MEDICAL DIRECTION COMMITTEE
1041 Technology Park Drive, Glen Allen, VA
April 5, 2018
10:30 AM

Members Present:	Members Absent:	Staff:	Others:
Lisa Dodd, D.O. - Chair	Christopher Turnbull, M.D.	Warren Short	Ron Passmore
Asher Brand, M.D.	Tania White, M.D.	Debbie Akers	Ed Moreland
Charles Lane, M.D.	Forrest Calland, M.D.	Billy Fritz	Gary Critzer
George Lindbeck, M.D.	Chief Eddie Ferguson	Cam Crittenden	Rob Logan
Marilyn McLeod, M. D.		Tim Perkins	Wayne Perry
John Morgan, M.D.			John Dugan
Scott Weir, M.D.			Matt Lawler
Allen Yee, M.D.			Greg Neiman
Paul Phillips, D.O.			Michael Biller
Stewart Martin, M.D.			

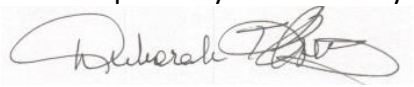
Topic/Subject		Discussion	Recommendations, Action/Follow-up; Responsible Person
I. Welcome		The meeting was called to order by Dr. Dodd at	
II. Introductions		Introductions were made, Attendance as per sign-in roster	
III. Approval of Agenda			**Approved by consensus**
IV. Approval of Minutes		Approval of minutes from January 4, 2018	**Approved by consensus**
V. Drug Enforcement Administration (DEA) & Board of Pharmacy (BOP) Compliance Issues		Nothing to report	
VI. Old Business		None	
VII. New Business			
A	Training & Certification Committee Report – Charles Lane (Given by G Lindbeck)	1. Streamlining BLS testing a. OEMS staff and CTS examiners have been revising scenarios and streamlining the criteria for critical failure. b. Adding SPO2, ETCO2 and Glucometry numbers. c. Implementation of new scenarios by July 1, 2018.	

Topic/Subject		Discussion	Recommendations, Action/Follow-up; Responsible Person
		d. Will then begin working on new scenarios.	
B	Trauma Committee Report – Dr. Forrest Calland (by Cam Crittenden)	1. Final work on plan and will be presented at the next meeting of the TSOMC. 2. Will be brought to the MDC committee and then to the Governors EMS advisory board in July and August.	
VIII. Research Requests		None	
A	AEMT Pilot Project	Dr. Brian Ekey, OMD with Blacksburg Rescue presented The CAMBA Pilot proposal to Medical Direction Committee (**Attachment: A**) Discussion with clarification from Dr. Ekey to the OMD Committee. Discussion whether this need to be formal IRB study. Clarification that this would be applied to both adult and pediatric patients.	**Attachment A:**
Committee Lunch Break –11:41 – 12:00			
IX. State OMD – George Lindbeck, MD			
A	Protecting Patient Access to Emergency Medications Act of 2017	Provided clarification concerning the act and stated that the hospital based distribution of drugs may not be viable but doesn't know what the future will look like. (**Attachment: B**)	
B	Fatigue Project	Presented information concerning the Fatigue Project. Displayed the Reference Document (**Attachment: C**)	
C	SOP Updates	Presented for final review (**Attachment: D**) Final review of Scope of Practice – Procedures & Formulary. To be presented to the Governors EMS Advisory Board as an action item for May meeting. Clarification and final revisions made by committee.	**Motion from M. McLeod – Accept SOP with revisions made and forward to Governor's EMS Advisory Board as action item, 2nd by C. Lane. Motion unanimously carried.**
D	EMS Physician Proposed Regulatory Changes	Presented the changes recommended by the workgroup to the proposed Chapter 32 of the new regulations (**Attachment: E**) Discussion and clarification with recommended changed by committee.	
E	Critical Care Transport Workgroup	From ACS visit realized Critical Care Interfacility transport does not have a good working definition of this process. Will continue to work toward a reference document.	
F	Suspension of OMD	Shared information with committee that a situation had occurred that warranted the suspension of OMD endorsement pending outcome of the situation. Advised that the courses and agencies were covered by the Regional and State OMD until definitive coverage could be arranged.	
Office of EMS Reports			
Division of Educational Development Staff			
A	Division of Educational Development Training Manager – Warren Short	1. National Registry has issued formal notification that Intermediate 99 testing will end on December 31, 2019. If a testing candidate has not passed by that date, they will have no further opportunities to certify at the Intermediate level. Stated that consideration should be given to dual enrolling students in an AEMT program in the event they are not successful on passing the I-99 examination. Program should consider a 'sunset date' to ensure student success in testing.	

	Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
B	BLS Training Specialist – Billy Fritz	1. EC Process a. Currently have 57 candidates and 80 applicants. b. Notifications are available in your EMS portal 2. Updates a. The DED Division will continue to present on the road for 2018. Schedule has not been determined pending the hiring of the new BLS Training Specialist. b. See the latest schedule on OEMS webpage: http://www.vdh.virginia.gov/emergency-medical-services/ems-educator-update-schedule/	
C	ALS Training Specialist – Debbie Akers	1. NR Stats (**ATTACHMENT: F**) a. State results continue to mirror National Registry 2. Accreditation (**ATTACHMENT: G**) a. Report distributed b. Any program listed with an asterisk next to their accreditation status are allowed to have 'in-house' CTS or psychomotor competency verification. 1.	**See Attachment 'F'** **See Attachment 'G'**
D	Training and Development Specialist – Chuck Faison (by Warren Short)	1. EMS Scholarship Program and Contracting with Regional Councils a. Is up and running. Has had some issues but those are being addressed. b. Next application cycle began on April 1. 2018 2. CE Auxiliary Contracts a. Made contact with the Regional Councils prior to the holidays. Actively working to create reporting templates for EMSTF funding from the CE & Auxiliary programs. b. IT anticipates development of templates in next two weeks to allow OEMS to gather pertinent data from these reports.	
Other OEMS Staff			
E	Assistant Director – Scott Winston	1. New licensure database is up and running. Agencies are allowed to submit information online that has been required in paper format in the past. 2. Variances are being completed online. Requires chief operations officer of agency and OMD to approve the variance. Reinforced need to stay engaged with OEMS OMD portal. 3. Comprehensive review of regulations underway. Meeting was held on Tuesday. Some terminology and outdated procedures will be addressed and updated. Attorney General is doing an intensive 4. Present proposed draft of EMS Regulations to Advisory Board in November. Then before a Public Comment period and then before Board of Health. Possibly another 12 months before final action. 5. Ron Passmore will be starting with the Office as the new Regulation and Compliance Manager on April 25th. 6. Tim Perkins is new Manager of Division of Community Health and Technical Resources. Will begin recruitment of new EMS Systems planner. 7. New HR analyst 8. General Assembly update: a. Reconvenes on the 11th. Biggest issue will be the budget.	

Topic/Subject		Discussion	Recommendations, Action/Follow-up; Responsible Person
		b. Number of bills related to EMS were reviewed but none that were problematic. c. OEMS will be responsible for providing information that the hospital will be responsible for providing the cost of the air medical transport and whether the provider is in or out of network. Strong interest in developing statewide medical protocols for air medical transport. d. Bill passed that allows out of state practitioners in bordering states to practice in Virginia without certification in the state if participating in a large gathering of individuals. Specifically in the Halifax/Pittsylvania County area that hosts multiple large events each year. Agency will be required to communicate with OEMS a minimum of 10 days prior to the event of a list of names of providers who will be participating at each event so office can collaborate with neighboring state on provider level of certification, etc.	
F	Community Health and Technical Resources – Tim Perkins	1. Reported on the new focus for the Community Health and Technical Resources Division. They will be reorganizing the Community Paramedicine workgroup in the near future. He will be working with Dr. Year.	
G		2.	
PUBLIC COMMENT		John Dugan reported on that the next VHAC Coalition meeting will be held on Friday, May 11th in Chesterfield.	
For The Good Of The Order			
Future Meeting Dates for 2018		July 12th, October 4th	
Adjournment		14:27	

Respectfully submitted by:



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Deborah T. Akers
OEMS Staff Liaison
April 5, 2018

Attachment A

The CAMBA Project

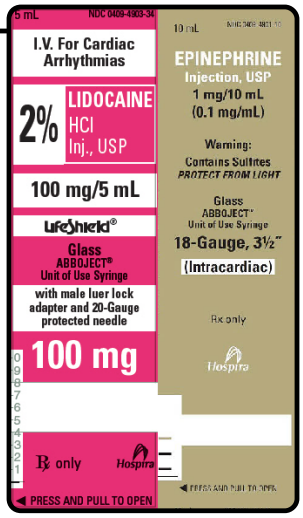
Proposal for Prehospital Pilot Study: Cardiac Arrest Medications By AEMTs

The CAMBA Pilot

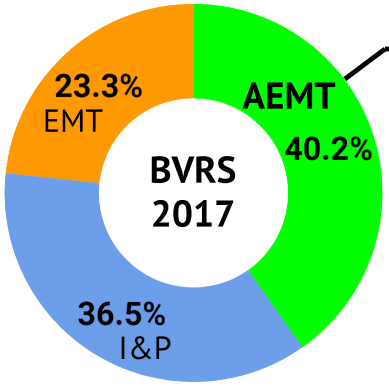
Drs. Ekey, LePera, and Stanley, BVRS OMDs; 4/5/18

The Idea

- Virginia EMS has long supported the concept of EMTs, Advanced EMTs and Paramedics. **AEMTs are a critical bridge** where Paramedics are in short supply.
- AEMTs can already provide several components of comprehensive ACLS: CPR, AED, an IO, and a BIAD. The only missing intervention is drug therapy.
- The **ACLS algorithm recommends drug therapy** during cardiac arrest. Proof of outcomes may be debated, but there is little evidence of harm.
- **AEMTs are already taught Epinephrine and Lidocaine.** Indications during cardiac arrest could easily be added to the curriculum. ACLS already suggests administration during active CPR. **It does not require rhythm interpretation.**
- Risks are minimal. Transport may be delayed, but the AHA supports field resucitation if comprehensive ACLS is available.



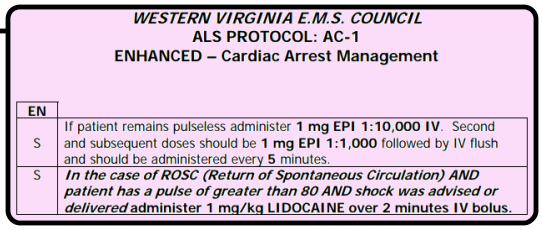
The Impact



- AEMTs are responsible for a significant percentage of calls run in the commonwealth, and **AEMTs are critical for rural squads.**
- Rural agencies frequently have longer transport times and do not have access to paid career Paramedics to provide ACLS.
- Drugs for **AEMTs could bring ACLS to rural communities.**
- Increased field resucitation may also reduce futile transport and limit the risk to providers of doing CPR in a moving vehicle.

Examples

- Historically EMT-ST and **EMT-Enhanced gave Epinephrine** during cardiac arrest. (And Lidocaine after cardiac arrest.)
- Additional training modules above national scope (such as combi-tube) have been previously endorsed by VA OEMS.



WESTERN VIRGINIA E.M.S. COUNCIL
ALS PROTOCOL: AC-1
ENHANCED – Cardiac Arrest Management

EN	
S	If patient remains pulseless administer **1 mg EPI 1:10,000 IV**. Second and subsequent doses should be **1 mg EPI 1:1,000** followed by IV flush and should be administered every **5** minutes.
S	*In the case of ROSC (Return of Spontaneous Circulation) AND patient has a pulse of greater than 80 AND shock was advised or delivered* **administer 1 mg/kg LIDOCAINE over 2 minutes IV bolus.**

The Proposal

We propose a pilot study of the ability of an AEMT to provide Epinephrine and Lidocaine during cardiac arrest. The investigators could seek IRB approval. Squads with strong physician QA/QI oversight and appropriate protocols and training could apply. An independent review panel could maintain continuous oversight and data review to ensure ongoing safety.

1) Prelim
- **Guidance from Medical Direction**
- OEMS Prelim OK

→ 2) Prepare
- Assign Lead
- Further Research
- Design Study

→ 3) IRB Approval
- Finalize Design
- Seek Exemption
- Squads Apply

→ 4) Implement
- Data Collection
- Ongoing Safety
- Publish Results

Attachment B

Protecting Patient Access to Emergency Medications Act of 2017

Public Law 115–83
115th Congress

An Act

To amend the Controlled Substances Act with regard to the provision of emergency medical services.

Nov. 17, 2017
[H.R. 304]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Protecting Patient Access to Emergency Medications Act of 2017.
21 USC 801 note.

SECTION 1. SHORT TITLE.

This Act may be cited as the "Protecting Patient Access to Emergency Medications Act of 2017".

SEC. 2. EMERGENCY MEDICAL SERVICES.

Section 303 of the Controlled Substances Act (21 U.S.C. 823) is amended—

(1) by redesignating subsection (j) as subsection (k); and

(2) by inserting after subsection (i) the following:

"(j) EMERGENCY MEDICAL SERVICES THAT ADMINISTER CONTROLLED SUBSTANCES.—

"(1) REGISTRATION.—For the purpose of enabling emergency medical services professionals to administer controlled substances in schedule II, III, IV, or V to ultimate users receiving emergency medical services in accordance with the requirements of this subsection, the Attorney General—

"(A) shall register an emergency medical services agency if the agency submits an application demonstrating it is authorized to conduct such activity under the laws of each State in which the agency practices; and

"(B) may deny an application for such registration if the Attorney General determines that the issuance of such registration would be inconsistent with the requirements of this subsection or the public interest based on the factors listed in subsection (f).

"(2) OPTION FOR SINGLE REGISTRATION.—In registering an emergency medical services agency pursuant to paragraph (1), the Attorney General shall allow such agency the option of a single registration in each State where the agency administers controlled substances in lieu of requiring a separate registration for each location of the emergency medical services agency.

"(3) HOSPITAL-BASED AGENCY.—If a hospital-based emergency medical services agency is registered under subsection (f), the agency may use the registration of the hospital to administer controlled substances in accordance with this subsection without being registered under this subsection.

"(4) ADMINISTRATION OUTSIDE PHYSICAL PRESENCE OF MEDICAL DIRECTOR OR AUTHORIZING MEDICAL PROFESSIONAL.—Emergency medical services professionals of a registered emergency

medical services agency may administer controlled substances in schedule II, III, IV, or V outside the physical presence of a medical director or authorizing medical professional in the course of providing emergency medical services if the administration is—

"(A) authorized by the law of the State in which it occurs; and

"(B) pursuant to—

"(i) a standing order that is issued and adopted by one or more medical directors of the agency, including any such order that may be developed by a specific State authority; or

"(ii) a verbal order that is—

"(I) issued in accordance with a policy of the agency; and

"(II) provided by a medical director or authorizing medical professional in response to a request by the emergency medical services professional with respect to a specific patient—

"(aa) in the case of a mass casualty incident; or

"(bb) to ensure the proper care and treatment of a specific patient.

"(5) DELIVERY.—A registered emergency medical services agency may deliver controlled substances from a registered location of the agency to an unregistered location of the agency only if the agency—

"(A) designates the unregistered location for such delivery; and

Notification. Time period.

"(B) notifies the Attorney General at least 30 days prior to first delivering controlled substances to the unregistered location.

"(6) STORAGE.—A registered emergency medical services agency may store controlled substances—

"(A) at a registered location of the agency;

"(B) at any designated location of the agency or in an emergency services vehicle situated at a registered or designated location of the agency; or

"(C) in an emergency medical services vehicle used by the agency that is—

"(i) traveling from, or returning to, a registered or designated location of the agency in the course of responding to an emergency; or

"(ii) otherwise actively in use by the agency under circumstances that provide for security of the controlled substances consistent with the requirements established by regulations of the Attorney General.

"(7) NO TREATMENT AS DISTRIBUTION.—The delivery of controlled substances by a registered emergency medical services agency pursuant to this subsection shall not be treated as distribution for purposes of section 308.

Records.

"(8) RESTOCKING OF EMERGENCY MEDICAL SERVICES VEHICLES AT A HOSPITAL.—Notwithstanding paragraph (13)(J), a registered emergency medical services agency may receive controlled substances from a hospital for purposes of restocking an emergency medical services vehicle following an emergency

response, and without being subject to the requirements of section 308, provided all of the following conditions are satisfied:

"(A) The registered or designated location of the agency where the vehicle is primarily situated maintains a record of such receipt in accordance with paragraph (9).

"(B) The hospital maintains a record of such delivery to the agency in accordance with section 307.

"(C) If the vehicle is primarily situated at a designated location, such location notifies the registered location of the agency within 72 hours of the vehicle receiving the controlled substances.

Notification. Deadline.

"(9) MAINTENANCE OF RECORDS.—

"(A) IN GENERAL.—A registered emergency medical services agency shall maintain records in accordance with subsections (a) and (b) of section 307 of all controlled substances that are received, administered, or otherwise disposed of pursuant to the agency's registration, without regard to subsection 307(c)(1)(B).

"(B) REQUIREMENTS.—Such records—

"(i) shall include records of deliveries of controlled substances between all locations of the agency; and

"(ii) shall be maintained, whether electronically or otherwise, at each registered and designated location of the agency where the controlled substances involved are received, administered, or otherwise disposed of.

"(10) OTHER REQUIREMENTS.—A registered emergency medical services agency, under the supervision of a medical director, shall be responsible for ensuring that—

"(A) all emergency medical services professionals who administer controlled substances using the agency's registration act in accordance with the requirements of this subsection;

"(B) the recordkeeping requirements of paragraph (9) are met with respect to a registered location and each designated location of the agency;

"(C) the applicable physical security requirements established by regulation of the Attorney General are complied with wherever controlled substances are stored by the agency in accordance with paragraph (6); and

"(D) the agency maintains, at a registered location of the agency, a record of the standing orders issued or adopted in accordance with paragraph (9).

"(11) REGULATIONS.—The Attorney General may issue regulations—

"(A) specifying, with regard to delivery of controlled substances under paragraph (5)—

"(i) the types of locations that may be designated under such paragraph; and

"(ii) the manner in which a notification under paragraph (5)(B) must be made;

"(B) specifying, with regard to the storage of controlled substances under paragraph (6), the manner in which such substances must be stored at registered and designated locations, including in emergency medical service vehicles; and

"(C) addressing the ability of hospitals, emergency medical services agencies, registered locations, and designated

locations to deliver controlled substances to each other in the event of—

"(i) shortages of such substances;

"(ii) a public health emergency; or

"(iii) a mass casualty event.

"(12) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed—

"(A) to limit the authority vested in the Attorney General by other provisions of this title to take measures to prevent diversion of controlled substances; or

"(B) to override the authority of any State to regulate the provision of emergency medical services consistent with this subsection.

"(13) DEFINITIONS.—In this section:

"(A) The term 'authorizing medical professional' means an emergency or other physician, or another medical professional (including an advanced practice registered nurse or physician assistant)—

"(i) who is registered under this Act;

"(ii) who is acting within the scope of the registration; and

"(iii) whose scope of practice under a State license or certification includes the ability to provide verbal orders.

"(B) The term 'designated location' means a location designated by an emergency medical services agency under paragraph (5).

"(C) The term 'emergency medical services' means emergency medical response and emergency mobile medical services provided outside of a fixed medical facility.

"(D) The term 'emergency medical services agency' means an organization providing emergency medical services, including such an organization that—

"(i) is governmental (including fire-based and hospital-based agencies), nongovernmental (including hospital-based agencies), private, or volunteer-based;

"(ii) provides emergency medical services by ground, air, or otherwise; and

"(iii) is authorized by the State in which the organization is providing such services to provide emergency medical care, including the administering of controlled substances, to members of the general public on an emergency basis.

"(E) The term 'emergency medical services professional' means a health care professional (including a nurse, paramedic, or emergency medical technician) licensed or certified by the State in which the professional practices and credentialed by a medical director of the respective emergency medical services agency to provide emergency medical services within the scope of the professional's State license or certification.

"(F) The term 'emergency medical services vehicle' means an ambulance, fire apparatus, supervisor truck, or other vehicle used by an emergency medical services agency for the purpose of providing or facilitating emergency medical care and transport or transporting controlled substances to and from the registered and designated locations.

"(G) The term 'hospital-based' means, with respect to an agency, owned or operated by a hospital.

"(H) The term 'medical director' means a physician who is registered under subsection (f) and provides medical oversight for an emergency medical services agency.

"(I) The term 'medical oversight' means supervision of the provision of medical care by an emergency medical services agency.

"(J) The term 'registered emergency medical services agency' means—

"(i) an emergency medical services agency that is registered pursuant to this subsection; or

"(ii) a hospital-based emergency medical services agency that is covered by the registration of the hospital under subsection (f).

"(K) The term 'registered location' means a location that appears on the certificate of registration issued to an emergency medical services agency under this subsection or subsection (f), which shall be where the agency receives controlled substances from distributors.

"(L) The term 'specific State authority' means a governmental agency or other such authority, including a regional oversight and coordinating body, that, pursuant to State law or regulation, develops clinical protocols regarding the delivery of emergency medical services in the geographic jurisdiction of such agency or authority within the State that may be adopted by medical directors.

"(M) The term 'standing order' means a written medical protocol in which a medical director determines in advance the medical criteria that must be met before administering controlled substances to individuals in need of emergency medical services.

"(N) The term 'verbal order' means an oral directive that is given through any method of communication including by radio or telephone, directly to an emergency medical services professional, to contemporaneously administer a controlled substance to individuals in need of emergency medical services outside the physical presence of the medical director or authorizing medical professional.".

Approved November 17, 2017.

LEGISLATIVE HISTORY—H.R. 304:

CONGRESSIONAL RECORD, Vol. 163 (2017):
Jan. 9, considered and passed House.
Oct. 24, considered and passed Senate, amended.
Nov. 2, House concurred in Senate amendment.

○

Attachment C

The Fatigue Project

FATIGUE IN EMS

Developing Evidence Based Fatigue Risk Management Guidelines for Emergency Medical Services

WHAT IS FATIGUE?

Fatigue is...

> *a subjective, unpleasant symptom, which incorporates total body feelings ranging from tiredness to exhaustion creating an unrelenting overall condition which interferes with an individual's ability to function to their normal capacity.*[1]

1: Ream E, Richardson A. Fatigue: a concept analysis. Int J Nurs Stud. 1996;33(5):519-29.

THE FATIGUE IN EMS PROJECT

The overall goal of this project was to develop, test, and disseminate evidence-based guidelines for fatigue risk management tailored to the EMS setting. The project was comprised of three phases.

PHASE 1 aimed to evaluate the quality of evidence germane to use of caffeine, napping during shift work, shorter shift duration, and other strategies to mitigate fatigue. The primary outcome of PHASE 1 was a set of recommendations based on a review of the best available evidence and collated into a guideline for fatigue mitigation. Evidence-based guidelines are

> *systematically developed statements designed to help administrators, practitioners, and patients make decisions about appropriate health care for specific circumstances.*[2]

PHASE 2 aims to test one or more recommendations, and PHASE 3 aims to develop a freely available biomathematical model for EMS administrators to use while creating shift schedules.

2: Institute of Medicine. Clinical Practice Guidelines We Can Trust. March 23, 2011. The National Academies of Sciences, Engineering, Medicine.

Learn more about Fatigue in EMS: *www.emsfatigue.org*

RECOMMENDATIONS FOR MITIGATING FATIGUE

1. Reliable and/or valid fatigue and sleepiness survey instruments should be used to measure and monitor fatigue in EMS personnel. [1]
2. EMS personnel should work shifts shorter than 24 hours in duration.
3. EMS workers should have access to caffeine as a fatigue countermeasure. [3]
4. EMS personnel should have the opportunity to nap while on duty to mitigate fatigue. [4]
5. EMS personnel should receive education and training to mitigate fatigue and fatigue-related risks. [5]

ABOUT THESE RECOMMENDATIONS

These recommendations were developed following a rigorous process known as the GRADE Methodology (Grading of Recommendations, Assessment, Development, and Evaluation).

Evidence from more than 38,000 pieces of literature was reviewed by more than two-dozen investigators. A summary of the evidence connected to seven research questions and six fatigue mitigation strategies was evaluated by a panel comprised of experts in sleep medicine, fatigue science, emergency medicine, prehospital emergency care, risk administration, and public safety.

Prior to formulating recommendations, the panel deliberated: 1) the quality of evidence; 2) the balance between benefits and harms for different strategies; 3) the values and preferences of EMS constituents; and 4) costs associated with different fatigue mitigation strategies.

The panel reached consensus on five recommendations. These recommendations are supported by a review and synthesis of the best available evidence. EMS administrators that choose to create a fatigue risk management program of their own should consider one or more of these recommendations to guide decision making regarding specific fatigue mitigation strategies.

NASEMSO

Contact the National Association of State EMS Officials
201 Park Washington Court, Falls Church, VA 22046
www.nasemso.org | info@nasemso.org
(703) 538-1799

Learn more about Fatigue in EMS: www.emsfatigue.org

Read the supplement in Prehospital Emergency Care:
http://tandfonline.com/action/showAxaArticles?journalCode=ipec20

Attachment D

Scope of Practice:
Procedures and Formulary

Virginia Office of Emergency Medical Services
Scope of Practice - Procedures for EMS Personnel

This SOP represents ***practice maximums*** .

PROCEDURE	SKILL	PROCEDURE SUBTYPE	EMR	EMT	AEMT	I	P
Specific tasks in this document shall refer to the Virginia Education Standards.							
AIRWAY TECHNIQUES							
Airway Adjuncts							
	Oropharyngeal Airway		●	●	●	●	●
	Nasopharyngeal Airway		●	●	●	●	●
Airway Maneuvers							
	Head tilt jaw thrust		●	●	●	●	●
	Jaw thrust		●	●	●	●	●
	Chin lift		●	●	●	●	●
	Cricoid Pressure		●	●	●	●	●
	Management of existing Tracheostomy			●	●	●	●
Alternate Airway Devices							
	Non Visualized Airway Devices	Supraglottic		●	●	●	●
Cricothyrotomy							
	Needle						●
	Surgical	Includes percutaneous techniques					●
Obstructed Airway Clearance							
	Manual		●	●	●	●	●
	Visualize Upper-airway				●	●	●
Intubation							
	Orotracheal - Over Age 12					●	●
	Nasotracheal						●
	Pediatric - Age 12 and under						●
	Drug assisted intubation (DAI) all ages	Includes:					●
		Drug facilitated intubation (DFI)					●
		Delayed sequence intubation (DSI)					●
		Rapid sequence intubation (RSI)					●
	Confirmation procedures			●	●	●	●
**** Endotracheal intubation is prohibited for all levels except Intermediate and Paramedic**							
Oxygen Delivery Systems							
	Nasal Cannula		●	●	●	●	●
	Venturi Mask			●	●	●	●
	Simple Face Mask		●	●	●	●	●
	Partial Rebreather Face Mask			●	●	●	●
	Non-rebreather Face Mask		●	●	●	●	●
	Face Tent			●	●	●	●

"Investigational medications and procedures which have been reviewed and approved by an Institutional Review Board (IRB) will be considered to be approved by the Medical Direction Committee solely within the context of the approved study. Investigators involved in IRB approved research are asked to present their study plans to the MDC for informational purposes so that the committee can maintain an awareness of on-going pre-hospital research in the Commonwealth. Those who desire to conduct non-IRB reviewed pilot projects, demonstration projects, or research are asked to present those proposals to the MDC prior to their implementation for review and approval by the MDC."

Use of medication not listed which is indicated by medical control and/or the operational medical director due to the use of a weapon of mass destruction is exempt from this list.

Virginia Office of Emergency Medical Services
Scope of Practice - Procedures for EMS Personnel

This SOP represents ***practice maximums*** .

PROCEDURE	SKILL	PROCEDURE SUBTYPE	EMR	EMT	AEMT	I	P
	Tracheal Cuff			●	●	●	●
	Oxygen Hood					●	●
	O2 Powered Flow restricted device			●	●	●	●
	Humidification			●	●	●	●
Suction							
	Manually Operated		●	●	●	●	●
	Mechanically Operated		●	●	●	●	●
	Pharyngeal		●	●	●	●	●
	Bronchial-Tracheal			●	●	●	●
	Oral Suctioning		●	●	●	●	●
	Naso-pharyngeal Suctioning			●	●	●	●
	Endotracheal Suctioning			●	●	●	●
	Meconium Aspiration Neonate with ET						●
Ventilation – assisted / mechanical							
	Mouth to Mask		●	●	●	●	●
	Mouth to Mask with O2		●	●	●	●	●
	Bag-Valve-Mask Adult		●	●	●	●	●
	Bag-Valve-Mask with supplemental O2 Adult		●	●	●	●	●
	Bag-Valve-Mask with supplemental O2 and reservoir Adult		●	●	●	●	●
	Bag-Valve-Mask Pediatric		●	●	●	●	●
	Bag-Valve-Mask with supplemental O2 Pediatric		●	●	●	●	●
	Bag-Valve-Mask with supplemental O2 and reservoir Pediatric		●	●	●	●	●
	Bag-Valve-Mask neonate/infant		●	●	●	●	●
	Bag-Valve-Mask with supplemental O2 Neonate/Infant		●	●	●	●	●
	Bag-Valve-Mask with supplemental O2 and reservoir Neonate/Infant		●	●	●	●	●
	Noninvasive positive pressure vent.	CPAP, fixed pressure		●	●	●	●
		CPAP, BiPAP, PEEP adjustable				●	●
	Jet insuflation						●
	Mechanical Ventilator (Manual/Automated Transport Ventilator)	Maintain long term/established			●	●	●
		Initiate/Manage ventilator				●	●
Anesthesia (Local)						●	●
Pain Control & Sedation							
	Self Administered inhaled analgesics			●	●	●	●

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Virginia Office of Emergency Medical Services
Scope of Practice - Procedures for EMS Personnel

This SOP represents ***practice maximums*** .

PROCEDURE	SKILL	PROCEDURE SUBTYPE	EMR	EMT	AEMT	I	P
	Pharmacological (non-inhaled)				●	●	●
	Patient controlled analgesia (PCA)	Maintain established			●	●	●
	Epidural catheters (maintain)	Maintain established				●	●
Blood and Component Therapy Administration		Maintain				●	●
		Initiate					●
Diagnostic Procedures							
	Blood chemistry analysis			●	●	●	●
	Capnography			●	●	●	●
	Pulmonary function measurement				●	●	●
	Pulse Oximetry			●	●	●	●
	Ultrasonography						●
Genital/Urinary							
	Bladder catheterization						
	Foley catheter	Place bladder catheter					●
		Maintain bladder catheter		●	●	●	●
Head and Neck							
	ICP Monitor (maintain)						●
	Control of epistaxis		●	●	●	●	●
		Inserted epistaxis control devices			●	●	●
	Tooth replacement		●	●	●	●	●
Hemodynamic Techniques							
	Arterial catheter maintenance						●
	Central venous maintenance				●	●	●
	Access indwelling port					●	●
	Intraosseous access & infusion				●	●	●
	Peripheral venous access and maintenance				●	●	●
	Umbilical Catheter Insertion/Management						●
	Monitoring Existing IVs			●	●	●	●
	Mechanical IV Pumps				●	●	●
Hemodynamic Monitoring							
	ECG acquisition		●	●	●	●	●
	ECG Interpretation					●	●
	Invasive Hemodynamic Monitoring						●
	Vagal Maneuvers/Carotid Massage					●	●
Obstetrics							

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Virginia Office of Emergency Medical Services
Scope of Practice - Procedures for EMS Personnel

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PROCEDURE	SKILL	PROCEDURE SUBTYPE	EMR	EMT	AEMT	I	P
	Delivery of newborn		●	●	●	●	●
Other Techniques							
	Vital Signs		●	●	●	●	●
	Bleeding control		●	●	●	●	●
		Tourniquets	●	●	●	●	●
	Foreign body removal	Superificial without local anesthesia		●	●	●	●
		Imbedded with local anesthesia/exploration				●	●
	Incision/Drainage						●
	Intravenous therapy				●	●	●
	Medication administration			●	●	●	●
	Nasogastric tube			●	●	●	●
	Orogastric tube			●	●	●	●
	Pericardiocentesis						●
	Pleural decompression					●	●
	Patient restraint physical			●	●	●	●
	Patient restraint chemical					●	●
	Sexual assault victim management			●	●	●	●
	Trephination of nails						●
	Wound closure techniques					●	●
	Wound management		●	●	●	●	●
	Pressure Bag for High altitude						●
	Treat and Release			●	●	●	●
	Vagal Maneuvers/Carotid Massage					●	●
	Intranasal medication administration	Fixed/unit dose medications	●	●	●	●	●
		Dose calculation/measurement			●	●	●
Resuscitation							
	Cardiopulmonary resuscitation (CPR) (all ages)		●	●	●	●	●
	Cardiac pacing					●	●
	Defibrillation/Cardioversion	AED	●	●	●	●	●
	Post resuscitative care			●	●	●	●
Skeletal Procedures							
	Care of the amputated part		●	●	●	●	●
	Fracture/Dislocation immobilization techniques		●	●	●	●	●
	Fracture/Dislocation reduction techniques	Manipulation of angulated/pulseless extremities		●	●	●	●
		Joint reduction techniques		●	●	●	●
	Spine immobilization techniques		●	●	●	●	●
Thoracic							

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Virginia Office of Emergency Medical Services
Scope of Practice - Procedures for EMS Personnel

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PROCEDURE	SKILL	PROCEDURE SUBTYPE	EMR	EMT	AEMT	I	P
	Thoracostomy (refer to "Other Techniques")						●
Body Substance Isolation / PPE			●	●	●	●	●
Lifting and moving techniques			●	●	●	●	●
Gastro-Intestinal Techniques							
	Management of non-displaced gastrostomy tube						●
Ophthalmological							
	Morgan Lenses			●	●	●	●
	Corneal Exam with fluorescein					●	●
	Ocular irrigation		●	●	●	●	●

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Virginia Office of Emergency Medical Services
Scope of Practice - Formulary for EMS Personnel

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CATEGORY		EMR	EMT	AEMT	I	P		
Analgesics								
	Acetaminophen		●	●	●	●		
	Nonsteroidal anti-inflammatory		●	●	●	●		
	Opiates and related narcotics			●	●	●		
	Dissociative analgesics							
	Ketamine 0.5 mg/kg or less IV/IN				●	●		
Anesthetics								
	Otic			●	●	●		
	General - initiate					●	includes Propafol	
	Ketamine greater than 0.5 mg/kg					●		
	General - maintenance				●	●	Excludes Propafol infusion at the Intermediate level	
	Ocular		●	●	●	●		
	Inhaled-self administered		●	●	●	●		
	Local			●	●	●		
Anticonvulsants				●	●	●		
Glucose Altering Agents								
	Glucose Elevating Agents		●	●	●	●		
	Glucose Lowering Agents				●	●		
Antidotes								
	Anticholinergic Antagonists				●	●		
	Anticholenesterase Antagonists	●	●	●	●	●		
	Benzodiazepine Antagonists							
	Narcotic Antagonists	●	●	●	●	●		
	Nondepolarizing Muscle Relaxant Antagonist							
	Beta/Calcium Channel Blocker Antidote				●	●		
	Tricyclic Antidepressant Overdose				●	●		
	Cyanide Antidote				●	●		
	Cholinesterase Reactivator	●	●	●	●	●		
Antihistamines & Combinations			●	●	●	●		

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Scope of Practice - Formulary for EMS Personnel

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CATEGORY		EMR	EMT	AEMT	I	P
Biologicals						
	Immune Serums				●	●
	Antibiotics		●	●	●	●
Blood/Blood products						
	Initiate					●
	Maintain				●	●
Blood Modifiers						
	Anticoagulants				●	●
	Antiplatelet Agents		●	●	●	●
	Hemostatic Agents		●	●	●	●
	Thrombolytics					●
	Anti-fibrinolytics (eg tranexamic acid)				●	●
Cardiovascular Agents						
	Alpha Adrenergic Blockers				●	●
	Adrenergic Stimulants				●	●
	Antiarrhythmics				●	●
	Beta Adrenergic Blockers				●	●
	Calcium Channel Blockers				●	●
	Diuretics				●	●
	Inotropic Agents				●	●
	Vasodilatory Agents		●	●	●	●
	Vasopressors				●	●
	Epinephrine for allergic reaction		●	●	●	●
Central Nervous System	Antipsychotic				●	●
	Sedatives					
	Benzodiazepines				●	●

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Scope of Practice - Formulary for EMS Personnel

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CATEGORY		EMR	EMT	AEMT	I	P	
Dietary Supplements/Electrolyte	Vitamins						
	Minerals - start at a health care facility	See section: Intravenous Fluids					
	Salts - start at a health care facility						
	Electrolytes Solutions - start at a health care facility						
	Hypertonic Saline				●	●	
Gas							
	Oxygen	●	●	●	●	●	
	Heliox				●	●	
Gastrointestinal							
	Antacids						
	OTC			●	●	●	
	Antidiarrheals		●	●	●	●	
	Antiemetics		●	●	●	●	
	EMT SL/PO route only						
	H2 Blockers		●	●	●	●	
Hormones	Steroids			●	●	●	
Intravenous Fluids	isotonic		●	●	●	●	EMT may tranport patient with IV fluids not requiring titration or adjustment
	hypotonic		●	●	●	●	
	hypertonic				●	●	
	M = Maintenance I = Initiate						
	Crystalloid, +/- Dextrose/Lactate		M	I/M	I/M	I/M	
	with Multi=vitamins		M	M	M	M	
	with Thiamine		M	M	M	M	
Neuromuscular Blockers						●	
Respiratory	Anticholinergics		●	●	●	●	
	Sympathomimetics						
	Beta agonists		●	●	●	●	
	Epinephrine (nebulized)				●	●	
Dosage and Concentration Calculation				●	●	●	
M = Maintenance							
I = Initiate							

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CATEGORY		EMR	EMT	AEMT	I	P		
	Note: EMT's may administer medications within their scope of practice in addition to assistance in administration of those medications. EMT's may access a drug kit to access those medications. MDC discussions.							

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Attachment E

Regulatory Proposed Changes

Summary of Proposed Changes in Regs Related to EMS Physicians
For discussion April 5, 2018 MDC Meeting

P8 lines 6-12 Goal is to widen definition to include less acute situations and non-traditional EMS roles

Lines 16-19 Includes EMS physicians as "EMS personnel" and deletes specific certification levels

P9 lines 1-3 Strikes mention of specifc certification levels

P42 lines 7-9 added "shall follow"

P52 lines 12 strike "emergency"

P53 lines 1-2 adds "other insurance"
Lines 3-4 a job description may serve as the OMD agreement
Lines 7-10 adds "non binding recommendations"

P107 lines 12-16 orders from on-line medical direction may be outside agency protocol but must be within SOP

P109 line 7 "made available" rather than "provide"

P146 lines 15-18 adds EMS subspecialty board certification

P147 lines 1-6 for discussion: should other board certifications be added to this list, e.g. anesthesia, critical care, or should it simply refer to "other" board certifications?
Section 5 merged with Section 4

P148 lines 12-19 for discussion: is there any penalty for lapsing due to unfulfilled requirements?

P149 for discussion: See above discussion about other board certifications.
For discussion: I would not recommend trying to run two separate "tracks" of workshops. Include the "vision/update" in the single workshop (we have been doing this, but if it requires additional emphasis/content we can do that). Trying to keep a short (1-2 hour?) legislative workshop available geographically might be difficult and not worth the travel time for many. Decrease requirement for non-EMS board certification to one workshop per five year endorsement period. Otherwise simplified.

P150 Changes in the responsibilities of OMD to include direct patient care.

P151 “Privileges” rather than “practice”

P152 Section 2050 modified to be consistent with previous changes

P154 Added “will collaborate” with course coordinator or EC

P155 Section 2065 Added the term “educational coordinator”

Section 2070 Added “will collaborate” with course coordinator or EC

Attachment F

National Registry Statistics

EMT Statistics
As of 04/03/2018

Virginia:

Report Date:	4/3/2018 7:35:48 PM
Report Type:	State Report (VA)
Registration Level:	EMT
Course Completion Date:	1st Quarter 2015 to 1st Quarter 2018
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
8133	68% (5544)	79% (6446)	80% (6486)	0% (4)	12% (947)	9% (699)

National Registry Statistics:

Report Date:	4/3/2018 7:33:24 PM
Report Type:	National Report
Registration Level:	EMT
Course Completion Date:	1st Quarter 2015 to 1st Quarter 2018
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
227986	68% (155750)	80% (182461)	81% (184050)	0% (198)	12% (26823)	7% (17048)

Individual Instructor Statistics are available on the OEMS webpage at the following link: http://www.vdh.virginia.gov/content/uploads/sites/23/2018/01/12-31-2017-EMT.pdf

Attachment G

Accreditation Report

Accredited Training Site Directory

As of April 3, 2018

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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	
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 – Initial	CoAEMSP
Southside Virginia Community College	18507	No	1	National – Continuing	CoAEMSP
Southwest Virginia Community College	11709	Yes*	4	National – Continuing	CoAEMSP
Stafford County & Associates in Emergency Care	15319	Yes*	3	National – Continuing	CoAEMSP
Thomas Nelson Community College	83012	Yes*		CoAEMSP – LOR	
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.

- John Tyler Community College under Letter of Review. Initial accreditation visit is scheduled for April, 2018.
- ECPI University has received their Letter of Review to conduct their first cohort class.
- Thomas Nelson Community College under Letter of Review to conduct their first cohort class.
- Loudoun County Fire and Rescue CoAEMSP site visit for continued accreditation conducted in February, 2018. Awaiting report.
- Northern Virginia Community College CoAEMSP site visit for continued accreditation conducted in February, 2018. Awaiting report.
- Stafford County & Associates in Emergency Care CoAEMSP site visit for continued accreditation is scheduled for August, 2018.

*** Indicates program has been approved for in-house psychomotor competency verification.**

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Accredited Intermediate 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	December 31, 2019
Danville Area Training Center	69009	No***	--	State – Full	December 31, 2019
Hampton Fire & EMS	83002	Yes	--	State – Full	December 31, 2019
Henrico County Fire Training	08718	Yes*	--	State – Full	August 31, 2020
James City County Fire Rescue	83002	Yes	--	State – Full	December 31, 2019
Norfolk Fire Department	71008	No	--	State – Full	July 31, 2021
Paul D. Camp Community College	62003	Yes	--	State – Full	May 31, 2021
Southwest Virginia EMS Council	52003	Yes	--	State – Full	December 31, 2019
UVA Prehospital Program	54008	No	--	State – Full	December 31, 2019
WVEMS – New River Valley Training Center	75004	No	--	State – Full	June 30, 2022

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

- All accredited programs whose expiration date was less than December 31, 2019 has been extended until that time based on the end date established by National Registry for I-99 testing. If these programs desire to remain accredited, they will be required to submit an AEMT reaccreditation self-study.

*** Indicates program has been approved for in-house psychomotor competency verification.**
**** Request has been received for in-house psychomotor competency verification.**
***** Request has been received for BLS accreditation to be added to ALS accreditation.**

Accredited AEMT Training Programs in the Commonwealth

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

*** Indicates program has been approved for in-house psychomotor competency verification.**

Accredited EMT Training Programs in the Commonwealth

Site Name	*Site Number*	*# of Alternate Sites*	*Accreditation Status*	*Expiration Date*
Arlington County Fire Training	01305	-	State – Letter of Review	
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
Chesterfield Fire & EMS	04103*	--	State – Full	July 31, 2020

- Arlington County Fire Training has been granted Letter of Review to conduct their first cohort EMT program.

*** Indicates program has been approved for in-house psychomotor competency verification.**
**** Request has been received for in-house psychomotor competency verification.**