MEDICAL DIRECTION COMMITTEE
Marriott – Short Pump, 4240 Dominion Blvd, Glen Allen, VA 23060
January 5, 2017
10:30 AM

Members Present:	Members Absent:	Staff:	Others:
Asher Brand, M.D.	Forrest Calland, M.D.	Gary Brown	Chad Blosser
Charles Lane, M.D.	Cheryl Lawson, M.D.	Scott Winston	Ron Passmore
George Lindbeck, MD	Marilyn McLeod, M. D. - Chair	Michael Berg	Wayne Perry
Christopher Turnbull, M.D.	Stewart Martin, M.D.	Tim Perkins	John Dugan
Tania White, M.D.		Warren Short	John Morgan, M.D.
Scott Weir, M.D.		Greg Neiman	
Allen Yee, M.D.		Debbie Akers	
Chief Eddie Ferguson		Peter Brown	

Topic/Subject		Discussion	Recommendations, Action/Follow-up; Responsible Person
I. Welcome		The meeting was called to order by Dr. Yee at 10:42 a.m.	
II. Introductions		Introductions were made, Attendance as per sign-in roster	
III. Approval of Agenda			**Approved by consensus**
IV. Approval of Minutes		Approval of minutes from October 6, 2016	**Approved by consensus**
V. Drug Enforcement Administration (DEA) & Board of Pharmacy (BOP) Compliance Issues		Dr Lindbeck stated that HR4365 did not make it to vote. Uncertain why. No other report on any issues.	
VI. Old Business		None	
VII. New Business			
A	Asher Brand	RSI White Paper (Attachment A) Dr. Brand presented a revised RSI White Paper. Reviewed by committee. Item discussed. Any comments please email to Asher. Will revisit paper in April.	**Attachment: A**
B	Trauma Committee Report – Dr. Forrest Calland	No current report.	
C	TCC Report – Dr. Charles Lane (Given by Ron Passmore & Greg Neiman)	Ron Passmore reported I-99 stakeholder town hall meetings were announced to TCC. Dates are as follows: February 2nd at Glen Allen on Thursday evening during State EMS Advisory Board meetings, February 23rd in Virginia Beach on Thursday afternoon at the VFCA Conference, Friday, March 31st or Saturday, April 1st in Roanoke in conjunction with the VAVRS Spring BOG meeting. Future locations will be Wytheville,	

Topic/Subject		Discussion	Recommendations, Action/Follow-up; Responsible Person
		Harrisonburg, Northern Neck and Northern Virginia. Greg Neiman reported that the Training and Certification Committee will be forwarding the change in the process for gaining certification as an Education Coordinator that includes a mentorship component to the EMS Advisory Board as an Action Item for their February meeting.	
VIII. Research Requests		None	
IX. State OMD – George Lindbeck, MD			
A.	Trauma Prehospital Workgroup	Deferred to next meeting to allow Dr. McLeod to provide update.	
B	Scope of Practice	No current items for discussion	
C	OMD Workshops	Advised the committee that there has been a change in the manner the OMD workshops are organized. Dates for workshops are as follows: February 13th – Full day at the Homestead March 31 in NOVA (Fairfax area) 4/04 – REMS 4/12 – WVEMS/SWVEMS (Higher Education Center – Abingdon). Dates will be established later for Central Shenandoah and Lord Fairfax regions. Continuing Education will be offered through the VCU Graduate Medical Education rather than through ACEP. Mike Berg stated that if anyone wishes to attend, until a registration system is established to email him at Michael.Berg@vdh.virginia.gov.	
D	Carfentanil Concerns	Issue was raised in December concerning the impact to EMS providers of Cafentanil. Dr. Lindbeck emphasized the importance of EMS providers to utilize resources such toxicology specialist and Hazmat if concerned that a toxicological agent has been encountered.	
Office of EMS Reports			
Division of Educational Development Staff			
A	BLS Training Specialist – Greg Neiman (Given by Debbie Akers)	1. EC Institute a. Next Institute is January in James City County. Approximately 20 participants are scheduled to attend. 2. Updates a. The DED Division will stay on the road for 2017. i. Friday & Saturday Updates will held in James City County on 1/27 and 1/28 b. See the latest schedule on the OEMS Webpage: http://www.vdh.virginia.gov/OEMS/Training/EMS_InstructorSchedule.htm 3. No more EMT Instructors left in the system.	
B	ALS Training Specialist – Debbie Akers	1. National Registry Issues a. Effective January 1, 2017, the new Paramedic testing process was implemented. This will impact the testing of AEMT and I-99's as test sites for Paramedic candidates will no longer be hosting the AEMT & Intermediate candidates. Be aware that AEMT & I-99 candidates may have to travel to find these test sites. b. Effective January 1, 2017, the Psychomotor Authorization to Test letter (PATT) is required for all	

	Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
		ALS testing candidates and they must be on the roster a minimum of 14 days prior to the test date. Information concerning this was not announced until the first week of November and it was causing issues for programs who had already established the testing schedule. Virginia has now authorized Early Access Eligibility with National Registry. Program Director and Medical Director now have the autonomy to determine when a provider has gained competency to move forward with the psychomotor testing even if all other components of the program have not been completed. Early eligibility access tab has been added to all ALS Program Directors in Virginia. c. Released the 2016 NCCP requirements in October. Virginia implemented the 2012 requirements when CE changes were completed in July, 2016. Will be working with the OIM division and eventually providers will be completing CE based on their recertification dates. More information will be forthcoming. d. Criminal history policy was discussed at the November 2016 National Registry Board of Directors meeting. Changes will be implemented including the removal of any restrictions for misdemeanor charges not related to the elderly, infirm or children. Other changes being considered. e. National Registry will now allow all CE requirements for Virginia providers to be completed through Distributive Education. f. Recertification process has been simplified. Quick Guide available on OEMS website providing recertification application instructions. 2. NR Pass Rates '**Attachment B'** a. Report Distributed 3. Accreditation ' **Attachment C'** a. Report Distributed 4. EMSTF **'Attachment D'** a. Report distributed. i. Special initiative funding for first half of fiscal year 2017 has been awarded and distributed. Information contained in the EMSTF Report. ii. Funding for rest of fiscal year 2017 is still in development	**See Attachment 'B'** **See Attachment 'C'** **See Attachment 'D'**
C	Division of Educational Development Training Manager – Warren Short	1. EMS Symposium a. Format changed to 1 hour rather than 1.5 hours. Will still have Precon, etc. available for longer sessions. b. Sunday sessions will remain a 2 hour session c. Currently only 417 submissions. Need 800-900 classes to satisfy new class hours. d. Call for presentations scheduled to close on January 15, 2017. May have to extend. e. Encouraged by Dr. Yee and Warren to consider submission of proposals. 2. New Scanners a. New scanner program has been introduced. Has conducted multiple webinars and will be offering more. b. Requires new security agreement to be signed. 3. Instructor Pass Percentages	

	Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
		a. New 16th percentile numbers will be published by mid-January. 4. EM005 Position a. Advertisement has closed. Initial interviews will be for two state employees who have applied. 5. Customer Service Satisfaction Survey a. New survey implemented on January 1, 2017. Will be made available through multiple methods including the signature line of all OEMS staff.	
D	Certification Test Coordinator – Peter Brown	1. Will be looking at reviewing and discussion changes to BLS testing for the future.	
Other OEMS Staff			
E	Regulation and Compliance Manager – Michael Berg	1. Regulations a. NOIRA has been submitted to the Attorney General's Office. Received approval from AG to move forward which means can start the regulatory process. b. Changes to the regulations are not significant. There will be a couple of variations on the amount of equipment required for the ambulance. As an example the need for a stair chair on all ambulances due to the weight of the new stretchers. The communication section has been completely rewritten. There are a couple of changes in the Medical Direction section. There are placeholders in place for future requirements such as the mental health awareness training bill. 2. Subcommittee workgroup dealing with issue of first responders not making available to hospitals the initial documentation for EMS calls that are then transported through other means (i.e., Medivac, etc.). Critical documentation and information from initial first medical contact and treatment is being lost.	
Committee Lunch Break – 12:10 – 12:45			
F	Executive Director – Gary Brown	1. General Assembly a. Opens on the 13th of January b. OEMS has been made the lead on three (3) Bills c. Will begin sending out a weekly Legislative grid starting on Friday, January 13th through adjournment and pick up again during reconvene session d. If there are any bills that you anyone desires to see placed on the legislative grid not listed, please let Gary know. 2. Trauma Systems Oversite and Management Committee a. March 16th Board of Health Meeting b. EMS and Trauma will be the topic for the education presentation at the meeting c. Meeting will be held at the Perimeter Center off of Gaskins and Mayland Drive in Henrico 3. Virginia Supreme Court Ruling#1:24 a. Addresses the payment of fines, court costs and reimbursement b. States the Courts must offer deferred and installment payment plans, prior to suspension of driver's license 4. Next RSAF Grant Cycle a. New scoring criteria have been implemented for March, 2017 and future funding cycles. Scoring criteria will be added for the following and will become part of the score:	

Topic/Subject		Discussion	Recommendations, Action/Follow-up; Responsible Person
		i. Health Professional Shortage Areas ii. Incorporate scoring for medically underserved areas iii. Fiscal Stress Index	
G	Assistant Director – Scott Winston	1. General Assembly 2. 3 Bills we are lead on a. HB1480 Mental Health Awareness Training for Law Enforcement, Paid Firefighters and EMS. i. Would require Department of Behavioral Health and Developmental Services to develop mental health awareness program ii. Would be required to be completed every 2 years for all individuals affiliated with licensed EMS Agency b. HB1531 Directs VDH/OEMS to amend regulations to require written witnessed informed consent of the patient (or designee) on forms other that the state standardized form c. SB867 amends existing statute pertaining to liens against persons whose negligence caused injury i. If you can prove negligence that caused EMS response may assess a fine of up to $200 for the response ii. Change would allow a provider or agency to assess a lien on person or personal representative iii. Requested and supported by trial lawyers association in Virginia d. Other Bills i. Bill regarding the authority of a Fire Chief over unmanned drones at the scene of an emergency ii. Bill on EVOC will require members of Fire Departments or Fire Companies who operate emergency vehicles to have EVOC	
H	EMS Systems Planner – Tim Perkins	1. Designation of Regional EMS Councils a. At the last Board of Health meeting, the 11 Regional EMS Councils were re-designated as required by statute. 2. State EMS Plan was approved at the last EMS Advisory Board meeting. Will be presented to the Board of Health at their March meeting. 3. A workgroup has been established by the Medivac committee dealing with Drones. 4. Encouraged everyone to promote the Standards of Excellence for EMS agencies.	
PUBLIC COMMENT			
For The Good Of The Order			
Future Meeting Dates for 2017		April 6, 2017, July 6, 2017, October 5, 2017	
Adjournment		1: 27 pm	

Attachment A

White Paper - RSI

Preliminary Draft RSI White Paper

Medical Direction Committee, EMS Advisory Board

Background

Rapid sequence intubation (RSI) is a common medical intervention for the acutely ill or injured. Increasingly, RSI is employed in the pre-hospital setting by Emergency Medical Service (EMS) Providers in Virginia. Briefly, the procedure involved administering medication that paralyzes the patient's muscles, along with an anesthesia medication that reduces the patient's consciousness. There is inherent danger in the procedure in that it requires abolishing the patient's ability to breath on their own; thus, the EMS provider must rapidly secure the airway with a tube and provide positive pressure ventilation for the patient.

Scientific Supports

Little evidenced exists to support pre-hospital RSI. Only one randomized controlled study exists looking at patient outcome[1]. Several non-randomized studies demonstrate that EMS providers can perform endotracheal intuition (ETI), the most technically difficult component of the RSI procedure: Although, significant contradictions exists in the literature exist and tube placement does not necessarily mean that it is helpful to the patient.

The study by Bernard, et.al. warrants scrutiny[2]. They compared outcomes in patients randomized to RSI with those randomized to standard airway management. The design is strong and the study is reasonably powered with 310 patients enrolled. The primary endpoints was neurological outcome at 6 months. The results showed RSI was *not* associated with improved neurological outcomes as defined by the study endpoint (despite the article's title). There was no difference survival to discharge. However, in *post-hoc analysis,* looking only at subgroup of the study population, a statistically significant difference was noted in one of 6 subgroups: The least severely injured patients were more likely to have good neurologic outcome if RSI was performed by EMS personnel. Oddly, the same subgroup showed no difference when it was split into 2 age brackets. Unfortunately, this commonly cited article's title that is not supported by its own data. Two retrospective propensity-matched analysis of isolated TBI patients showed higher mortality (primary endpoint) among those undergoing prehospital RSI [3].

Conclusion: RSI is widely employed and is recommended by experts and consensus groups such as A*dvanced Trauma Life Support, et.al*. Advances such as video-laryngoscopy and new supra-glottic devices may provide increased safety and better outcomes. Wide acceptance of such devices occurred after the Barnard study leaving open the possibility that RSI might reduce mortality by employing these new techniques.

Hemodynamic Responses to RSI

Hypotension is common after RSI[4][5], hypotension is noted to markedly increase mortality among multiple-trauma who have a concurrent TBI.[6] Clinical parameters can predict post-RSI hypotension[7]. The cause of hypotension after RSI remains unclear. Traditionally, the choice of anesthetic agent was thought to be pivotal. An alternative explanation might be that right ventricular preload is reduced by positive-pressure-ventilation (PPV) causing hypotension in patients with marginal preload. The latter hypothesis is supported by the direct association between shock-index (SI) and subsequent hypotension[8]. And by the finding that isolated TBI patients have a low rate of hypotension (such patients can be assumed to have normal preload)[9]. Also, Etomidate and Ketamine, with their different mechanisms of action, are associated with the same rate of hypotension[10]. A fascinating study by Perkins, et.al., demonstrated near universal hypertensive response to RSI[11] after drug administration but *before* PPV. Following positive pressure ventilation there were significant rates of hypotension[12].

The idea that any anesthetic agent can cause hypotension, as it severs the last "*adrenergic thread*" keeping the patient alive is not addressed in the literature. Therefore, in light of the aforementioned studies, it seems more plausible that post-RSI hypotension is a response to positive pressure ventilation among pre-load dependent patients — not to the anesthetic.

Conclusion: With respect to pre-hospital RSI, it is clear that a sizable portion of patients receiving this intervention will suffer from, potentially disastrous, hypotension — even if the procedure itself is performed to perfection. Attention to identifying and pre-treating high risk patients, perhaps with blood products, will reduce this risk. It may also prove to be that not performing RSI may be a better choice for some patients.

Hypoxia

Placing an endotracheal intubation after RSI can be technically challenging. It is reasonable to think that an adequately trained paramedic can achieve success rates in roughly 90-95% range. These success rates do not reflect complication rates nor the number of attempts required to achieve success. A case series in Europe reported a 18.3% hypoxia rate[13]; this in the hand's of EMS physicians with Anesthesia or Emergency Medicine training. A Norwegian study demonstrated a 11% hypoxia rate for RSI patients treated by EMS physicians[14]. In Australia an 17% rate was reported[15]. Hypoxia is associated with increased mortality particularly in patients with TBI. It is also very likely to produce secondary damage in other clinical situations and hypoxia often precedes death during or shortly after RSI.

Conclusion: Hypoxia is usually a preventable complication. A recent emphasis on pre-oxygenation may attenuate the aforementioned complication rate[16]. It stands to reason that adequate and ongoing training will reduce complication rates; and perhaps, alter the clinical algorithm regarding the decision to perform RSI in the first place.

Paramedic Training and Experience

ETI is a rare event for the vast majority of paramedics. Wang, et.al., reviewed 1,544,791patient care reports to determine rates of actual intubations per provider per year. He found that 67% of respondents performed 1 or 2 intubations in a year; another 37% performed none. The median number of opportunities was 3 per year. Air Medical Personnel had significantly higher rates[17]. Wang's data could not determine the number of intubation attempts to achieve success. Failure to achieve a first-pass intubation may be harmful[18] and are almost certainly associated with increased rates of hypoxia.

Intubation experience on live humans is directly associated with successful ETI[19]. To the best of our knowledge no consensus documents exist regarding training and experience that a paramedic should have prior to performing RSI. However, the National Standard Paramedic Curriculum recommends that paramedic students perform at least ***five*** live ETI prior to completion of the course. Rigorous didactic training has been associated with increased success rates[20]It is increasingly difficult for EMS students to gain intubation experience in the traditional Operating Room setting throughout Virginia[21]. Paramedics are frequently released to practice with very few live human intubations. Manakin and simulation labs to some extent have filled the void; however, we are not aware studies comparing simulation training versus live intubations and subsequent clinical performance. Evaluation of learning curves suggest that 60 or more intubations are required before achieving reasonable success rates, see an online review article for a nice review of multiple studies[22]. Emergency Medicine residents perform 46-87 intubations prior to graduation[23].

Conclusion: Paramedics complete training with far fewer that the 60-70 intubations that are associated with acceptable in first-pass rates. Paramedics intubate infrequently in the prehospital setting. Based on training and experience it is unlikely that paramedics have adequate experience to achieve high rates of success. It is possible that increased access to hospital based intubation can increase the intubation experience that paramedics have. It is unclear if simulation training can provide equivalent success rates as experience on live humans.

Document Conclusion

RSI is an inherently dangerous medical intervention. RSI requires expertise in intubation. Ground based EMS providers have few opportunities for intubation, although this varies by regional demographics. Paramedic students graduate with far fewer intubations that are associated with competence based on studies of Emergency Medicine and Anesthesiology Residents. Complications rates are high, some are technical and some are due to the physiologic consequences of PPV. For paramedics performing RSI a rigors ongoing training program, including frequent live human experience, and recurrent intensive didactic training. A rigorous quality-assurance program should be in place if RSI is performed in an EMS system.

The Virginia EMS Advisory Board's Medical Direction Recommendations for agencies employing Rapid Sequence Intubation

- "x" number supervised live human intubations should be completed and documented prior to a Paramedic release to perform RSI.
- "x" number supervised live human intubations should be completed each year documented to maintain RSI privileges.
- A rigorous quality-assurance program directly involving the EMS Agency's Medical Director should be in place.
- EMS Medical Directors should carefully evaluate the literature surrounding RSI prior to developing an agency specific RSI protocol.

Annals of Surgery Volume 252, [1] Number 6, December 2010, page 959
[2] Annals of Surgery Volume 252, Number 6, December 2010, page 959
[3] Prehosp Disaster Med. 2014 Feb;29 (1):32-6.
[4] Scandinavian Journal of Trauma, Resuscitation and Emergency Medicine 2013, 21:58
[5] Journal of Critical Care (2012) 27, 417.e9–417.e13
[6] Annals of Emergency Medicine. 2017; 64: 62.
[7] American J of Emergency Medicine. Volume 26, page 845.
[8] Journal of Critical Care (2012) 27, 417.e9–417.e13
[9] J Trauma Acute Care Surg. 2013 Apr;74(4):1074-80.
[10] Lancet 2009; 374: 293–300
[11] Injury, Int. J. Care Injured 44 (2013) 618–623
[12] Personal communication with lead author.
[13] J Trauma. 2008;64:487– 492.
[14] American Journal of Emergency Medicine (2011) 29, 639–644
[15] Air Medical Journal 35:1
[16] Annals of Surgery Volume 252, Number 6, December 2010, page 959
[17] Critical Care Medicine: August 2005 - Volume 33 - page 1718-1721
[18] The Journal of Emergency Medicine, Vol. 25, No. 3, pp. 251–256, 2003
[19] The Journal of Emergency Medicine, Vol. 25, No. 3, pp. 251–256, 2003
[20] Walker M, Jensen JL, Leroux Y, et al. Emerg Med J (2012) - online article
[21] Virginia Medical Direction Committee Minutes ? date in 2016

[22] http://openairway.org/how-many-intubations-does-it-take-to-become-competent/

[23] Acad Emerg Med. 1999 Jul;6(7):728-35.

Attachment B

National Registry BLS Statistics

EMT Statistics
As of 01/03/2017

Virginia:

Report Date:	1/3/2017 2:04:14 PM
Report Type:	State Report (VA)
Registration Level:	EMT
Course Completion Date:	4th Quarter 2014 to 1st Quarter 2017
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
5469	67% (3674)	78% (4270)	78% (4285)	0% (6)	19% (1033)	3% (146)

National Registry Statistics:

Report Date:	1/3/2017 2:06:17 PM
Report Type:	National Report
Registration Level:	EMT
Course Completion Date:	4th Quarter 2014 to 1st Quarter 2017
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
152215	68% (102979)	79% (120367)	80% (121314)	0% (94)	17% (25797)	3% (5034)

Individual Instructor Statistics are available on the OEMS webpage at the following link: http://www.vdh.virginia.gov/OEMS/Training/TPAM/Forms/EMT%20Performance%20Measure.pdf

Attachment C

Accreditation Report

Accredited Training Site Directory

As of January 3, 2017

Virginia
OFFICE OF EMERGENCY MEDICAL SERVICES
Virginia Department of Health

This Page

Intentionally

Left Blank

Accredited Paramedic Training Programs in the Commonwealth

Site Name	*Site Number*	*BLS Accredited*	*# of Alternate Sites*	*Accreditation Status*	*Expiration Date*
Central Virginia Community College	68006	Yes	--	National – Continuing	CoAEMSP
ECPI University	70017	Yes	--	CoAEMSP - LOR	CoAEMSP
J. Sargeant Reynolds Community College	08709	No	3	National – Continuing	CoAEMSP
Jefferson College of Health Sciences	77007	Yes	---	National – Continuing	CoAEMSP
John Tyler Community College	04115	Yes	--	CoAEMSP - LOR	
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	CoAEMSP
Piedmont Virginia Community College	54006	Yes	--	National – Continuing	CoAEMSP
Prince William County Dept of Fire and Rescue	15312	Yes	--	CoAEMSP – Initial	CoAEMSP
Rappahannock Community College	11903	Yes	--	CoAEMSP – 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	Yes	1	National – Continuing	CoAEMSP
Tidewater Community College	81016	Yes	3	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.

- Rappahannock Community College had their site visit in November, 2017. Awaiting final decision by CAAHEP.
- ECPI University has received their Letter of Review to conduct their first cohort class.

.

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	4*	State – Full	May 31, 2017
Dabney S. Lancaster Community College	00502	No	--	State – Full	July 31, 2017
Danville Area Training Center	69009	No	--	State – Full	July 31, 2019
Hampton Fire & EMS	83002	Yes	--	State – Full	February 28, 2018
Henrico County Fire Training	08718	No	--	State – Full	August 31, 2020
James City County Fire Rescue	83002	No	--	State – Full	February 28, 2019
Norfolk Fire Department	71008	No	--	State – Full	July 31, 2021
Paul D. Camp Community College	62003	No	--	State – Conditional	May 31, 2017
Southwest Virginia EMS Council	52003	No	--	State – Full	March 31, 2019
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.

Accredited AEMT Training Programs in the Commonwealth

Site Name	*Site Number*	*# of Alternate Sites*	*Accreditation Status*	*Expiration Date*
Frederick County Fire & Rescue	06906	--	State – Full	**July 31, 2020**

Accredited EMT Training Programs in the Commonwealth

Site Name	*Site Number*	*# of Alternate Sites*	*Accreditation Status*	*Expiration Date*
Navy Region Mid-Atlantic Fire EMS	71006	--	State – Full	July 31, 2018
City of Virginia Beach Fire and EMS	81004	--	State – Full	July 31, 2018
Frederick County Fire & Rescue	06906	--	State – Full	July 31, 2020
Chesterfield Fire & EMS	04103	--	State – Full	July 31, 2020

Attachment D

EMSTF Report

Emergency Medical Services Training Funds Summary

As of January 3, 2017

Virginia
OFFICE OF EMERGENCY MEDICAL SERVICES
Virginia Department of Health

Virginia
OFFICE OF EMERGENCY MEDICAL SERVICES
Virginia Department of Health

EMS Training Funds Summary of Expenditures

Fiscal Year 2015	*Obligated $*	*Disbursed $*
19 Emergency Ops	$2,480.00	$540.00
40 BLS Initial Course Funding	$745,888.50	$356,682.52
43 BLS CE Course Funding	$60,980.00	$33,503.80
44 ALS CE Course Funding	$146,335.00	$66,263.75
45 BLS Auxiliary Program	$90,625.00	$17,960.00
46 ALS Auxiliary Program	$552,376.00	$141,720.00
49 ALS Initial Course Funding	$1,009,204.00	$591,193.05
Total	**$2,607,888.50**	**$1,207,863.12**

Fiscal Year 2016	*Obligated $*	*Disbursed $*
40 EMT Initial Course	$664,632.00	$278,376.43
43 Category 1 CE Course	143,555.00	$54,521.25
45 Auxiliary Course	473,600.00	$122,015.00
49 ALS Initial Course	$1,067,940.00	$496,566.70
Total	**$2,349,727.00**	**$951,479.38**

Fiscal Year 2017	*Obligated $*	*Disbursed $***
40 EMT Initial Course		$69,061.25
43 Category 1 CE Course		$19,617.50
45 Auxiliary Course		$38,320.00
49 ALS Initial Course		$137,093.27
Total		**$264,092.02**

**** Payments made in FY 2017 for obligations from FY 2015 & FY 2016**

Special Initial Grant for funding of Initial Programs

A total of $703,647 was approved through the Special Initiative Grant for any initial certification program with a start date between 07/01/16 and 12/31/16. This was available to any non-profit licensed EMT agencies or other EMS organization operating on a nonprofit basis exclusively for the benefit of the general public and was distributed to 47 (78 courses) applicants.

Funding availability for remainder of Fiscal Year 2017 still in development.