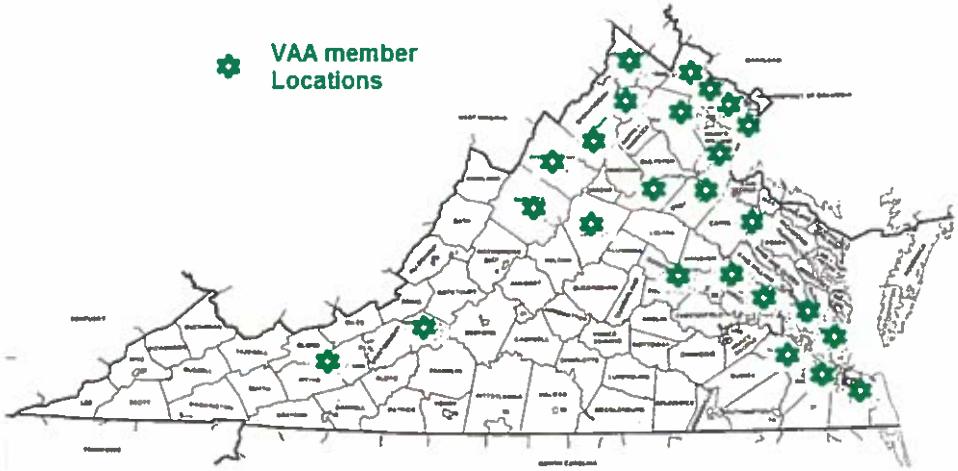
Interim

- Allow those agencies that can document adequate education, training and experience along with appropriate protocols and post transport review to utilize the IABP and/or other non-listed devices until a joint committee can put in place a permanent review and approval process

Ultimate

- Create a joint Committee from MDC, Virginia OEMS and VAA to review equipment, procedures and medications for interfacility transports with eventual proactive discussion of new tools and medications at their inception
- Have the EMS BOG approve a process for recognition of CCP / Interfacility Advanced Providers practicing within Virginia

VAA Member locations



Attachment E

Medical Transport Handout

Medical Transport, LLC
IABP Training/Release Process and
Quality Assurance for Transports of IABP Patients

Medical Transport, LLC has established a multi-step process for our Critical Care Paramedics to be eligible to transport patients who have an IABP in place during transfers. The following requirements must be met prior to beginning field training rotations:

- Complete either the Virginia Community College System Concepts of Critical Care class which is a Critical Care Paramedic and Critical Care RN training program or the UMBC Critical Care EMT-P training program. Both of the program cover over 100 hours of didactic education. The VCCS program requires 60 hours of critical care internship in local hospitals.
- Both programs offer in-depth training in arterial line monitoring, invasive pressure monitoring and maintenance of IABPs during interfacility transfers. This training includes a minimum of 16 hours of training on arterial line monitoring and invasive pressure monitoring. The programs also include at least 8 hours of training on IABP, counterpulsation theory, and troubleshooting of IABP problems during transport.
- After completion of the Critical Care Training Program, Medical Transport, LLC brings in the Clinical Education Specialist from Teleflex, who is the manufacturer of the Arrow IABPs that we utilize for IABP transports. This class is an additional 8 hour training program that reviews cardiac pathophysiology, counterpulsation theory, review of the operation of the Arrow IABP, and troubleshooting techniques and management of errors on the IABP during transport.
- The provider is then required to complete either 5 IABP transports with an experienced provider or complete an additional troubleshooting simulation of 5 IABP transports in a simulation environment using predesigned scenarios covering all of the common problems that occur with IABP patients.
- Medical Transport, LLC has a comprehensive Quality Assurance/Quality Improvement process as it relates to IABP transports. Every IABP transport undergoes a thorough review by our Quality Management Department. This review looks at all aspects of the transport to include proper assessment of the patient before, during and after the transport is complete. They review the required strips showing that the automatic timing was correct. Finally, if the reviewer has any questions or concerns with the transport the run is forwarded to the Quality Management Supervisor for additional review and the Supervisor and reviewer then meet with the provider.

CONCEPTS IN CRITICAL CARE
HOSPITAL AND TRANSPORT
CLASS SCHEDULE
SPRING 2013

Class meets from 0800 to 1700 each Thursday

Concerning Anatomy and Physiology of Adults, all systems must be reviewed by students outside of class. As this is an advanced class, this information has been covered in nursing and paramedic classes. Only very abridged versions of certain sections of the physiology will be covered in class. We will cover pediatrics as a quick review. If needed, questions pertaining to A & P will be answered during class. Please review Chapters 21, and 22 initially. The remaining A & P topics can be reviewed prior to covering the appropriate topics in class. This material will be tested... **you need to know it!**

DATE		TOPIC	REFERENCES
R 10 Jan 13		Overview and Introduction; Coordination of Critical Care, Standards and Protocols; Ethics; Occupational Hazards; Legalities Critical Care Pharmacology; Drug and Fluid Calculations	Outline, Handouts, Chapters 1, 2, 3 Check blackboard! Handouts, Outline,
R 17 Jan 13		Pediatric Anatomy and Physiology (abridged), Specific adult A & P topics Clinical Assessment Pulmonary System Airway Management: Artificial Airways, Oxygen toxicity, Suctioning	Chapters 11, 21, Chapter 24, pgs 657-670, Outline
R 24 Jan 13	**Test 1**	Finish Airway, ABGs, X-rays, Chest tubes and drainage systems (Air Leak Disorders) Lab Data and Diagnostic Studies: A-a gradient, bronchoscopy, Oxygen blends Continued	As above, plus Chapter 22, 23, Outline/Handouts Read chapter 23 on Pulmonary disorders
R 31 Jan 13 Jeff		Hypo and Hyperbarics: Flight physiology	Outlines, Handouts, Videos on BB Outlines and Handouts
R 7 Feb 13	**Test 2**	Rapid sequence sedation Mechanical Ventilation	Handouts/Outline, Pgs 152-158 Handouts, Outline, Chapter 25, pgs 670-680

R 14 Feb 13 Jeff		Mechanical Ventilation, PEEP, CPAP, BiPAP continued, Disorders Pediatric Anatomy and Physiology (abridged), Hemodynamic physiology, Clinical Assessment Cardiovascular System	As above Chapter 11,16, Handouts/Outline
R 21 Feb 13 Jeff	**Test 3**	Cardiac Lab and Diagnostic Studies Cardiac Therapeutic Modalities: Cardiac Cath and surgery, PTCA, Atherectomy, Stents and Lasers, Pacemakers	Chapter 17 Handouts/Outline Chapter 19 Handouts/Outline Read Chapter 18!
R 28 Mar 13 Jeff		IV Fluids and Endocrine Case Studies Renal Clinical Assessment and Management	Chapters 34 and 35, Outline Read Chapter 28 Chapters 29 and 30; Outline
R 7 Mar 12		No Class – Spring Break	
12 Lead EKG starts R 14 Mar 13 Jeff		2010 ACLS Review, including CP algorhythm; Intro 12 lead EKG, set up 12 Lead EKG: Rate, Rhythm. Intervals Bundle Branch Blocks	2010 Guidelines (download from http://circ.ahajournals.org/content/122/18_suppl_3/S640.full?sid=1e528eee-e629-42bd-baea-c709065db86f Grauer, Ken 12 Lead Interpretation, 3rd edition
R 21 Mar 13	**Test 1**	12 Lead EKG: Bundle Branch Blocks, Axis, Hemiblocks, Practice 12 Lead EKG: Chamber Enlargement	As above
R 28 Mar 13 Jeff	**Test 2**	12 Lead EKG: Ischemia, Injury, Infarction Angina, MI 12 Lead EKG: Unusual MIs, Miscellaneous changes, Practice	As above
R 04 Apr 13		**12 Lead Final Exam** Bedside Hemodynamic Monitoring, Arterial lines, CVP, Pulmonary Artery lines	 Chapter 18, 19, Outline

R 11 Apr 13 Jeff	**TEST 4**	Continue Hemodynamic monitoring, Study cases Intraaortic Balloon Pump (IABP) Certification Class - Datascope	Chapters 18 ,20 Outline Chapter 19, Workbook
R18 Apr 13		Neurological Assessment and Management Trauma and Shock	Chapters 26 and 27; Outline Read Chapter 25 Chapters 37 and 38; Outline
R 25 Apr 13 Jeff	**Test 5**	GI Clinical Assessment and Alteration Management: Lab data and diagnostics, GI intubation: NGT, Feeding tubes, Balloon tubes, Peg/G tubes High risk OB, Pediatrics	Chapters 32 and 33, Outlines Read Chapter 31 Chapter 11, 12, Handouts
R 3 May 13		**FINAL EXAM**	

Medical Transport Clinical Competency Checklist

Title: AutoCat Intra-Aortic Balloon Pump	**Employee:** (print name)
Dept: Operations	**Employee:** (signature)
Ref. Arrow AutoCat Intra-Aortic Balloon Pump	**Instructor:** **SCT-FTO:** (print name)
Competency Ref: IABP.doc SCT	**Instructor:** **SCT-FTO:** (signature)

Competency Statement: The employee will demonstrate the proper application and use of the AutoCat Intra-Aortic Balloon Pump.

Performance Criteria	**Instruction**		**Competency**	
Operation	**Date**	**Instructor**	**Date**	**FTO**
'Prior to arrival at the patient' procedures				
Break seal and inspect gear bag for all necessary equipment. (see checklist)				
Sign out AutoCat on clipboard.				
Safely lift AutoCat into back of ambulance.				
Transport AutoCat with wheels locked and safely positioned in the patient compartment area.				
At patient bedside, inspect and observe patient and note/record findings.				
(Note sheath size and balloon size; observe sheath site is clean and dry; check site for bleeding, oozing or hematoma; assess distal pulses, sensation and color in leg with sheath; assess radial pulse on same side of sheath prior to transfer)				
Inspect AutoCat EKG cables. Attach EKG cables to the patient and tape in place.				
Inspect patients' balloon pump tubing for "flecks" of blood.				
Test flush the patients A-Line for patency.				
Retrieve proper Arterial Line Cable from gear bag. Attach A-Line cable to AutoCat and ensure all connections properly secured. Lay cable next to patients current A-Line Cable.				
6. Attach proper 30cc/40cc/50cc adapter to AutoCat with additional length of tubing. Lay tubing next to patients balloon pump tubing.				
7. Turn on AutoCat (back panel) and mute alarm. Turn Helium tank to open position and ensure adequate psi.				
8. Ensure Trigger Mode set to EKG and ensure good				

EKG tracing				
9. Select "AutoPilot" mode and "Standby".				
10. Mirror patients pumping data on AutoCat with patients' current IABP settings. (i.e.: 1:1, 2:1, 3:1, or 8:1). Ensure proper balloon size is sensed on AutoCat and matches patients current balloon size.				
11. Place patients balloon pump in stand by.				
12. Disconnect A-Line and Transducer from patients balloon pump and connect to AutoCat. Tape Transducer to the patients' lateral thigh to meet the phlebostatic line. Ensure A-Line still flushes.				
13. Disconnect Balloon Tubing from patients current balloon pump and attach to AutoCat extra length of tubing.				
14. Take AutoCat to "Assist" and ensure that the AutoCat settings are in operation in AutoPilot mode.				
15. Ensure timing of inflation and deflation are accurate. Remove non-AutoCat EKG leads.				
16. ***Print out a strip to attach to your PPCR.*** In the unit, ensure the AutoCat is plugged in to conserve power.				
Maintenance:				
1. After each patient use, wipe down all patient cables with disinfectant wipes as per manufacturers instructions. Inspect all cords for frays or cuts.				
2. After each patient use, restock the gear bag and ensure all equipment in good working order. Reseal bag and record tag number.				
3. After returning AutoCat to office, sign AutoCat back in on the clipboard. Plug in AutoCat to maintain proper battery charge. Ensure Helium tank is turned off.				
4. Notify Coordinator of any operational problems or equipment problems as soon as possible. Place unit out of service with dispatch if necessary.				
END OF COMPETENCY				

Competency Checklist: IABP
Position Title: _____ Employee Name: _____ Unit: _____
Cluster Area: Helium leak

Method of Instruction Key:	Method of Evaluation Key:
P = Protocol/Procedure Review	O = Observation (in clinical setting)
E = Education Session	RD = Return Demonstration
S = Self Learning Package	T = Written Test
C = Clinical Practice	V = Verbal Review
D = Demonstration	

	Self-Assessment by Employee				Validation of Competency		
	Never Done	Needs Review/ Practice	Competent	Method of Instruction (Use Instruction Key on Left)	Date	Initials	Evaluation Method (Use Evaluation Key on Left)
A. SITUATION							
You are Loading a 68 year old male patient into your unit with a Intraortic balloon pump in place. The patient is S/P cardiac cath with 2 patent IV sites, Heparin at 16 units per kilogram on ideal weight of 80 kilograms, Integrilin 2 mcg/kg/ min, NTG 50 mcg/min.. The right groin has a 6fr sheath in the right femoral artery. The left groin has an 8fr sheath in the left femoral artery with the IABP catheter. Both sights are clean and dry without hematomas and plus 2 equal distal pulses. The balloon is 40cc. The pump is 1-1 with an augmented pressure 10 over the systolic pressure. The pump is running on autopilot. You and your crew has placed the patient on your stretcher and have switched the drips and EKG to your equipment without any problems. While loading the patient the alarm goes off on the IABP. Find and correct the alarm.							
B. SUTDENT EVALUATION							
1. Checks IABP to see what the alarm is. The alarm is lost helium							
2. Beginning at the patient, begins checking for							
A. Blood in the tubing, if found, scrapes to verify on the outside or inside							
B. Checks all connections to make sure they are connected and tight							
C. Finds the helium tubing has become disconnected from pump							
D. Corrects problem by reconnecting tubing to the pump.							
E. Reestablishes the IABP by pushing green on button							
F. Rechecks pump settings.							
G. Rechecks distal pulses.							
H. Rechecks catheter sight.							
I. Recheck patient							

Initials	Signature	Initials	Signature	Initials	Signature

Competency Checklist: IABP
Position Title: _____ Employee Name: _____ Unit: _____
Cluster Area: Helium lost

Method of Instruction Key:	Method of Evaluation Key:	Self-Assessment by Employee			Validation of Competency		
P = Protocol/Procedure Review E = Education Session S = Self Learning Package C = Clinical Practice D = Demonstration	O = Observation (in clinical setting) RD = Return Demonstration T = Written Test V = Verbal Review	Never Done	Needs Review/ Practice	Competent	Date	Initials	Evaluation Method (Use Evaluation Key on Left)
A. SITUATION							
48 year old female patient who came in with a STEMI. Patient went to the Cath lab and they found 3 lesions:							
95% Circ, 90% LAD and a 95% RCA. Patient is currently on a IABP 1-1 with an augmented pressure 10 above systolic							
pressure, oxygen by NC at 6 lpm, lungs clear and SpO2 is 98%. Two IV's both are 20 gauge and sights are clean							
and dry, flushes well. A 6 fr sheath is in the right femoral artery with a clean dry sight, no hematomas and + 2 distal pulses.							
A 8 fr. In the left femoral artery with the IABP catheter, sight is clean and dry, no hematoma and +2 distal pulses.							
You have place the patient on your stretcher with no problems during the move and loading the patient in unit							
Your patient is obese with a weight 140 Kg. Integrilin is running at 2 mcg./kg/min. and NTG at 75 mcg/min. Ideal weight							
For Heparin is 70 KG.							
B. EVALUATION							
A. Alarm checked to identify the problem							
B. Verbally identifies alarm as lost helium							
C. Starts at the patient checking for loose connections and possible blood in line							
D. Looks for kinked line							
E. Alarm will not clear until student identifies the patient has her leg crossed causing the tubing to kink, once the leg							
has been uncrossed the alarm is able to be reset.							
F. Instructs patient the importance in not crossing legs							
G. Takes sheet places across knees and tucks ends under sides of stretcher to remind patient no to cross legs							
H. Rechecks the sight for hematomas and bleeding at the cath sight							
I. Rechecks distal pulses							

Competency Checklist: IABP
Position Title: _____ Employee Name: _____ Unit: _____
Cluster Area: Helium lost

Initials	Signature	Initials	Signature	Initials	Signature

Competency Checklist: IABP
Position Title: _____ Employee Name: _____ Unit: _____
Cluster Area: Helium lost 2

Method of Instruction Key:	Method of Evaluation Key:	Self-Assessment by Employee				Validation of Competency		
P = Protocol/Procedure Review E = Education Session S = Self Learning Package C = Clinical Practice D = Demonstration	O = Observation (in clinical setting) RD = Return Demonstration T = Written Test V = Verbal Review	Never Done	Needs Review/ Practice	Competent	Method of Instruction (Use Instruction Key on Left)	Date	Initials	Evaluation Method (Use Evaluation Key on Left)
A. SITUATION								
65 year old male patient found in the Cath lab post cath with a 95% blockage to the left main, patient conscious alert with a 9 fr. Sheath to the right groin, good clean dry sight with equal +3 distal pulses. Heparin is 10units/kg/hr with an ideal weight of 80 kg and o2 at 2 lts. IABP is switched with no problems and patient is placed on your stretcher. Once patient is loaded into your unit the low helium alarm sounds.								
B. EVALUATION								
A. Alarm checked to identify the problem								
B. Verbally identifies alarm as lost helium								
C. Starts at the patient checking for loose connections and possible blood in line								
D. Looks for kinked line								
E. Alarm will not clear until student identifies the tubing is caught and kinked off in the stretcher the tubing must be Untangled from stretcher and straightened before the alarm is able to be reset.								
F. Checks tubing for cuts								
G. Rechecks the sight for hematomas and bleeding at the cath sight								
H. Rechecks distal pulses								

Initials	Signature	Initials	Signature	Initials	Signature

Competency Checklist: IABP
Position Title: _____ Employee Name: _____ Unit: _____
Cluster Area: Pump Failure

Method of Instruction Key:	Method of Evaluation Key:	Self-Assessment by Employee				Validation of Competency		
P = Protocol/Procedure Review E = Education Session S = Self Learning Package C = Clinical Practice D = Demonstration	O = Observation (in clinical setting) RD = Return Demonstration T = Written Test V = Verbal Review	Never Done	Needs Review/ Practice	Competent	Method of Instruction (Use Instruction Key on Left)	Date	Initials	Evaluation Method (Use Evaluation Key on Left)
A. SITUATION								
You are Loading a 58 year old male patient into your unit with a Intraortic balloon pump in place. The patient is S/P cardiac cath. IV times 2, good sights. Heparin at 16 units per kilogram, ideal weight 80 kilograms. Integrin 2 mcg/kg/min. 99% Left main. The right groin has a 6fr in the right femoral artery. The left groin has a 8fr in the left femoral artery with the IABP catheter. Both sights are clean and dry without hematomas and plus 2 equal pulses distil. The balloon is 40cc. The pump is 1-1 with an augmented pressure 10 over the systolic pressure. The pump is running on autopilot. You and your crew has placed the patient on your stretcher and have switched the drips and EKG to your equipment without any problems. After loading the patient the alarm goes off on the IABP. Find and correct the alarm.								
B. SUTDENT EVALUATION								
1. Checks IABP to see what the alarm is. The alarm is pump failure.								
2. A. Turn off IABP and disconnect tubing from machine.								
B. Inflate balloon using 60 cc syringe to the max cc of the balloon								
C. contact the receiving Hospital of the failure								
D. Rechecks distil pulses.								
E. Rechecks catheter sights.								
F. Recheck patient								
G. Contact EMS 2								
H. After call send a detailed description of the event to EMS 2 and the Training Supervisor								

Initials	Signature	Initials	Signature	Initials	Signature

Competency Checklist: IABP
Position Title: _____ Employee Name: _____ Unit: _____
Cluster Area: Balloon Failure

Method of Instruction Key:	Method of Evaluation Key:	Self-Assessment by Employee				Validation of Competency		
P = Protocol/Procedure Review E = Education Session S = Self Learning Package C = Clinical Practice D = Demonstration	O = Observation (in clinical setting) RD = Return Demonstration T = Written Test V = Verbal Review	Never Done	Needs Review/ Practice	Competent	Method of Instruction (Use Instruction Key on Left)	Date	Initials	Evaluation Method (Use Evaluation Key on Left)
A. SITUATION								
You are Loading a 66 year old male patient into your unit with a Intraortic balloon pump in place. The patient is S/P cardiac cath. IV times 2, good sights. Heparin at 14 units per kilogram, ideal weight 77 kilograms. Integrin 2 mcg/kg/min. 90% Left main. The right groin has a 6fr in the right femoral artery. The left groin has a 9fr in the left femoral artery with the IABP catheter. Both sights are clean and dry without hematomas and plus 2 equal pulses distil. The balloon is 40cc. The pump is 1-1 with an augmented pressure 10 over the systolic pressure. The pump is running on autopilot. You and your crew has placed the patient on your stretcher and have switched the drips and EKG to your equipment without any problems. After loading the patient the alarm goes off on the IABP. Find and correct the alarm.								
B. SUTDENT EVALUATION								
1. Checks IABP to see what the alarm is. The alarm is helium loss								
2. A. Check the tubing beginning at the patient								
B. You find small red spots in the tubing								
C. Try to wipe and scrape off spots without success								
D. Disconnect tubing and clamp tubing near patient. Disconnect from pump.								
E. Contact the receiving Hospital and notify of the failure								
F. Rechecks distal pulses.								
G. Rechecks catheter sight.								
H. Recheck patient								
I. Contact EMS 2								
J. After call send a detailed description of the event to EMS 2 and Training Supervisor								

Initials	Signature	Initials	Signature	Initials	Signature

Competency Checklist: IABP
Position Title: _____ Employee Name: _____ Unit: _____
Cluster Area: Bleeding at Sheath sight

Method of Instruction Key:	Method of Evaluation Key:	Self-Assessment by Employee				Validation of Competency		
P = Protocol/Procedure Review E = Education Session S = Self Learning Package C = Clinical Practice D = Demonstration	O = Observation (in clinical setting) RD = Return Demonstration T = Written Test V = Verbal Review	Never Done	Needs Review/ Practice	Competent	Method of Instruction (Use Instruction Key on Left)	Date	Initials	Evaluation Method (Use Evaluation Key on Left)
A. SITUATION								
68 year old female patient who came in with a STEMI. Patient went to the Cath lab and they found a 95% Left Main								
and a 95% RCA. Patient is currently on a IABP 1-1 with an augmented pressure 10 above systolic pressure								
Oxygen by NC at 6 lts., lungs clear and pulsox stats are 99%. Two IV's both are 20 gauge and sights are clean								
and dry, flushes well. A 6 fr. In the right femoral artery with a clean dry sight, no hematomas and + 3 distal pulses.								
A 9 fr. In the left femoral artery with the IABP catheter, sight is clean and dry, no hematoma and +3 distal pulses.								
You have placed the patient on your stretcher with no problems. You and your crew have loaded the patient in the unit								
Your patient is obese with a weight 140 Kg. Integrin is running at 2 mcg./kg/min. and NTG at 75 mcg/min. Ideal weight								
For Heparin is 70. You have started to transport. During transport you check the IABP sight and note moderate								
Bleeding from the sight.								
B. EVALUATION								
A. Immediately start to hold pressure at the cath sight with several fingers.								
B. Have your partner notify dispatch and EMS 2								
C. Notify receiving Hospital								
D. Recheck BP								
E. If BP low start or increase IV fluids								
F. Holds pressure for at least 20 minutes								
G. After 20 minutes release pressure and check for further bleeding								
H. Rechecks BP								
I. Rechecks distal pulses								
J. After call sends a detailed report to EMS 2 and the Training Supervisor								

Initials	Signature	Initials	Signature	Initials	Signature

Attachment F

POST Form

HIPAA permits disclosure to health care professionals and authorized decision makers for treatment

Virginia Physician Orders for Scope of Treatment (POST)

This is a Physician Order Sheet based on the patient's current medical condition and wishes. Any section not completed creates no presumption about the patient's preferences for treatment.

Name Last / First / M.I.	
Address	
City / State / Zip	
Date of Birth (mm/dd/yyyy)	Last 4 Digits of SSN ☐☐☐☐

A ✓one only

CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.

☐ Attempt Resuscitation ☐ Do Not Attempt Resuscitation (DNR/No CPR)

When Do Not Attempt Resuscitation is checked, qualified healthcare personnel are authorized to honor this order as if it were a Durable DNR Order.

When not in cardiopulmonary arrest, follow orders in B & C

B ✓one only

Comfort Measures are always provided, regardless of the level of care chosen

MEDICAL INTERVENTIONS: Patient has pulse and / or is breathing.

☐ **Comfort Measures:** Treat with dignity and respect. Keep warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Transfer to hospital *only* if comfort needs cannot be met in current location. Also see "Other Instructions" if indicated below.

☐ **Limited Additional Interventions:** Includes comfort measures described above. Do not use intubation or mechanical ventilation. May consider less invasive airway support (e.g., CPAP or BIPAP). Use additional medical treatment, antibiotics, IV fluids and cardiac monitoring as indicated. Transfer to hospital if indicated. Avoid intensive care unit. Also see "Other Instructions" if indicated below.

☐ **Full Interventions:** In addition to Comfort Measures above, use intubation, mechanical ventilation, cardioversion as indicated. Transfer to hospital if indicated. Include intensive care unit. Also see "Other Instructions" if indicated below.

Other Instructions: _____

C ✓one only

ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and fluids by mouth if feasible.

☐ NO feeding tube (Not consistent with patient's goals given current medical condition)

☐ Feeding tube for a defined trial period (specific goal to be determined in consultation with treating physician)

☐ Feeding tube long-term if indicated

Other Instructions: _____

DISCUSSED WITH:

☐ Patient ☐ Agent under Advance Medical Directive ☐ Court Appointed Guardian ☐ Other person legally authorized

PHYSICIAN: My signature below indicates that I have discussed the decisions documented herein with the patient or the person legally authorized to consent on the patient's behalf and have considered the patient's goals for treatment, to the best of my knowledge.

Physician Name (Print) (Mandatory)	Physician Phone (Mandatory)
Physician Signature (Mandatory)	Date (Mandatory)

Signature of the Patient OR the Person Legally Authorized to Consent on Patient's Behalf (Mandatory)

Patient's Signature	Patient's Name (Print)
Signature of Person Signing on Behalf of the Patient	Name of Person Signing on Behalf of the Patient
Describe Authority to Sign for Patient (Medical Power of Attorney, Guardian, Spouse, Adult Child, Parent, Sibling, Other Blood Relative)	
Phone	Address

FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

© 2014 Virginia POST Collaborative.
Do not alter this form.
Rev. 2/2014

www.virginiapost.org

HIPAA permits disclosure to health care professionals and authorized decision makers for treatment

NAME _____ **LAST 4 SSN** ☐ ☐ ☐ ☐

CARE SETTING OF ORIGIN

☐ Long-Term Care ☐ Hospital ☐ Home ☐ Hospice facility ☐ Outpatient Practice ☐ Other _____

Name of Care Setting: _____

Signature of Healthcare Professional Preparing Form:	Name of Healthcare Professional Preparing Form (Print)	Date Prepared

The intent of this form is to reflect decisions for life-sustaining treatment based on the patient's current medical condition. This form should be reviewed with a treating physician and updated when the patient's medical condition changes, when the patient moves to a new facility or when the patient's preferences change. If a patient is unable to make decisions and is therefore unable to sign this form, the directions on this form should reflect the patient's preferences as best understood by the person authorized to consent under Virginia Law. HIPAA permits disclosure to health care professionals and electronic registry as necessary for treatment.

Directions for Healthcare Professionals

Completing POST

- The orders should reflect patient's current preferences.
- A physician, nurse practitioner or physician assistant who has a bona fide physician/patient relationship with the patient must sign POST. Nurse practitioners and physician assistants are authorized to sign POST forms under the Code of Virginia Sections §64.1-2957.02 and §54.1-2952.2. Health care organizations may have policies that impose limitations on this authority based on their individual scope of practice.
- Use of original form is encouraged. A photocopy, fax or electronic version may be honored as if it were an original.

Using POST

- When comfort cannot be achieved in the current setting, the patient, including someone who has chosen "Comfort Measures," should be transferred to a setting able to provide comfort (e.g. treatment of a hip fracture).
- IV medication to enhance comfort may be appropriate for a patient who has chosen "Comfort Measures."
- Always offer food and fluids by mouth if medically feasible.

Revoking/Making Changes to POST

- To change POST, the current POST form must be voided and a new POST form completed. If no new form is completed, full treatment and resuscitation may be provided.
- As long as the patient can make his/her own decisions, the patient may revoke consent for POST and may request changes to POST. If a patient tells a healthcare professional that he/she wishes to revoke his/her consent to POST or change POST, the healthcare professional caring for the patient should draw a line through the front of the form and write "VOID" in large letters on the original, with the date and the professional's signature, and notify the patient's physician. A new POST form may then be completed if desired by the patient.
- If not in a healthcare facility, the patient who can make his/her own decisions may revoke consent for POST orders by voiding the form as described above and informing a healthcare professional. The healthcare professional must then notify the patient's physician so that appropriate orders may be written and a new POST form created if desired by the patient.
- If the patient signs this form, the patient's treatment goals should be honored if the patient becomes unable to make decisions, as provided in the Code of Virginia § 54.1-2986.1.
- If the patient is unable to make healthcare decisions, a legally authorized medical decision maker, in consultation with the treating physician, may sign this form, revoke consent to, or request changes to the POST orders to continue carrying out the patient's own preferences in light of changes in the patient's condition.

Persons Legally Authorized to Consent for Patient Incapable of Making an Informed Decision:
An agent named in an Advance Directive (§54.1-2983) may consent for the patient under the terms of the Advance Directive. If the patient has no Advance Directive, the following persons may consent for the patient in this order: guardian, spouse, adult child, parent, adult sibling, other relative in descending order of blood relationship (§54.1-2986)

FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

POST forms are available to medical care providers and organizations that have agreed to the standards set forth by the Virginia POST Collaborative.
Contact: inquiry@virginiapost.org

SAMPLE

Attachment G

Chesterfield MIHP Presentation

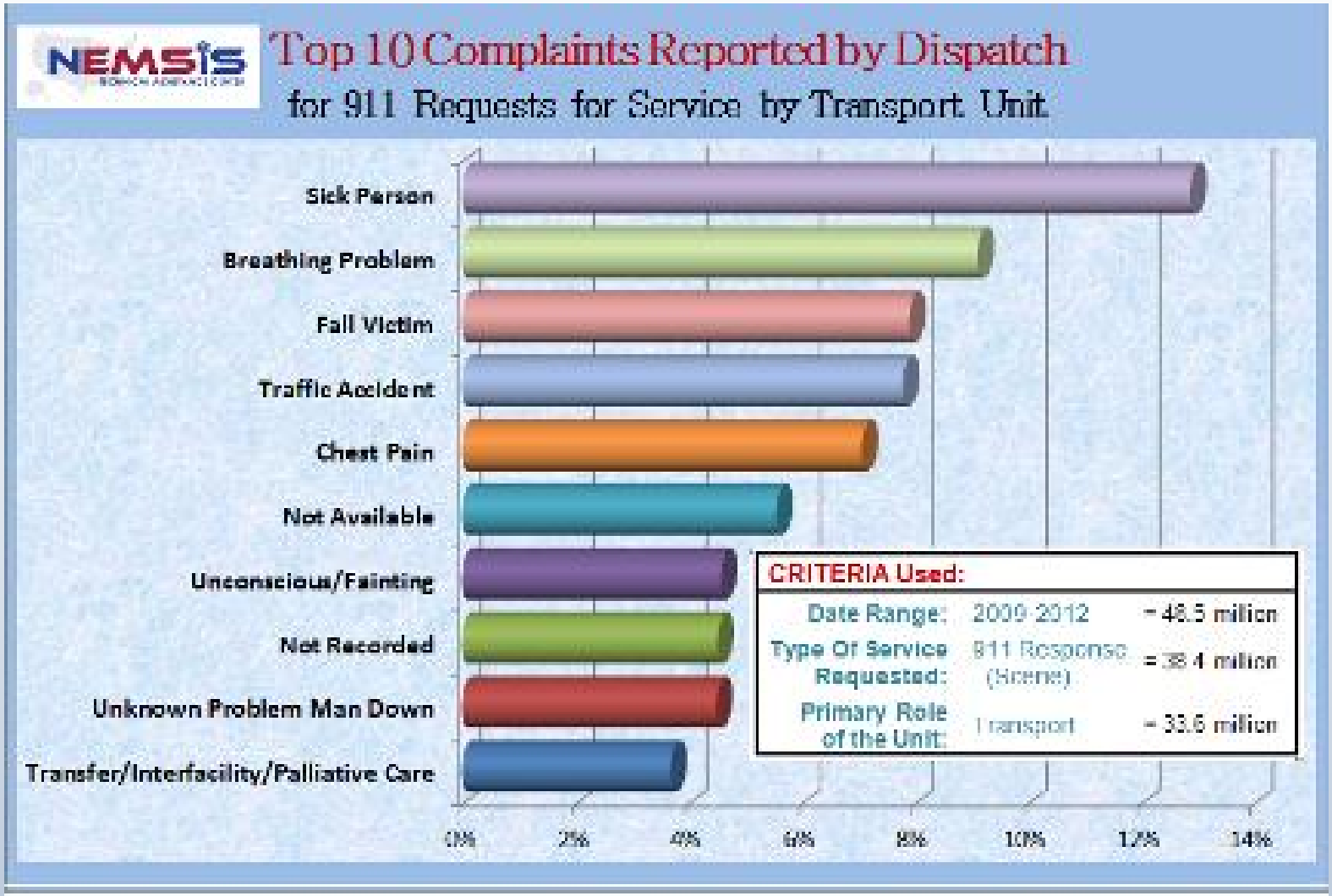
Community Paramedic Program

Chesterfield Fire and Emergency Medical Services

“EMS?”

- 9-1-1 safety net access for non-emergent healthcare
  - 36.6% of 9-1-1 requests
    - *12 months Priority 3 calls (37,508/102,601)*
- Reasons people use emergency services
  - *To see if they needed to*
  - *It’s what we’ve taught them to do*
  - *Because their doctors tell them to*
  - *It’s the only option*
- 37 million house calls/year
  - 30% of these patients don’t go with us to the hospital

EMS Calls for Service



1996 EMS Agenda for the Future

Communities of S
Report Revisited

The Folsom Group

American Board of Family Medicine Young Leaders Advisory Group

ABSTI

INTRO

AC *Annals* Journal Club selection, see inside back cover or http://www.annfammed.org/AJC/.

Conflicts of interest: the authors report none.

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ANNALS OF FAMILY MEDICINE

National Organization of State Offices of Rural Health

NOSORH: the membership organization of state offices of rural heal

National Association of

Joint Committee on Rural
National Association of State Eme
National Organization of S
State Perspectives Discussion Paper on Deve

State Emergency Medical Services (EMS) Offices and Stat
principle that rural EMS systems should be able to respond
or illness strikes someone in need. In 2009 the National A
National Organization of State Offices of Rural Health (NO
Care (JCREC). This Committee is dedicated to advancing
affordable, and high quality emergency care services in rur
Access to EMS and Health Care in Rural Communities: A S
Associations. This discussion paper is intended to further t
Plan.

Statement of Purpose:

The concept of community paramedicine represents
evolutions available to community-based healthcare
utilizing Emergency Medical Service providers in an
patient access to primary and preventative care, pro
home model, decreases emergency department util
patient outcomes. As the Community Paramedicine
states and local communities need assistance in ide
challenges. This discussion paper offers insight into
for Community Paramedicine programs. As well, it a
guide for states.

Community Paramedicine in Action

At 2:35 am on a cold November morning the Emerg
received a call from a man, frantic with concern abo
hard time breathing and I don't know what to do!" Af
labored breathing, the dispatcher alerted the approp
caller through further assessment questions and wa

Kennedy was just finishing a patient care report to g
over the radio, "Medic 1, Alleghany EMS, Hillsborou
3415 Washo Drive. Patient conscious and alert. Co
the clipboard shut and grabbing the radio, Kennedy
1, her paramedic response car. While Kennedy navi
Critical Access Hospital in town out to Washo drive,
unfolding. Knowing that even though the fire departi
sirens, they would most likely get there before she c
patient comfortable and may be able to give a quick

The husband, Carl, watched nervously as the first re
his wife had suffered from an infection of the lining c
dependence on medications to keep her lungs from
Just yesterday they had decided with her primary ca
an effort to try and wean her off slowly. It looked no

Discussion Paper on Community Paramedicine December 2010 Page | 1

EMERGENCY

MEDICAL

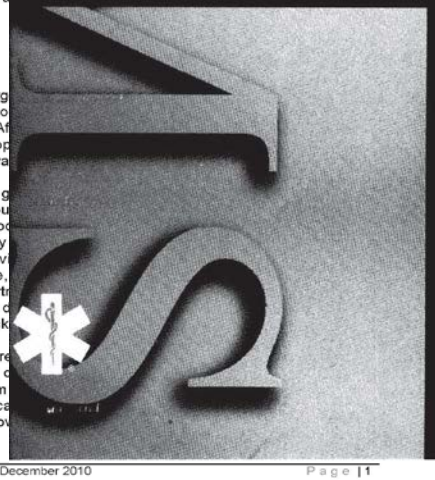
SERVICES

AGENDA

FOR

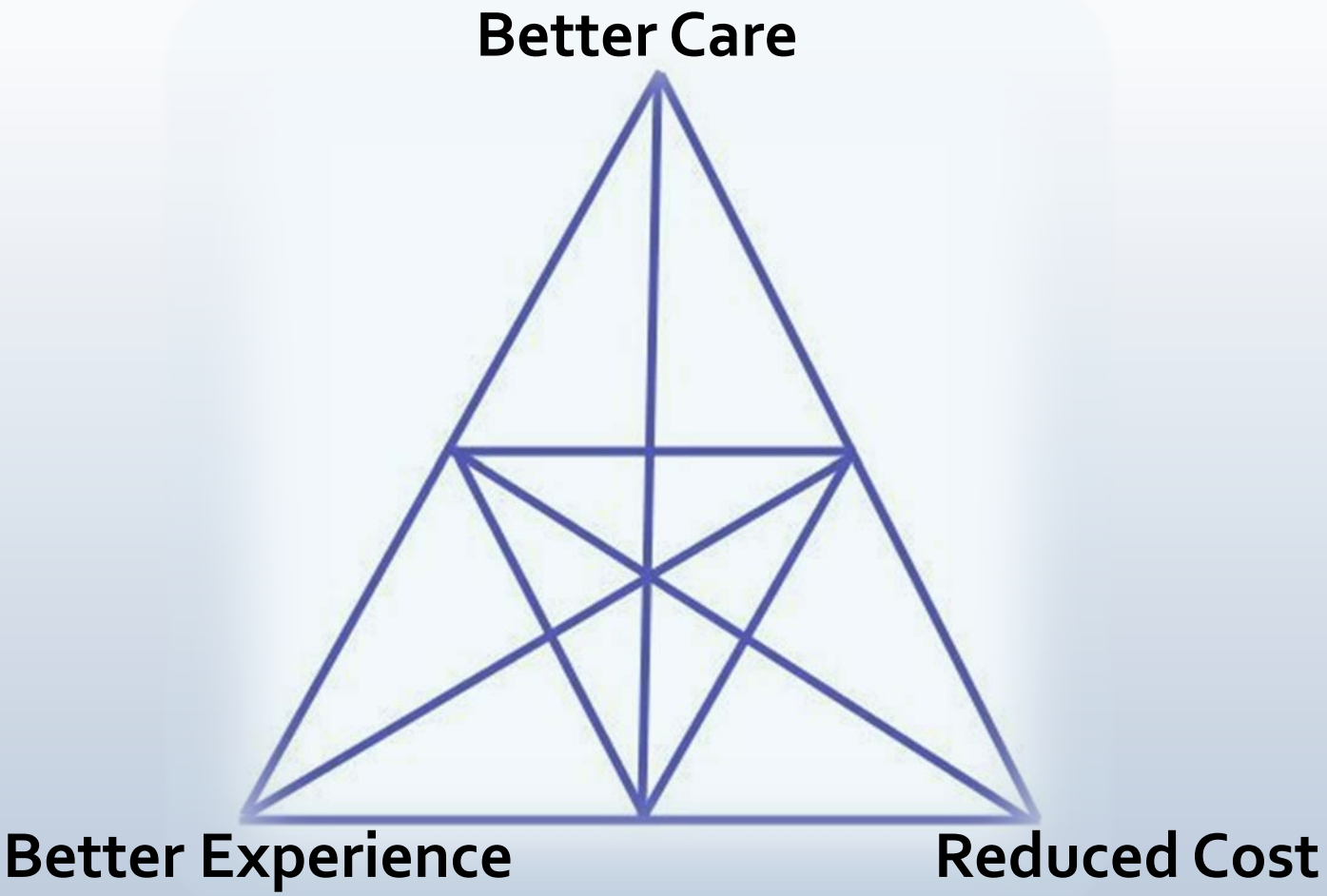
THE

FUTURE



DOT/HS/NHTSA
150267

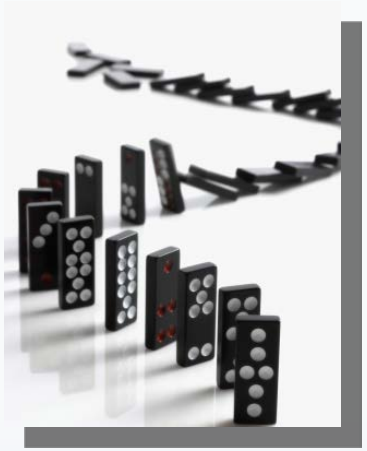
The
TripleAim™
OPTIMIZING HEALTH, CARE EXPERIENCE, AND COSTS FOR POPULATIONS


Better Care
Better Experience
Reduced Cost

5 Components of Triple AIM

- Focus on individuals and families
- Redesign of primary care services and structures
- Population health management
- Cost control platform
- System integration and execution

Our New Environment:



- New partnerships/New opportunities
  - Aligned incentives & risk sharing
  - Bundled payments based on episode of care
  - *Performance-based* payments
  - Payment based on ***OUTCOMES***

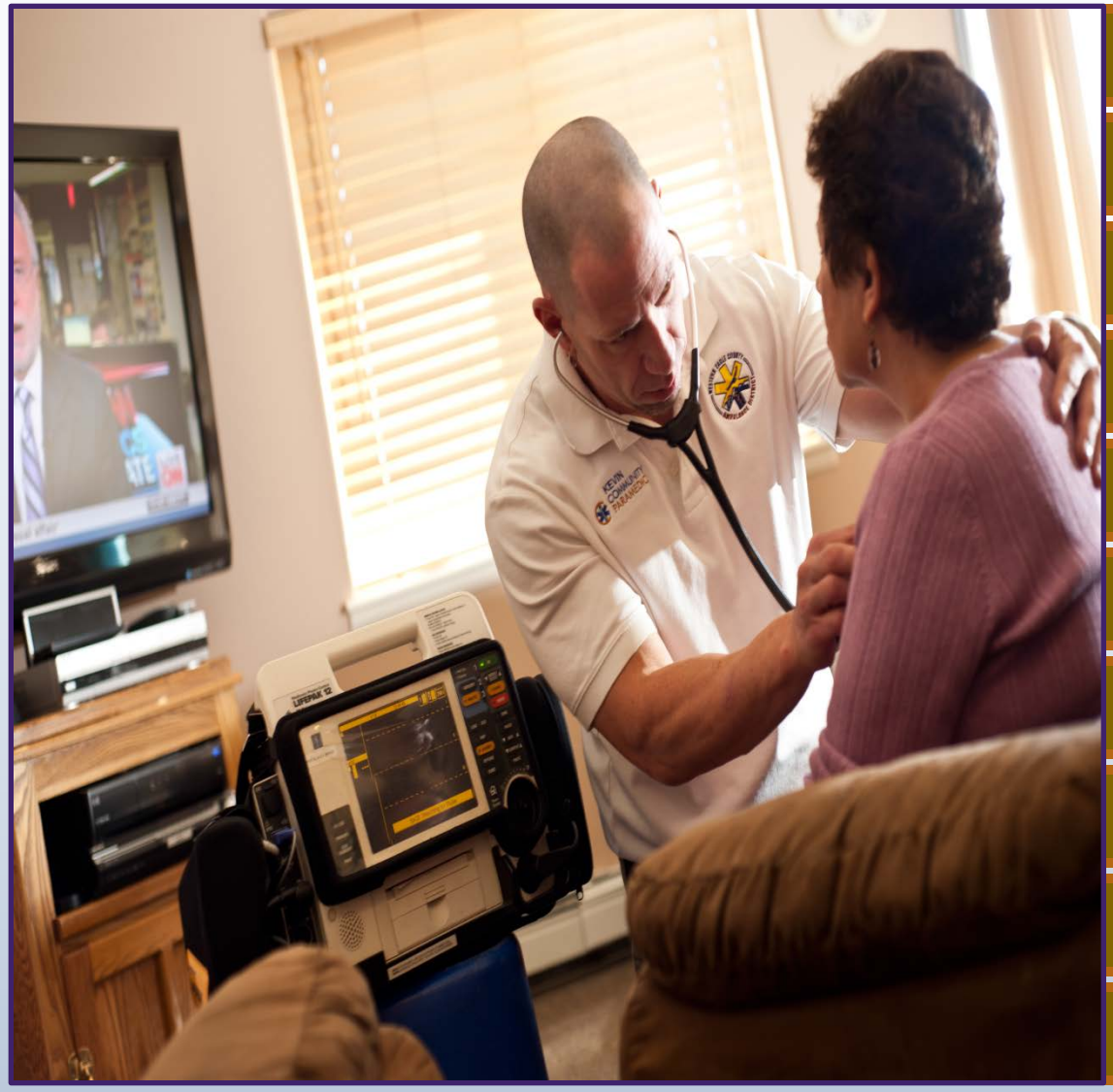
What is Community Paramedicine?

A service designed for health care cost reduction

A service to increase continuity of care between providers

Specified response to health care gaps in our individual communities

Roles of the Community Paramedic



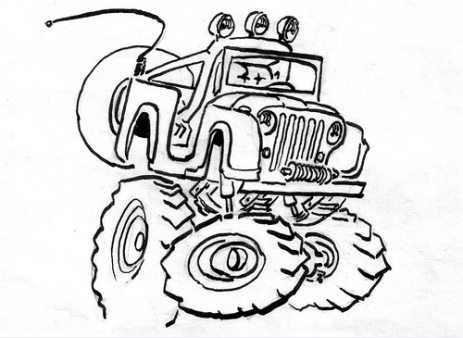
- Emergency Care
- Primary Care
- Public Health
- Public Education
- **Readmission Reduction**
- Wellness
- Discharge Continuity
- Disease Management
- Lab testing
- Prevention

Patient Navigation

- Community Health Program
- Loyal customer Programs
- High Risk Dx Readmissions
  - CHF
  - DM
  - COPD
  - Mental health
- Observational Admission Avoidance
- Hospice Revocation Avoidance

Local Needs!

Trailblazers!



United States

- Minnesota, Colorado, Texas, North Carolina, South Carolina, Pennsylvania

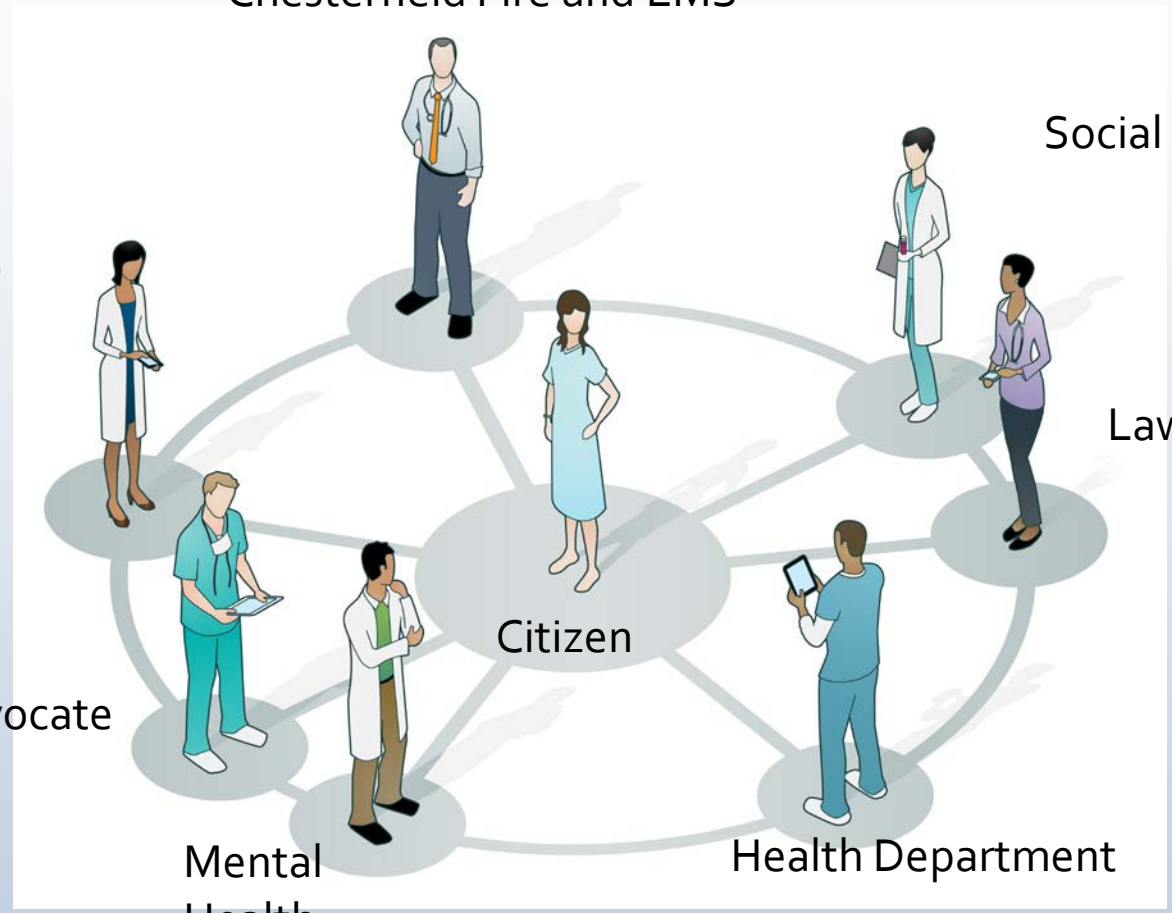
Canada

- Nova Scotia, Toronto, Manitoba, Winnipeg

Chesterfield Fire and EMS Community Paramedic

- Serves as a mobile patient advocate
- Navigates citizen to the right resources to meet their needs
- Provides community risk reduction services
- Delivers health promotion services in the home and community

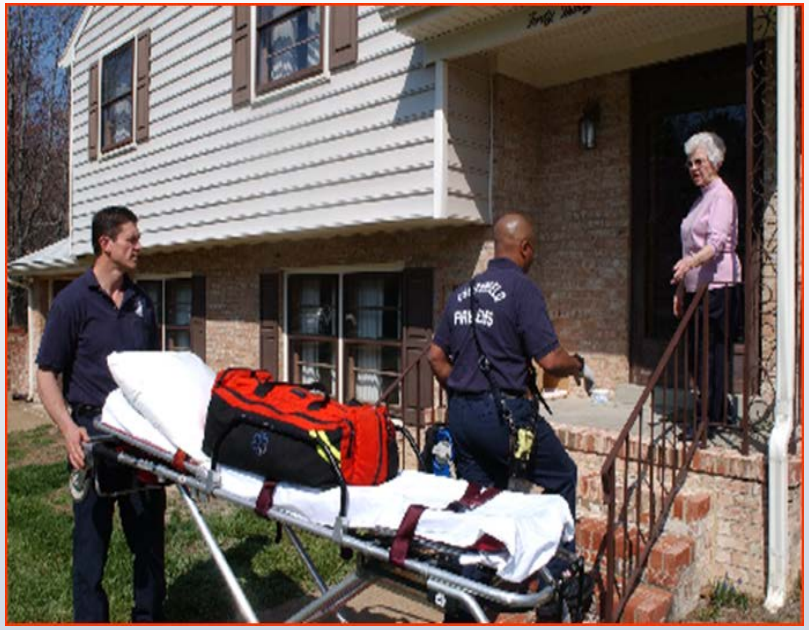
Accessing the Circle of Services



Taking Healthcare to the Patient

- Community Paramedic has an expanded role and provides expanded services
- The application of the Paramedics' knowledge, skills, and abilities in a different environment
- Providing care which benefits the patients, county, and stakeholders along the spectrum of care

Community Paramedic Concept



- Proactive vs. Reactive
- Improve quality of life for citizens via education and navigating patient care
- Reduce costly ED visits, hospitals admissions, and readmissions

Community Paramedicine Development

- Loyal customer (911 usage) reduction

- Redirect patients to the most appropriate facility (not necessarily an emergency department)

- Development of injury and illness prevention programs such as Elderly Fall Reduction Program

- Work with chronic disease patients to reduce readmissions (future)

Mental Health Challenges

- No one else to turn to
- Loyal Customers (Uses 911 for access into the system)
- 911 abilities (Emergency Room, Crisis)
- Law Enforcement (ECO's)

Mental Health/Crisis

- Crisis Intervention Team (Police / Mental Health)
- New Crisis Triage Center at Chippenham Campus
- Mental Health access vs. Emergency Room transport
- Chester House

Washington Post Average ED Payment

$1233.00

Diagnosis	Median charge ($) (95% CI)	Mean charge ($) (95% CI)	Inter-quartile range (IQR)	Minimum charge	Maximum Charge
Sprains & strains	1051 (982–1110)	1498 (1304–1692)	1018	4	24110
Other injury	1151 (1003–1281)	2103 (1770–2437)	1594	46	27238
Open wounds of extremities	979 (864–1090)	1650 (1341–1959)	924	29	25863
Normal pregnancy and/or delivery	1204 (1027–1384)	2008 (1701–2315)	2008	19	18320
Headache	1210 (1093–1344)	1727 (1510–1943)	1572	15	17797
Back problems	871 (741–984)	1476 (1265–1687)	1189	66	10403
Upper respiratory infection	740 (651–817)	1101 (891–1312)	827	19	17421
Kidney stone	3437 (2917–3877)	4247 (3642–4852)	3742	128	39408
Urinary tract infection	1312 (1025–1580)	2598 (1780–3416)	1975	50	73002
Intestinal infection	1354 (1114–1524)	2398 (1870–2927)	1960	29	29551
Total outpatient conditions	1233 (1199–1268)	2168 (2103–2233)	1957	3.5	73,002

All diagnoses have an IQR of greater than $800. The diagnoses with the largest IQRs were kidney stone ($3742), normal pregnancy and delivery ($2008), and urinary tract infection (UTI) ($1975).

doi:10.1371/journal.pone.0055491.t003

Psychiatric Initiative Savings Analysis

Program Potential			
Category	Base	Avoided	Savings
Psych Patients 30% Reduction	1,307	30%	392.1
Psych ED Bed Hours	14	392	5,488
ED Payments	$1,233.00	392	$483,336.00
Total Payments Avoidance			$483,336.00
Total ED Bed Hours Returned			5488

Loyal Customer Reduction

- Identify high frequency users
  - Residential
  - Facility based
- Chart review
- Formulate action plan
- Collaborate with resources identified for patient

Mobile Integrated Healthcare/Community Paramedic Program

Program Progress Report

Loyal Customer 911 Usage Reduction Program

CP #	911 Calls 12 Months Prior	911 Calls Post (1)	Calls Avoided	Average Transport $	Projected Savings
5	37	0	37	$459.00	$16,983.00
11	29	12	17	$459.00	$7,803.00
18	5	0	5	$459.00	$2,295.00
20	23	0	23	$459.00	$10,557.00
25	15	1	14	$459.00	$6,426.00
40	10	0	10	$459.00	$4,590.00
50	23	0	23	$459.00	$10,557.00
57	11	4	7	$459.00	$3,213.00
68	17	0	17	$459.00	$7,803.00
83	10	4	6	$459.00	$2,754.00
84	6	0	6	$459.00	$2,754.00
95	24	3	21	$459.00	$9,639.00
107	5	1	4	$459.00	$1,836.00
131	24	0	24	$459.00	$11,016.00
				$459.00	$0.00

214.00 Total Savings **$98,226.00**

Loyal Customer Response Reduction Savings Analysis

Category	Base	Avoided	Savings
Ambulance Charge	$459.00	214	$98,226.00
ED Charges	$1233.00	214	$263,862.00
Total Charge Avoidance			$362,088.00

Elderly Care and Fall Prevention Challenges

Numbers based on CDC

- One third of citizens older than 65 will fall
- 5% of those will be admitted to a Hospital
- 12% admitted will be discharged to a Nursing Home

Home Safety and Risk Reduction

- Home risk assessment
  - ✓ Fall Preventions
  - ✓ Smoke Alarms
- Resources
  - ✓ FREE (Foundation for Rehabilitation Equipment & Endowment)
  - ✓ Project Lifesaver (Chesterfield Police)
  - ✓ Adult Day Center
  - ✓ Directory of Services for Older Adults

Predicted Fall Data

for Chesterfield 2015

Population >65 for 2015	42,865
Predicted Falls	14,274
Predicted Admissions	713
Predicted Deaths	**31**
Predicted Costs of Admissions	$17,680,054.23

Potential Cost Saving for Falls in Chesterfield

Reduction	Cost Savings
5% Reduction	$1,245,502.72
10% Reduction	$2,490,405.42
15% Reduction	$3,736,508.16
20% Reduction	$4,982,010.88
25% Reduction	$6,226,013.75

Chronic Disease Challenges

- Home Health Care can take up to 72 hours
- Discharge instructions may be confusing
- High readmissions rates
- Diminished quality of life

Chronic Disease Care

- Initial focus will be on congestive heart failure
- Home visit within 24 to 36 hours after discharge
- Full assessment done in the home to include ECG, Labs, Medication Reconciliations
- Conferencing with Medical Specialist (if needed)
- Follow up appointments

Hospital Readmission Reduction Program

Program Potential			
30-Day Readmissions			
Category	Base	Avoided	Savings
Ambulance Charges	$431.29	30	$12,938.70
ED Charges	$1233.00	30	$36,990.00
ED Bed Hours	6	30	180
Admission Payment	$17,500.00	30	$525,000.00
Total Savings			$574,928.70

Potential Bed Hours Saved

Program Potential			
Category	Base	Avoided	Total Hours Saved
Psych ED Bed hours	14	392	5488
Loyal Customers	2.65	773	2048.45
Falls	2.65	121	320.65
CHF	2.65	30	79.5
Total Category Bed Hours			7936.6

Enrollment into Program

Referrals

- ✓ Hospitals upon a discharge for chronic disease
- ✓ Providers from Chesterfield Fire and EMS Operations
- ✓ Citizens from the county internet website

Enrollment Period

Thirty to Ninety Days

Staffing

- Disease Focused Education
- Three Paramedics
- Level of providers

Benefits for Chesterfield County

- Improved health and safety of our citizens
- Reduction in low acuity patient transport
- Increased unit availability
- Improved access to county resources
- The right patient to the right facility

Home visit

- Initial visit 2 hours
- General Assessment
  - Social History
  - Mental (PHQ9)
  - ADL's
  - PMH
  - Patient Assessment
  - Education
  - Interventions
  - Chart
- Home Risk Assessment
  - Fire Safety
  - Fall Prevention
  - DME
- Medication Inventory

At all time looking for needs to improve health at home

Chesterfield Fire and EMS Community Paramedic General Assessment

Date

CP Number

Name				Age	
Address				CA Number	
City		State		Zip Code		Phone	
Last 4 of SSN		Sex		D.O.B		Alt. Phone	

Interview Questions	Yes	No
Does the pt have a PCP		
Does the pt have special needs		
Does the pt have insurance		
Does the pt understand when 911 is appropriate		
Does pt understand how to access medical resources		
Pt been educated on other means of transportation		
Is the pt current on their medications		
Is follow up needed		
When was the last time the pt access 911	Date	

Vaccine/Immunizations

Pneumonia	Influenza	Tetanus	Pediatric
Within 5 years	This year	Date last given:	Up-to-date
65 or older	Unknown		Unknown
Unknown	Under 13 vaccinated	Unknown	

Additional Forms

Med Rec | CHF | Asthma / COPD | Diabetes | Wound Care | Home Risk

Social Hx

ETOH (CAGE)

1. Have you ever felt the needs to cut down on drinking? Y N
2. Do you feel annoyed by people complaining of your drinking? Y N
3. Do you feel guilty about your drinking? Y N
4. Do you ever drink an eye-opener in the morning to relieve shakes? Y N

Two or more affirmative responses suggest that the Pt. is a problem drinker. Is the Pt. interested in quitting or counseling? Y N

Tobacco

Cigarettes Use

Never YES Pk per day 0

Date Quit

Other

Pipe Cigar Snuff Chew

Interested in quitting Y N

Illicit drug

Do you use any recreational drugs? Y N

Ever used needles to inject drugs? Y N

Physicians / Specialist / Dentist / Outpatient services

Practitioner name	Specialty

Patient Concerns or Needs

ADL's	Independent	Needs Help	Dependent	Does Not Do
Bathing				
Dressing				
Grooming				
Oral Care				
Toileting				
Transferring				
Walking				
Climbing Stairs				
Eating				
Shopping				
Cooking				
Managing Medications				
Using the Phone				
Housework				
Doing Laundry				
Driving				
Managing Finances				

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day	Score
1. Little interest or pleasure in doing things	0	1	2	3	0
2. Feeling down, depressed, or hopeless	0	1	2	3	0
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3	0
4. Feeling tired or having little energy	0	1	2	3	0
5. Poor appetite or overeating	0	1	2	3	0
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down	0	1	2	3	0
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3	0
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3	0
9. Thoughts that you would be better off dead, or hurting yourself	0	1	2	3	0

Healthcare professional: For interpretation of TOTAL, please refer to accompanying score care).

Total 0

10. If you checked off any problems, how difficulty have these Problems made it for you to do your work, take care of things at home, or get along with people?

Not difficulty at all | Very difficulty | Somewhat Difficulty | Extremely difficulty

Enrollee Signature:

Chesterfield Fire and EMS
Community Paramedic
CHF Assessment

Date

Name		CP Number	
Address		CA Number	
City	State	Zip Code	Phone

Patient's Knowledge of Their Disease	Yes	No
Does the patient understand their disease process?		
Does the patient understand their discharged orders?		
Does the patient have a follow up visit within 7 days? (If no PCP appt. the CP/staff will refer)		
Barriers of care removed to ensure follow-up occurs?		
Does the patient understand red flags?		
Follow-up communication established with patient?		
Identify transport availability for post follow-up risk?		
Does the patient have a DDNR or Advance Directives		
If yes, where is a hard copy		

Stages of CHF			
Stage 1	Stage 2	Stage 3	Stage 4

Weight		
Does the patient record weight daily?	Yes	No
Patient's goal weight		
Patient's current weight		
Change in weight + or -		

Patient Assessment			
Shortness of Breath	Better	Worse	Unchanged
Fatigue	Better	Worse	Unchanged
Dyspnea	Better	Worse	Unchanged
Orthopnea	Better	Worse	Unchanged
Pedal Edema	Better	Worse	Unchanged
Cough	Better	Worse	Unchanged
Sputum Production	Better	Worse	Unchanged

Vitals						
Current Blood Pressure			Goal Blood Pressure			
Time	BP	Pulse	RR	SpO2	BG	Temp
Abdominal Girth			Pitting Edema Scale			

12-Lead ECG Summary

Lung Sounds			
Rigth		Left	

Lab Results or ISTAT							
NA:		K:		CL:		HCO:	
BUN:		Cret:		Glucose:		WBC:	
Hgb:		Hct:		PLT:		Lactate:	

Referrals

Patient Concerns

Patient agrees to enroll in the Community Paramedic Program	Yes	No
Patient Signature:	Length of Enrollment	

Chesterfield Fire & EMS

Community Paramedic:

Home Risk Assessment Checklist

Resident Name:		DOB:		Date	

Outside of house

1. Sidewalk / pathway to house is level and free from any hazards	1. Yes ☐	No ☐	N/A ☐
2. Driveway is free from debris / snow / ice.	2. Yes ☐	No ☐	N/A ☐
3. Outside stairs are stable and have sturdy handrails.	3. Yes ☐	No ☐	N/A ☐
4. Porch lights are working and provide adequate lighting.	4. Yes ☐	No ☐	N/A ☐

Living Room

1. Furniture is of adequate height and offers arm rest that assist in getting up and down.	1. Yes ☐	No ☐	N/A ☐
2. Floor is free from any clutter that would create a tripping hazard	2. Yes ☐	No ☐	N/A ☐
3. All cords are properly secured in a manner that does not cause tripping hazards.	3. Yes ☐	No ☐	N/A ☐
4. All rugs are secured to the floor with double sided tape.	4. Yes ☐	No ☐	N/A ☐
5. Lighting is adequate to light the room.	5. Yes ☐	No ☐	N/A ☐
6. All lighting has an easily accessible on/off switch.	6. Yes ☐	No ☐	N/A ☐
7. Phone is readily accessible near favorite seating area.	7. Yes ☐	No ☐	N/A ☐
8. Emergency numbers are printed near all phones in the house.	8. Yes ☐	No ☐	N/A ☐

Kitchen

1. Items used most often are within easy reach on low shelves.	1. Yes ☐	No ☐	N/A ☐
2. Step stool is present, is sturdy and has handrails.	2. Yes ☐	No ☐	N/A ☐
3. Floor mats are non-slip tread and secured to the floor.	3. Yes ☐	No ☐	N/A ☐
4. Oven controls are within easy reach.	4. Yes ☐	No ☐	N/A ☐
5. Kitchen lighting is adequate and easy to reach switches.	5. Yes ☐	No ☐	N/A ☐
6. ABC fire extinguisher is located in kitchen at egress point.	6. Yes ☐	No ☐	N/A ☐
7. Not cooking with loose clothing and using pot holders	7. Yes ☐	No ☐	N/A ☐

Stairs

1. Carpet / wood are properly secured.	1. Yes ☐	No ☐	N/A ☐
2. Handrails are present and sturdy.	2. Yes ☐	No ☐	N/A ☐
3. Stairs are free from clutter.	3. Yes ☐	No ☐	N/A ☐
4. Stairway is adequately lit.	4. Yes ☐	No ☐	N/A ☐

Bathroom

1. Tub and shower have a non-slip surface.	1. Yes ☐	No ☐	N/A ☐
2. Tub / shower have a grab bar for stability.	2. Yes ☐	No ☐	N/A ☐
3. Toilet has a raised seat.	3. Yes ☐	No ☐	N/A ☐
4. Grab bar is attached near toilet for assistance.	4. Yes ☐	No ☐	N/A ☐
5. Pathway from the bedroom the bathroom is free from clutter and well lit for ease of movement in the middle of the night.	5. Yes ☐	No ☐	N/A ☐

Bedroom

1. Floor is free from clutter.	1. Yes ☐	No ☐	N/A ☐
2. Light is near bed and easy to turn on.	2. Yes ☐	No ☐	N/A ☐
3. Phone is next to bed and within easy reach.	3. Yes ☐	No ☐	N/A ☐
4. Flashlight is near bed in case of emergency.	4. Yes ☐	No ☐	N/A ☐

General

1. Smoke alarm in all areas of the house (each floor) and	1. Yes ☐	No ☐	N/A ☐
2. CO detectors on each floor of the house and tested.	2. Yes ☐	No ☐	N/A ☐
3. Flashlights are handy throughout the house.	3. Yes ☐	No ☐	N/A ☐
4. Resident has all medical information readily available and in an Area emergency providers will easily find.	4. Yes ☐	No ☐	N/A ☐
5. All heaters are 3 feet away from any type of flammable material.	5. Yes ☐	No ☐	N/A ☐

Overall Tips

1. Homeowner has good non-skid shoes to move around the house.	1. Yes ☐	No ☐	N/A ☐
2. Assisted walking devises are readily accessible and in good condition.	2. Yes ☐	No ☐	N/A ☐
3. There is a phone near the floor for ease of reach in case of fall.	3. Yes ☐	No ☐	N/A ☐
4. All 02 tubing is less than 50ft. and is not a tripping hazard.	4. Yes ☐	No ☐	N/A ☐
5. Resident has had an annual hearing and vision check by a physician.	5. Yes ☐	No ☐	N/A ☐
6. Resident has the proper hearing and visual aids prescribed and are in good working condition.	6. Yes ☐	No ☐	N/A ☐
7. All medications are properly stored and labeled to avoid confusion on dosage, time to take, and avoidance of missed doses.	7. Yes ☐	No ☐	N/A ☐

For all selections marked NO the following recommendations are noted below:

After evaluation I recommend the resident be considered for the following referrals:

Signature of resident:

Signature of Community Paramedic:

Resources

- FREE
- Health South Rehabilitation
- Home Care Agencies
- Hospice
- Building Inspectors Office
- Social Services
- Mental Health
- ALF's and SNF's
- Senior Advocate
- PCP's
- Police
- Animal Control
- YMCA
- Meals on Wheels
- Senior Connections
- CVS
- Hospitals

- **Sheltering Arms Rehabilitation**
- **Life long Learning Institute**
- **Moving Companies**
- **Endocrinologist**
- **LogistiCare**
- **Home Alert Pendants**
- **Virginia QIO**

Questions

Attachment H

DUO-Dote Notification

U.S. Food and Drug Administration
Protecting and Promoting *Your* Health

FDA alerts health care providers and emergency responders of expiration date extensions of certain auto-injectors manufactured by Meridian Medical Technologies

[03/27/2015] FDA is alerting health care professionals and emergency responders of updated dates through which DuoDote auto-injectors, manufactured by Meridian Medical Technologies, may be used beyond the manufacturer's labeled expiration date. To help ensure patient safety, these products should have been — and should continue to be — stored as labeled.

This posting updates FDA's **May 13, 2014 alert (/Drugs/DrugSafety/ucm376367.htm)**, which notified health care professionals and emergency responders of a two-year extension of the labeled expiration dates of certain lots of DuoDote auto-injectors. The table below is an updated list of DuoDote auto-injector lots and new use dates. This new list, which replaces previously posted lists, includes each of the lots listed in FDA's **May 13, 2014 posting (/Drugs/DrugSafety/ucm376367.htm)**, **March 28, 2014 posting (/Drugs/DrugSafety/ucm376367.htm#march2014)**, **December 24, 2013 posting (/Drugs/DrugSafety/ucm376367.htm#december2013)**, and **September 5, 2013 memorandum (/downloads/Drugs/DrugSafety/UCM376385.pdf)**, as well as 10 new lots.

FDA is not requiring or recommending that the identified lots in the following table be relabeled with their new use dates. However, if replacement DuoDote product becomes available during the extension period, then it is expected that the DuoDote lots in this updated table will be replaced and properly disposed of as soon as possible.

Please contact Brad Leissa at **brad.leissa@fda.hhs.gov (mailto:brad.leissa@fda.hhs.gov)** or Brooke Courtney at **brooke.courtney@fda.hhs.gov (mailto:brooke.courtney@fda.hhs.gov)** with questions regarding this table.

DuoDote auto-injector lots eligible for use beyond the manufacturer's labeled expiration date (updated March 27, 2015).

Lot Number	Manufacturer's Original Expiry Date	New Use Date
8AE795	October 31, 2012	October 31, 2015
9AE306	January 31, 2013	January 31, 2016
9AE307	March 31, 2013	March 31, 2016
9AE356	March 31, 2013	March 31, 2016
9AE545	March 31, 2013	March 31, 2016
9AE548	May 31, 2013	May 31, 2016
9AE636	May 31, 2013	May 31, 2016
9AE645	June 30, 2013	June 30, 2016
9AE835	September 30, 2013	September 30, 2016
0AE158	December 31, 2013	December 31, 2016
0AE159	December 31, 2013	December 31, 2016
0AE287	February 28, 2014	February 28, 2017
0AE458	April 30, 2014	April 30, 2017
0AE500	May 31, 2014	May 31, 2017
0AE501	May 31, 2014	May 31, 2017
0AE792	September 30, 2014	September 30, 2017
1AE200	December 31, 2014	December 31, 2017
1AE201	February 28, 2015	February 28, 2018
1AE406	April 30, 2015	April 30, 2018
1AE502	March 30, 2015	March 30, 2018
1AE515	May 31, 2015	May 31, 2018
1AE516	June 30, 2015	June 30, 2018

1AE701	August 31, 2015	August 31, 2018
1AE702	September 30, 2015	September 30, 2018
1AE703	September 30, 2015	September 30, 2018
2AE752	October 31, 2016	October 31, 2019

[10/24/2014] FDA is alerting health care professionals and emergency responders that specific lots of AtroPen (atropine), CANA (diazepam), morphine sulfate, and pralidoxime chloride auto-injectors manufactured by Meridian Medical Technologies can be used for up to one additional year beyond the manufacturer's labeled expiration date.

This notice is in follow up to FDA's November 22, 2013, statement, and will help mitigate potential shortages of these medically necessary drugs.

To help assure patient safety, products should have been − and should continue to be − stored under the manufacturer's labeled storage conditions.

The list of lots of these four products that can be used for up to an additional year beyond the manufacturer's labeled expiration date can be found in FDA's **October 2, 2014, memorandum (/downloads/Drugs/DrugSafety/UCM420224.pdf)**.

Please contact Brad Leissa at **brad.leissa@fda.hhs.gov (mailto:brad.leissa@fda.hhs.gov)** or Brooke Courtney at **brooke.courtney@fda.hhs.gov (mailto:brooke.courtney@fda.hhs.gov)** with questions.

FDA further extends expiration dates of DuoDote auto-injector lots manufactured by Meridian Medical Technologies

[05/13/2014] FDA is alerting health care professionals and emergency responders that two more lots (8AE795 and 9AE306) of DuoDote auto-injectors, manufactured by Meridian Medical Technologies, can be used for up to two years beyond the manufacturer's labeled expiration date. To help ensure patient safety, these products should have been — and should continue to be — stored under their labeled storage conditions.

This updates FDA's **March 28, 2014 alert**, which notified health care professionals and emergency responders of a two-year extension of the labeled expiration date of certain lots of DuoDote auto-injectors. The table below is an updated list of DuoDote auto-injector lots and new use dates. This

new list includes each of the lots listed in FDA's **March 28, 2014, posting (/Drugs/DrugSafety/ucm376367.htm#march2014)** and **December 24, 2013, posting (/Drugs/DrugSafety/ucm376367.htm#december2013)**, and **September 5, 2013, memorandum (/downloads/Drugs/DrugSafety/UCM376385.pdf)**; and also includes the two new lots.

DuoDote auto-injector lots eligible for use up to two years beyond the manufacturer's labeled expiration date (updated May 13, 2014).

Lot Number	Manufacturer's Original Expiry Date	New Use Date (up to 2 years beyond manufacturer's original expiry date)
8AE795	October 31, 2012	October 31, 2014
9AE306	January 31, 2013	January 31, 2015
9AE307	March 31, 2013	March 31, 2015
9AE356	March 31, 2013	March 31, 2015
9AE545	March 31, 2013	March 31, 2015
9AE548	May 31, 2013	May 31, 2015
9AE636	May 31, 2013	May 31, 2015
9AE645	June 30, 2013	June 30, 2015
9AE835	September 30, 2013	September 30, 2015
0AE158	December 31, 2013	December 31, 2015
0AE159	December 31, 2013	December 31, 2015
0AE287	February 28, 2014	February 28, 2016
0AE458	April 30, 2014	April 30, 2016
0AE500	May 31, 2014	May 31, 2016
0AE501	May 31, 2014	May 31, 2016
0AE792	September 30, 2014	September 30, 2016

If replacement DuoDote product becomes available during the two-year extension period, then it is expected that the DuoDote lots in this updated table will be replaced and properly disposed of as soon as possible.

FDA is not requiring or recommending that the identified lots be relabeled with the new use date. Please contact Brad Leissa at **brad.leissa@fda.hhs.gov (mailto:brad.leissa@fda.hhs.gov)** or Brooke Courtney at **brooke.courtney@fda.hhs.gov (mailto:brooke.courtney@fda.hhs.gov)** with questions regarding this table.

[03/28/2014] FDA is alerting health care professionals and emergency responders that certain lots of DuoDote auto-injectors, manufactured by Meridian Medical Technologies, can be used for up to two years beyond the manufacturer's labeled expiration date. To help ensure patient safety, these products should have been — and should continue to be — stored under their labeled storage conditions.

This updates FDA's **December 2013 alert (http://www.fda.gov/Drugs/DrugSafety/ucm376367.htm#december2013)**, which notified health care professionals and emergency responders of a one-year extension of the labeled expiration date of certain lots of DuoDote auto-injectors. The table below is an updated list of DuoDote auto-injector lots and new use dates. This new list includes each of the lots listed in FDA's **September 5, 2013, DuoDote memorandum (http://www.fda.gov/downloads/Drugs/DrugSafety/UCM376385.pdf)**[1] and **December 24, 2013, posting (http://www.fda.gov/Drugs/DrugSafety/ucm376367.htm)**[2], and also includes one new lot, 0AE792.

DuoDote auto-injector lots eligible for use up to two years beyond the manufacturer's labeled expiration date (updated March 28, 2014).

Lot Number	Manufacturer's Original Expiry Date	New Use Date (up to 2 years beyond manufacturer's original expiry date)
9AE307	March 31, 2013	March 31, 2015
9AE356	March 31, 2013	March 31, 2015
9AE545	March 31, 2013	March 31, 2015
9AE548	May 31, 2013	May 31, 2015
9AE636	May 31, 2013	May 31, 2015
9AE645	June 30, 2013	June 30, 2015
9AE835	September 30, 2013	September 30, 2015

0AE158	December 31, 2013	December 31, 2015
0AE159	December 31, 2013	December 31, 2015
0AE287	February 28, 2014	February 28, 2016
0AE458	April 30, 2014	April 30, 2016
0AE500	May 31, 2014	May 31, 2016
0AE501	May 31, 2014	May 31, 2016
0AE792	September 30, 2014	September 30, 2016

If replacement DuoDote product becomes available during the two-year extension period, then it is expected that the DuoDote lots in this updated table will be replaced and properly disposed of as soon as possible.
FDA is not requiring or recommending that the identified lots be relabeled with the new use date. Please contact Brad Leissa at **brad.leissa@fda.hhs.gov (mailto:brad.leissa@fda.hhs.gov)** or Brooke Courtney at **brooke.courtney@fda.hhs.gov (mailto:brooke.courtney@fda.hhs.gov)** with questions regarding this table.

[12/24/2013] FDA is now alerting health care providers and emergency responders of more lots of DuoDote auto-injectors, manufactured by Meridian Medical Technologies, a Pfizer, Inc., company, that can be used for up to an additional year past the manufacturer's labeled expiration date. To help assure patient safety, products should have been stored under labeled storage conditions.

In follow up to the **November 22, 2013, FDA drug safety statement (/Drugs/DrugSafety/ucm376367.htm)**, the following table is a cumulative list of DuoDote lots listed in FDA's **September 5, 2013, memorandum (/downloads/Drugs/DrugSafety/UCM376385.pdf)** and additional lots identified by FDA in December 2013 to further address stakeholder needs.

For questions related to this table, please contact Brad Leissa at **brad.leissa@fda.hhs.gov (mailto:brad.leissa@fda.hhs.gov)** or Brooke Courtney at **brooke.courtney@fda.hhs.gov (mailto:brooke.courtney@fda.hhs.gov)**.

DuoDote auto-injector lots eligible for use up to one year beyond the manufacturer's labeled expiration date (updated December 24, 2013)

	Manufacturer's Original Expiry Date	New Use Date (up to 1 year beyond manufacturer's original expiry date)
9AE307	March 31, 2013	March 31, 2014
9AE356	March 31, 2013	March 31, 2014
9AE545	March 31, 2013	March 31, 2014
9AE548	May 31, 2013	May 31, 2014
9AE636	May 31, 2013	May 31, 2014
9AE645	June 30, 2013	June 30, 2014
9AE835	September 30, 2013	September 30, 2014
0AE158	December 31, 2013	December 31, 2014
0AE159	December 31, 2013	December 31, 2014
0AE287	February 28, 2014	February 28, 2015
0AE458	April 30, 2014	April 30, 2015
0AE500	May 31, 2014	May 31, 2015
0AE501	May 31, 2014	May 31, 2015

FDA alerts health care providers and emergency responders of a potential extension of expiration dates for certain auto-injectors manufactured by Meridian Medical Technologies

[11/22/2013] The U.S. Food and Drug Administration is aware of a disruption in supply to health care providers and emergency response personnel of Atropen (atropine), DuoDote (atropine/pralidoxime chloride), morphine sulfate, pralidoxime chloride, and diazepam auto-injectors manufactured by Meridian Medical Technologies, a Pfizer Inc. company. FDA and Meridian are working together to resolve the disruption as quickly as possible, but it is unclear how long this disruption may persist.

As communicated on **September 5, 2013 (PDF - 39KB) (/downloads/Drugs/DrugSafety/UCM376385.pdf)**, FDA concluded that it was scientifically supported that certain lots of DuoDote can be used for an additional year beyond the manufacturer's original labeled expiration date. FDA is continuing to assess whether these

identified lots of DuoDote can receive further expiration date extensions if needed, and whether additional lots of DuoDote that were not listed in FDA's September 5, 2013, memo can have their expiration date extended.

FDA is currently reviewing data for the potential use of Atropen (atropine), DuoDote (atropine/pralidoxime chloride), morphine sulfate, pralidoxime chloride, and diazepam auto-injectors beyond their labeled expiration dates in order to mitigate any potential shortages of these medically necessary drugs. Products nearing or beyond their labeled expiration dates **should be retained** until further guidance is provided by FDA.

What health care providers and emergency response personnel should know:

- Health care providers and emergency response personnel who have any of the auto-injectors manufactured by Meridian identified above that are nearing or beyond the labeled expiration date should retain the products until FDA is able to provide additional information regarding the continued use of these products.
- Due to medical necessity and potential drug shortages, FDA is reviewing data for the potential use of these products beyond their labeled expiration dates.
- FDA will provide additional information about use of these products beyond the labeled expiration date in the coming weeks. Until FDA provides additional information, these expired auto-injectors may be used for patient care under emergency situations when no other product is available.
- Health care providers and emergency response personnel should maintain and monitor these products under the storage conditions described in the product labeling information.
- FDA continues to work with Meridian to resolve manufacturing issues.
- It is unclear at this time when Meridian will have additional inventory of these auto-injectors available.

If health care providers and emergency response personnel have additional questions about these auto-injectors, please contact Meridian's customer service office at 1-866-478-6277.

FDA asks health care providers and consumers to report any adverse events that are associated with the use of any of these products to either Pfizer Safety (1-800-438-1985) or to the **FDA's MedWatch Adverse Event Reporting (http://www.fda.gov/medwatch)** program by:

- completing and submitting the report online at **www.fda.gov/medwatch/report.htm (http://www.fda.gov/medwatch/report.htm)**; or

- downloading and completing the **form ()**, then submitting it via fax at 1-800-FDA-0178.

More in Drug Safety and Availability (/Drugs/DrugSafety/default.htm)

Counterfeit Drugs (/Drugs/DrugSafety/ucm169812.htm)

Drug Alerts and Statements (/Drugs/DrugSafety/ucm215175.htm)

Medication Guides (/Drugs/DrugSafety/ucm085729.htm)

Drug Safety Communications (/Drugs/DrugSafety/ucm199082.htm)

Drug Shortages (/Drugs/DrugSafety/DrugShortages/default.htm)

Postmarket Drug Safety Information for Patients and Providers (/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/default.htm)

Information by Drug Class (/Drugs/DrugSafety/InformationbyDrugClass/default.htm)

Medication Errors (/Drugs/DrugSafety/MedicationErrors/default.htm)

Drug Safety Podcasts (/Drugs/DrugSafety/DrugSafetyPodcasts/default.htm)

Safe Use Initiative (/Drugs/DrugSafety/SafeUseInitiative/default.htm)

Drug Recalls (/Drugs/DrugSafety/DrugRecalls/default.htm)

Drug Supply Chain Integrity (/Drugs/DrugSafety/DrugIntegrityandSupplyChainSecurity/default.htm)

Attachment I

Continuing Education Hours Proposal - TCC

Virginia Department of Health
Office of Emergency Medical Services
Technician Continuing Education

25-MAR-2015 EMST06D

Name: Ima E Emtee
1001 Technology Park Dr
Glen Allen, VA 23059

Certification Number : B201500001
Level : EMT
Expiration : 30-MAR-2020

Level: B EMERGENCY MEDICAL TECHNICIAN 40.0 Hours Required

Topic	Description	Required Hours	Hours Taken	Class Date
NCCR:	REQUIRED			
AIRWAY, RESPIRATION AND VENTILATION				
Area: 11	VENTILATION	3.0	_____ 0.0	
Area: 12	OXYGENATION	1.0	_____ 0.0	
CARDIOVASCULAR				
Area: 13	POST-RESUSCITATION CARE	0.5	_____ 0.0	
Area: 14	VENTRICULAR ASSIST DEVICES (VADs)	0.5	_____ 0.0	
Area: 15	STROKE	1.0	_____ 0.0	
Area: 16	PEDIATRIC CARDIAC ARREST (Lecture)	1.0	_____ 0.0	
Area: 17	PEDIATRIC CARDIAC ARREST (Skills)	1.0	_____ 0.0	
Area: 18	CHEST PAIN FROM CARDIOVASCULAR DISEASE	1.0	_____ 0.0	
Area: 19	CARDIAC RATE DISTURBANCE (Ped)	1.0	_____ 0.0	
TRAUMA				
Area: 20	CENTRAL NERVOUS SYSTEM (CNS) INJURY	0.5	_____ 0.0	
Area: 21	TOURNIQUETS	0.5	_____ 0.0	

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Virginia Department of Health
25-MAR-2015 Office of Emergency Medical Services EMST06D
Technician Continuing Education

Name: Ima E Emtee
1001 Technology Park Dr
Glen Allen, VA 23059

Certification Number : B201500001
Level : EMT
Expiration : 30-MAR-2020

Level: B EMERGENCY MEDICAL TECHNICIAN 40.0 Hours Required

Topic	Description	Required Hours	Hours Taken	Class Date
NCCR:	REQUIRED			
TRAUMA (con't)				
Area: 22	FIELD TRIAGE	1.0	_____ 0.0	
MEDICAL				
Area: 23	SPECIAL HEALTHCARE NEEDS	1.0	_____ 0.0	
Area: 24	OB EMERGENCIES	1.0	_____ 0.0	
Area: 25	COMMUNICABLE DISEASES	0.5	_____ 0.0	
Area: 26	PSYCHIATRIC & TOXICOLOGY EMERGENCIES	1.5	_____ 0.0	
Area: 27	ENDOCRINE	1.0	_____ 0.0	
Area: 28	IMMUNOLOGIC DISEASES	1.0	_____ 0.0	
OPERATIONS				
Area: 29	AT-RISK POPULATIONS	0.5	_____ 0.0	
Area: 30	PEDIATRIC TRANSPORT	0.5	_____ 0.0	
Area: 31	AFFECTIVE CHARACTERISTICS	0.5	_____ 0.0	
Area: 32	ROLE OF RESEARCH	0.5	_____ 0.0	
NCCR	**REQUIRED**		**0.0**	Hours taken

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0.0 Hours Applied

Virginia Department of Health
Office of Emergency Medical Services
Technician Continuing Education

25-MAR-2015 EMST06D

Name: Ima E Emtee
1001 Technology Park Dr
Glen Allen, VA 23059

Certification Number : B201500001
Level : EMT
Expiration : 30-MAR-2020

Level: B EMERGENCY MEDICAL TECHNICIAN 40.0 Hours Required

Topic	Description	Required Hours	Hours Taken	Class Date
LCCR + ICCR:	APPROVED			
LCCR + ICCR	**APPROVED**		**0.0**	Hours taken
			0.0	**Hours Applied**

APPLIED HOURS: 0.0
Recertification Hours 40.0

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Virginia ALS Continuing Education Requirements – All Levels

Virginia Office of EMS
Division of Educational Development
1041 Technology Park Drive
Glen Allen, VA 23059

804-888-9120

AREA #	DIVISION HOURS PER CERTIFICATION LEVEL					NCCR Section 1A—Mandatory Core Content
	E		I		C	**Airway, Respiration, Ventilation**
40	2		2		3	Artificial Ventilation
41	1		1		0	Capnography
42	1		0		0	Advanced Airway Management in the Perfusing Patient
						Cardiovascular
43	2		2		0.5	Post-Resuscitation Care
44	0.5		0.5		0	Ventricular Assist Devices (VADs)
45	1.5		1.5		1	Stroke
46	2		2		0.5	Cardiac Arrest
47	0.5		0.5		0	Congestive Heart Failure
48	2.5		2.5		2	Pediatric Cardiac Arrest
49	1		1		0	Acute Coronary Syndrome
50	0		0		1	Chest Pain from Cardiovascular Disease
51	0		0		1	Cardiac Rate Disturbance
						Trauma
52	2		1		0.5	Central Nervous System (CNS) Injury
53	0.5		0.5		0.5	Tourniquets
54	1		1		1	Field Triage
55	0.5		0.5		0	Fluid Resuscitation
						Medical
56	2		2		0.5	Special Healthcare Needs
57	1		1		1	OB Emergencies
58	1		1		1	Communicable Diseases
59	1		1		0	Medication Delivery
60	1		1		0	Pain Management
61	1		1		0.5	Psychiatric Emergencies
62	0		0		1	Toxicological Emergencies
63	0		0		1	Endocrine
64	0		0		1	Immunological Diseases
						Operations
65	1		1		1	At-Risk Populations
66	0.5		0.5		0.5	Pediatric Transport
67	0.5		0.5		0.5	Culture of Safety
68	1		1		1	Affective Characteristics
69	1		1		0	Crew Resource Management
70	1		1		1	Role of Research
	30		***28***		***20 +5***	**MANDATORY CORE CONTENT TOTAL**

	30		**28**		**20**	**NCCR HOURS REQUIRED PER LEVEL**
					5	**Additional NCCR hours from Paramedic List**
	30		**27**		**25**	**LCCR + ICCR Hours**
	60		**55**		**50**	**TOTAL HOURS REQUIRED PER LEVEL**

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Attachment J

National Registry Statistics

BLS NR Statistics (EMR/EMT)
As of 04/07/2015

State Statistics:	**(Over 18)**	**(Under 18)**
Results sent to National Registry:	7,433	714
Successful within 3 attempts:	4,831/6,510 = 74%	349/569 = 61%
No test attempt to date:	923 = 12%	159 = 22%

Those who tested:

	Attempted	Passed	%	Failed	%
	>18/<18	**>18/<18**	**>18/<18**	**>18/<18**	**>18/<18**
First	6,510/555	4,197/313	65%/44%	2,313/555	35%/56%
Second	1,261/121	521/49	41%/40%	740/72	40%/60%
Third	337/24	113/9	34%/38%	224/15	66%/62%
Fourth	70/5	31/1	44%/20%	39/4	56%/80%
Fifth	18/1	9/0	50%/0%	9/1	50%/100%
Sixth	3/0	1/0	33%/--	2/0	67%/--

Over 18 Break down by Year

	4/1/14-4/7/15	**4/1/13-3/31/14**	**7/1/12-3/31/13**
Results sent to National Registry:	3,029	2,873	1,531
Successful within 3 attempts:	1,870/2,534 – 74%	1,896/2,570 – 74%	1,065/1,406 = 76%
No test attempt to date:	495 = 16%	303 = 12%	125 = 8%
Those who tested:	Current	>1 year	> 2 years

	Attempted	Passed	%	Failed	%
	C/>1/>2	**C/>1/>2**	**C/>1/>2**	**C/>1/>2**	**C/>1/>2**
First	2,534/2,570/1,406	1,678/1,610/909	66%/63%/65%	856/960/497	34%/37%/35%
Second	396/566/299	167/228/126	42%/40%/42%	229/338/173	58%/60%/58%
Third	71/169/97	25/58/30	35%/34%/31%	46/111/67	65%/66%/69%
Fourth	6/37/27	1/19/11	17%/51%/41%	5/18/16	83%/49%/59%
Fifth	1/10/7	0/5/4	0%/50%/57%	1/5/3	0%/50%/43%
Sixth	--/3/--	--/1/--	--/33%/--	--2/--	--/67%/--

Under 18 Break down by Year

	4/1/14-4/7/15	4/1/13-3/31/14	7/1/12-3/31/13
Results sent to National Registry:	353	281	80
Successful within 3 attempts:	145/258 = 56%	124/231 = 54%	31/80 = 39%
No test attempt to date:	95 = 26%	50 = 18%	14 = 18%
Those who tested:	Current	>1 year	> 2 years

	Attempted	Passed	%	Failed	%
	C/>1/>2	**C/>1/>2**	**C/>1/>2**	**C/>1/>2**	**C/>1/>2**
First	258/231/66	125/94/23	48%/41%/35%	258/231/66	52%/59%/65%
Second	41/60/20	17/26/6	41%/43%/30%	24/34/14	59%/57%/70%
Third	6/12/6	3/4/2	50%/33%/33%	3/8/4	50%/67%/67%
Fourth	2/2/1	0/1/0	0%/50%/0%	2/1/1	100%/50%/100%
Fifth	--/1/--	--/1/--	--/100%/--	--/0/--	--/0%/--
Sixth	--/--/--	--/--/--	--/--/--	--/--/--	--/--/--

The National statistics for this same period are as follows:

EMT

Report Date: 4/7/2015 1:54:58 PM
Report Type: State Report (VA)
Registration Level: EMT-Basic / EMT
Course Completion Date: 3rd Quarter 2012 to 2nd Quarter 2015
Training Program: All

View Legend | Printer-Friendly Version

Show All | Show Only Percentages | Show Only Numbers

The results of your report request are as follows:

Attempted The Exam	First Attempt Pass	Cumulative Pass Within 3 Attempts	Cumulative Pass Within 6 Attempts	Failed All 6 Attempts	Eligible For Retest	Did Not Complete Within 2 Years
6549	65% (4269 / 6549)	75% (4922 / 6549)	76% (4966 / 6549)	0% (3 / 6549)	18% (1197 / 6549)	6% (385 / 6549)

EMR

Report Date: 4/7/2015 4:04:52 PM
Report Type: State Report (VA)
Registration Level: First Responder / EMR
Course Completion Date: 3rd Quarter 2012 to 2nd Quarter 2015
Training Program: All

View Legend | Printer-Friendly Version

Show All | Show Only Percentages | Show Only Numbers

The results of your report request are as follows:

Attempted The Exam	First Attempt Pass	Cumulative Pass Within 3 Attempts	Cumulative Pass Within 6 Attempts	Failed All 6 Attempts	Eligible For Retest	Did Not Complete Within 2 Years
240	68% (164 / 240)	73% (176 / 240)	73% (176 / 240)	0% (0 / 240)	18% (44 / 240)	8% (20 / 240)

Attachment K

Accreditation Report

Accredited Training Site Directory

As of April 7, 2015

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Accredited Paramedic Training Programs in the Commonwealth

Site Name	Site Number	BLS Accredited	# of Alternate Sites	Accreditation Status	Expiration Date
American National University[1]	77512	Yes	--	National – Suspended	CoAEMSP
Central Virginia Community College	68006	Yes	--	National – Continuing	CoAEMSP
Rappahannock Community College	11903	Yes	--	CoAEMSP – LOR	
Historic Triangle EMS Institute	83009	No	1	CoAEMSP – Initial	CoAEMSP
J. Sargeant Reynolds Community College	08709	No	5	National – Continuing	CoAEMSP
Jefferson College of Health Sciences	77007	Yes	--	National – Continuing	CoAEMSP
Lord Fairfax Community College	06903	No	--	National – Initial	CoAEMSP
Loudoun County Fire & Rescue	10704	No	--	National – Continuing	CoAEMSP
Northern Virginia Community College	05906	No	1	National – Continuing	CoAEMSP
Patrick Henry Community College	08908	No	--	CoAEMSP – Initial	
Piedmont Virginia Community College	54006	Yes	--	National – Continuing	CoAEMSP
Prince William County Dept of Fire and Rescue	15312	Yes	--	CoAEMSP – LOR	
Germanna-Rappahannock EMS Council[2]	63007	No	--	Suspended LOR	
Southside Virginia Community College	18507	No	1	National – initial	CoAEMSP
Southwest Virginia Community College	11709	Yes	4	National – Continuing	CoAEMSP
Stafford County & Associates in Emergency Care	15319	No	1	National – Continuing	CoAEMSP
Tidewater Community College	81016	Yes	4	National – Continuing	CoAEMSP
VCU School of Medicine Paramedic Program	76011	Yes	5	National – Continuing	CoAEMSP

Programs accredited at the Paramedic level may also offer instruction at EMT- I, AEMT, EMT, and EMR, as well as teach continuing education and auxiliary courses.

- [1]American National University has suspended their CoAEMSP accreditation for a period of up to 2 years.
- [2]Germanna-Rappahannock EMS Council has suspended their Letter of Review.
- Prince William County has completed their first cohort class and are awaiting their initial accreditation site visit.
- Rappahannock Community College has obtained a LOR to allow them to conduct their first cohort class starting in fall of 2014.
- Central Shenandoah EMS Council is in the process of accreditation at the paramedic level in Virginia which is described on the OEMS web page at: http://www.vdh.virginia.gov/OEMS/Training/Paramedic.htm

Accredited Intermediate[1] Training Programs in the Commonwealth

Site Name	*Site Number*	*BLS Accredited*	*# of Alternate Sites*	*Accreditation Status*	*Expiration Date*
Central Shenandoah EMS Council	79001	Yes	2*	State – Full	May 31, 2016
Danville Area Training Center	69009	No	--	State – Full	July 31, 2019
Dabney S. Lancaster Community College	00502	No	--	State – Full	July 31, 2017
Hampton Fire & EMS	83002	Yes	--	State – Full	February 28, 2017
James City County Fire Rescue	83002	No	--	State – Full	February 28, 2019
John Tyler Community College	04115	No	--	State – Full	April 30, 2017
Nicholas Klimenko and Associates	83008	Yes	2	State – Full	July 31, 2016
Norfolk Fire Department	71008	No	--	State – Full	July 31, 2016
Rappahannock Community College	11903	Yes	3	State – Full	July 31, 2016
Roanoke Regional Fire-EMS Training Center	77505	No	--	State – Full	July 31, 2015
Southwest Virginia EMS Council		No	--	State – Conditional	December 31, 2015
UVA Prehospital Program	54008	No	--	State – Full	July 31, 2019
WVEMS – New River Valley Training Center	75004	No	--	State – Full	June 30, 2017

Programs accredited at the Intermediate level may also offer instruction at AEMT, EMT, and EMR, as well as teach continuing education and auxiliary courses.

- Paul D Camp Community College site visit has been conducted and final report will be submitted in the next couple of weeks.
- Henrico Fire-School of EMS initial self-study has been received and is being reviewed by the office. A site team will be assigned in the next month.
- Roanoke Regional Fire-EMS Training Center's re-accreditation visit will take place in late May/early June.
- *Central Shenandoah EMS Council is now accredited at the BLS level and two alternate sites were approved to offer BLS education only.

Accredited AEMT Training Programs in the Commonwealth

Site Name	*Site Number*	*# of Alternate Sites*	*Accreditation Status*	*Expiration Date*

- Frederick County Fire/EMS site visit has been conducted and the final report is being completed.

Accredited EMT Training Programs in the Commonwealth

Site Name	*Site Number*	*# of Alternate Sites*	*Accreditation Status*	*Expiration Date*
Navy Region Mid-Atlantic Fire EMS		--	State – Full	July 31, 2018
City of Virginia Beach Fire and EMS		--	State – Full	July 31, 2018

- Frederick County Fire/EMS site visit has been conducted and we are awaiting final report.
- Chesterfield Fire and EMS site visit has been conducted and we are awaiting final report.
- Harrisonburg Rescue Squad site visit has been scheduled for April 20, 2015.

Attachment L

EMSTF Report

Emergency Medical Services Training Funds Summary

As of April 6, 2015

EMS Training Funds Summary of Expenditures

Fiscal Year 2013	*Obligated $*	*Disbursed $*
19 Emergency Ops	$1,460.00	$755.00
40 BLS Initial Course Funding	$729,348.00	$358,521.61
43 BLS CE Course Funding	$125,160.00	$49,936.21
44 ALS CE Course Funding	$297,360.00	$78,575.00
45 BLS Auxiliary Program	$80,000.00	$18,280.00
46 ALS Auxiliary Program	$350,000.00	$161,005.00
49 ALS Initial Course Funding	$1,102,668.00	$591,256.40
Total	**$2,685,996.00**	**$1,258,329.22**

Fiscal Year 2014	*Obligated $*	*Disbursed $*
19 Emergency Ops	$1,120.00	$280.00
40 BLS Initial Course Funding	$780,912.00	$375,809.00
43 BLS CE Course Funding	$94,010.00	$37,100.00
44 ALS CE Course Funding	$224,950.00	$79,520.00
45 BLS Auxiliary Program	$130,000.00	$61,300.00
46 ALS Auxiliary Program	$304,000.00	$180,640.00
49 ALS Initial Course Funding	$1,188,504.00	$554,235.43
Total	**$2,723,496.00**	**$1,289,724.43**

Fiscal Year 2015	*Obligated $*	*Disbursed $*
19 Emergency Ops	$2,480.00	$540.00
40 BLS Initial Course Funding	$708,484.50	$257,513.81
43 BLS CE Course Funding	$56,780.00	$18,523.80
44 ALS CE Course Funding	$139,370.00	$41,623.75
45 BLS Auxiliary Program	$88,705.00	$7,280.00
46 ALS Auxiliary Program	$526,176.00	$77,040.00
49 ALS Initial Course Funding	$1,009,204.00	$351,486.24
Total	**$2,531,199.50**	**$754,007.60**

Attachment M

Scanner Update Notification

Division of Educational Development

Date: March 26th, 2015

Subject: Motorola CE Scanners REQUIRED Update

In the past weeks, the Office of Emergency Medical Services (OEMS) scanner recordation software has experienced significant problems with uploading data. It was discovered during this time period the scanners have compatibility issues with upgrades currently underway to the OEMS Portal system. As we move forward with upgrades to the OEMS Portal, the current operating systems for the handheld CE scanners will not be compatible with the OEMS Portal and will not be able to upload electronic CE files.

After significant technical review, there is an update available to ensure continued compatibility for the scanner operating system. This update will have to be installed by OEMS. To receive the software update, those in possession of Motorola handheld CE scanners have the following options for upgrade:

1. **In person at Instructor Updates.** Additional time will be scheduled in conjunction with Instructor Updates to allow for scanner upgrades. Due to the amount of time required for the upgrade process, anyone wanting their scanner upgraded during an Instructor Update will have to contact Adam Harrell prior to the update to schedule an appointment. The Instructor Update schedule can be found at: http://www.vdh.virginia.gov/OEMS/Training/EMS_InstructorSchedule.htm
2. **Mail the scanner to OEMS.** You will be responsible for the postage in sending the scanner to OEMS; and OEMS will mail the package back to you once upgraded (NOTE: OEMS will not be held responsible for any damages to your device incurred during transit. Should you want insurance coverage, YOU are responsible for making the appropriate arrangements for shipping and return.) Please only send the scanner, we do not need the charger or other accessories. When sending the package to OEMS, ensure you have placed some form of notification inside the package noting where OEMS should ship the scanner back to. At a minium, please include the following information:
   a. Contact Person's Name
   b. Contact Person's email
   c. Contact person's contact phone number
   d. Full address for returning the scanner

   Packages should be addressed to:

   Virginia Office of Emergency Medical Services
   Attn: Adam Harrell/Scanner Upgrade
   1041 Technology Park Drive
   Glen Allen, VA 23059

3. **In person delivery to OEMS.** You may deliver your scanner to OEMS anytime during normal business hours at the address above. Upgrade at the time of delivery is not guaranteed. Should you wish to have your scanner upgraded at the time of in-person delivery, please contact Adam Harrell at 804-888-9120 to schedule an appointment.

You must have this update applied to your scanner if you wish to continue using it for recording CE. If you do not receive this update your scanner will no longer be able to upload data after:

AUGUST 1, 2015

NOTE: This upgrade will wipe your systems memory. Prior to upgrading your device, it is your responsibility to ensure you have backed up any information on your device and/or uploaded any stored electronic CE files.

If you have any questions please contact Adam Harrell at adam.harrell@vdh.virginia.gov or 804-888-9120.