MEDICAL DIRECTION COMMITTEE
Office of Emergency Medical Services
Embassy Suites, 2925 Emerywood Parkway, Richmond, VA 23294
Thursday, January 4, 2024
10:30 AM

Members Present:	Members Absent:	Staff:	Others:
Allen Yee, M.D., Chair	Amir Louka M.D.	Debbie Akers	Gary Samuels
Stewart Martin, M.D.	Benjamin Palachick, M.D.	Chad Blosser	Greg Neiman
Charles Lane, M.D.		Michael Berg	Valerie Quick
John Morgan, M. D.		Jessica Rosner	Michelle Ludeman
Chief Eddie Ferguson		Scott Winston	John Dugan
Kayla Long, D.O.		Wanda Street	Monte Dixon
George Lindbeck, M.D.		Daisy Banta	Peppy Winchel
Samuel Bartle, M.D.		Karen Owens	Michael Player
Asher Brand, M.D.		Ron Passmore	Dr. Neha Sullivan
Christopher Turnbull, M.D.		Daniel Linkins	Damien Coy
Paul Phillips, D. O.		Jeffrey Reynolds	Ed Rhodes
Tania White, M.D.		Wayne Perry	Caroline Juran
E. Reed Smith, M.D.		Kelsey Rideout	Jeff Ferguson
Scott Weir, M.D.			

Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
I. Welcome	Dr. Yee called the meeting to order at 10:35 a.m.	
II. Introductions	All attendees introduced themselves.	
III. Approval of Agenda	Approval of today's agenda. **A motion was made and seconded to approve the agenda. All committee members were in favor of the motion. The agenda was approved.**	**The agenda was approved as submitted.**
IV. Approval of Minutes	Approval of the October 5, 2023, minutes. **A motion was made and seconded to approve the minutes. All committee members were in favor of the motion. The minutes were approved.**	**The minutes were approved as submitted.**
V. Drug Enforcement Administration (DEA) & Board of Pharmacy (BOP) Compliance Issues	a. **Virginia Board of Pharmacy Regulations (Schedule 6) – Caroline Juran, Executive Director, Virginia Board of Pharmacy** Ms. Juran introduced herself stating that she has been with the Board of Pharmacy for 18 years. Three things are driving the discussion right now, 1) The Federal Bill passed by Congress HR304, entitled Protecting Patient Access to Emergency Medications of 2017. We will talk more about this later. 2) In 2021 the Office of EMS asked the Board of Pharmacy to develop a guidance document that summarizes the curb requirements at the State	**Attachment 'A'**

Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
	level with respect to EMS services, regarding drug kits using the hospital exchange process that is commonly used. 3) The Food and Drug Administration (FDA) has recently announced that it will start enforcing the Drug Supply Chain Security Act effective November 2024. It was set to go into effect in November 2023, but it was delayed due to supply chain logistical challenges. It is anticipated that each EMS agency will need its own Controlled Substance Registration (CSR) in order to then obtain a DEA Registration. It is not known how many DEA Registrations and CSRs will be needed. It is unclear if each agency will require a registration or each locality. Ms. Juran went through the slide presentation and explained situations/scenarios in which a CSR is needed. The committee engaged in robust discussion concerning types of drugs, drug boxes, and other concerns. Dr. Sullivan asked if a workgroup can be started to continue the conversation/collaboration with OMDs and the Board of Pharmacy. Dr. Yee stated that it may be better to form a workgroup with the Legislative and Planning Committee. Mike Player stated that a workgroup has already been started which includes the Regional Council Directors, OEMS, VAGEMSA, Fire Chiefs, VHHA, VAVRS, and many others. They are looking at transitions that will meet the requirements of the FDA as well as positioning the regions for whatever happens with DEA down the line. Some of the things they are looking at the regional kits and morphing them into a one-to-one exchange as in Northern Virginia in the interim. The workgroup has met twice, one of which was in November 2023. The next meeting is January 8. This has been extremely helpful per Dr. Yee. Ms. Juran stated the Board of Pharmacy meets quarterly and the next meeting is in March.	
VI. Fitch & Associates Introduction	Mr. Todd Sheridan explained who Fitch and Associates is and what they do. Fitch will be providing on-site management services to the Office of EMS for the next 6-months and make recommendations. He introduced the team: Guillermo "G" Fuentes, Mike Pointer, and Frank Gresh (who will provide on-site day-to-day leadership at the Office of EMS). Fitch will look closely at all facets of EMS. Part of their strategy is to look at operational efficiencies and opportunities of the organization. With everything that is going on internally it creates an opportunity to ask 1) what are we required to do, 2) what are we morally and ethically able to do and should do and 3) what are the nice to haves. They will consider a design for the present and for the future. A report will be created with recommendations for the Office of EMS.	
VII. Special Reports	**a. Quarterly Data Report – Jessica Rosner, OEMS Epidemiology** Jessica gave the data report for the 3rd Quarter of 2023 (as of December 6, 2023). There were just over 435,000 EMS calls. They were listed by incident, disposition and type of service requested. She went over the chest pain, stemi, stroke, trauma emergency responses (Steps 1, 2, and 3), pain incidents (by scale scores and age groups, Council, etc.), pediatric patients, and asthma data. The report can be found here: https://www.vdh.virginia.gov/emergency-medical-services/ems-trauma-data/data-reports/ and click on Medical Direction Committee Reports. The committee discussed the validity of the data.	**Attachment 'B'**

Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
VIII. Unfinished Business	**a. VA Code 37.2-808 – Psych TDO Law – AG Guidance – Dr. Yee, Dr. Lindbeck** No update. Dr. Lindbeck asked if anyone had any specific questions or concerns to take to the AG's office. There were no specific responses. **b. TQI Culture of Safety White Paper – Dr. Morgan, Dr. Sullivan, Chief Ferguson** **c. OMD Bill of Rights White Paper – Dr. Morgan, Dr. Sullivan, Chief Ferguson** The workgroup identified that there is a gap compared to the firefighter/EMT bill of rights. There is an opportunity to generate a white paper that spells out the baseline expectations for Medical Direction, potential conflicts, items that can be incorporated into contracts between agencies and Medical Directors. There may be opportunities to enhance the state document with very specific things. The workgroup is working through the document and hopes to have a draft at the next meeting. **d. Scope of Practice Modification Process – Dr. Yee** Ron Passmore explained that the Scope of Practice has to go through a modified regulatory process which will take at least 6 months on average. It still has to be posted and gone through public comments. This is a recent change. It was advised to make changes on a yearly basis unless it is an urgent matter that needs to be changed right away.	
IX. New Business	**a. ChemPak Medications – Scope of Practice & Formulary – Dr. Asher Brand** The committee briefly discussed this. It was brought up in a meeting and the discussion was on doing some education on ChemPaks and making them more widely known. Dr. Lindbeck stated that they are under Antidotes on the Formulary. We are good on this. **b. TCC Issues – Dr. Charles Lane** There is an action being brought forth from the Training and Certification Committee on the number of clinical hours which is a minimum of 24 and a minimum of 12 hours in the field for Advanced EMT. The patient contacts can be in any clinical setting**. A motion was made by Dr. Lane. The motion was seconded by Dr. Martin. All committee members were in favor of the motion. The motion carried.**	
X. Research Requests	None.	
XI. State OMD Issues – Dr. George Lindbeck	**a. Decedent Blood/Body Fluid Exposure Process – Valerie Quick/Karen Owens** Valerie introduced herself and stated that represents the Provider Health and Safety Committee on which she started this project about 6 or 7 years ago. This stemmed from the Ryan White Act of 2009. The goal is to have a process to obtain blood from decedents and to get it tested. There are two different processes. The first one is the general process where we obtain it from the hospital within 48 hours. She created an algorithm to follow and explained the process. The other process is if they are in a funeral home. An OMD may have to accompany the provider or whoever is obtaining the blood. Valerie explained the kit and the costs associated with it. She is seeking assistance from the MDC to get a process for certain individuals to obtain the blood. Dr. Lindbeck will develop a handout on who can obtain the blood, methods of obtaining it, etc. Kits are obtained from ViroMed. On the form you can delegate who gets the results.	**Attachment 'C'** **Attachment 'D'** **Dr. Lindbeck will create a handout for this process.**

Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
XII. Office of EMS Division Reports	**Accreditation, Certification and Education** **Chad Blosser, Education Program Manager** The EMS Scholarship report has been posted on the OEMS website. There are 509 individuals that have been approved but have yet to be paid ($878,000). We have 44 as of yesterday sitting in the approval process. Originally there was $1.5 million in available funds now there is $1.3 million available for scholarships. No payments have been made since the middle of September. Currently, there are 765 educators in the Commonwealth. An Institute is scheduled in three weeks in Leesburg, VA. Thirty new educators will participate in the Institute. There are 254 Education Coordinator pending candidates in the pipeline. **Debbie Akers, Division Director** Debbie stated that the only change in accreditation is the addition of Spotsylvania County. All accredited programs have been extended another year. Virtual accreditations will be held. On October 20, all of the QA/QI contractors were let go. The process is suspended but not terminated. **Executive – Cam Crittenden, Acting Director; Scott Winston, Assistant Director** Scott reported that quite a bit has happened since November which was very good. We ended the fiscal year with a significant budget deficit. He is happy to report that we received funds from the Department of Motor Vehicles, and we have been able to make some payments to Regional Councils and Return to Localities. We also have received some reallocated funds from VDH. Scott also discussed legislative bills related to EMS. **Regulation & Compliance – Ron Passmore, Division Director** **Emergency Operations – Karen Owens, Division Director** **Community Health and Technical Resources – Tim Perkins, Division Director** **Trauma & Critical Care – Mindy Carter, Division Director** **Additional OEMS Staff Reports – FARC –** Mike Berg gave a brief update on FARC division matters. There will not be a spring grant cycle. All previous grants that were awarded will be honored. The Financial Assistance Review Committee is looking at hardship grants and also ambulance needs (evaluation tool) and invoicing. **Daniel Linkins** – OMD Workshop in February. The committee discussed Bylaw changes in establishing the chair of the committee, term limits, and other concerns. Gary Samuels stated that the Bylaw Committee will be working on updating the Bylaws for each committee this Spring. **Dr. Brand made a motion to take these matters to the Bylaw Workgroup. The motion was seconded by Dr. E. Reed Smith. All committee members were in favor of the motion. The motion carried.**	**Attachment 'E'** **Attachment 'F'**
XIII. PUBLIC COMMENT	None.	
XIV. Future Quarterly Meeting Dates	~~January 4, 2024~~ April 4, 2024 July 11, 2024	

Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
	October 3, 2024	
XV. Adjournment	The meeting adjourned at approximately 1:39 p.m.	

Respectfully submitted by:
Wanda L. Street
Executive Secretary, Sr.

Attachment A

VA Board of Pharmacy Regulations Presentation

EMS Drug Kits

VDH Medical Direction Committee Meeting
January 4, 2024

Caroline Juran, RPh
Executive Director
Virginia Board of Pharmacy

Recent and Upcoming Actions

- U.S. Congress passed H.R.304 - *Protecting Patient Access to Emergency Medications Act of 2017*
- Board of Pharmacy *Guidance Document 110-41*
  - https://www.dhp.virginia.gov/media/dhpweb/docs/pharmacy/guidance/110-41.pdf
  - Summarizes hospital pharmacy drug exchange models, EMS preparation of its drug kits, and how to obtain a CSR for various purposes
- FDA to begin enforcing the *Drug Supply Chain Security Act* in 11/2024
  - Requires interoperable, electronic tracing at package level
  - May impact hospital drug kit exchange process

H.R.304 - *Protecting Patient Access to Emergency Medications Act of 2017*

- Requires DEA to promulgate regulations for new registration category for EMS agencies to administer Schedule II-V drugs.
- Notice of proposed rulemaking published 10/5/2020. Written public comment period closed 12/4/2020. Final regulations have not been published.
- Anticipated each EMS agency will need its own Controlled Substance Registration (CSR) to register with DEA. The current process by which kits are exchanged with hospital pharmacies in Virginia will likely no longer be allowed.

Models in Other States

- Per DEA, EMS vehicles have obtained drugs by operating under the registration of a hospital through one of two options.
  1. **EMS vehicle owned and operated by a hospital handles drugs under the hospital's registration.** EMS vehicle obtains drugs from hospital's pharmacy or emergency room, as an extension of the hospital pharmacy.
  2. **EMS agency is registered under a hospital registration by agreement**—that is, a private EMS agency enters into a formal agreement with a specified hospital to act as the hospital's agent. The hospital supplies each EMS vehicle with a prepared kit containing controlled substances needed by the EMS agency and replenishes the kit as necessary. (*more common*)
- **VA's model:** Most EMS do not have DEA registration, obtain sealed drug kit from a hospital, and exchange opened kits at various hospitals. Difficult for hospital pharmacies to ensure oversight.

Board of Pharmacy
Guidance Document 110-41

Current EMS Requirements and Allowances

- The following DOES NOT require a CSR:
  - Hospital pharmacy drug kit exchange model – kit for kit
  - Storage of prescription-only devices, medical gases, needles and syringes with no added drug.

- The following DOES require a CSR:
  - One-to-one exchange of Schedule VI* drugs with a hospital pharmacy
  - Storage of intravenous and irrigation fluids and/or any other Schedule II-VI drugs in the EMS station
  - EMS station or agency ordering and stocking its own drug inventory and preparing/stocking its own kits.
  - Storage of prepared hospital kits within the EMS station.

*Schedule VI = FDA-approved prescription-only drugs not in Schedules II-V. AKA "legend" drugs in other states.

Hospital Pharmacy Kit for Kit Exchange

- No CSR or DEA registration for an EMS station is required to participate.
- Most common practice; kit exchanged with local hospital pharmacy.
- Contains drugs in Schedules II – VI.
- Kit must be sealed; requirements to exchange kit once kit opened.
- Record of drugs administered must accompany the opened kit when exchanged.
- Sealed kit must be stored within the ambulance and at appropriate temperature.
- Kit may not be taken from the ambulance and stored within the EMS station.
  - Exception: if station had CSR for their address which authorized them to stock drugs within the building.

Medical Devices, Oxygen, and Syringes

- No CSR for an EMS station is required if:
  - Only stocking medical devices such as tubing, catheters, devices in an intubation kit, oxygen masks, nebulizer equipment, etc. with no added drug;
  - Stocking medical oxygen tanks;
  - Stocking needles and syringes.

One-to-One Exchange of Schedule VI Drugs between Hospital and EMS

In lieu of exchanging entire kit for a new sealed kit, EMS may obtain authority to exchange the "used" Schedule VI drug for a new Schedule VI drug without exchanging entire kit.

- Requires CSR. Can be issued to individual EMS station or EMS agency or multiple EMS agencies within a single jurisdiction (City/county)
- CSR for this specific purpose (no alarm or inspection needed).
- Hospital would need to provide Schedule VI drugs in a kit separate from the II-V.

One-to-One Exchange of Schedule VI Drugs

Applying for a CSR for one-to-one exchange:

- If CSR is for multiple stations or multiple agencies within a single jurisdiction, attach a list of the names and addresses of each station that intends to participate in the one-to-one exchange of Schedule VI drugs.
- Check “activity” for EMS Agency.
- Check box for Schedule VI in section for schedules requested.
- Provide a written description of business practice and indicate the CSR is being obtained for one-to-one exchange of Schedule VI drugs.
- No inspection is required.
- Must notify the Board of Pharmacy of any change in location for the CSR or to the list of agency stations participating.
- Responsible party must be someone authorized to administer drugs; supervising practitioner is the EMS OMD.
- Any change in responsible party or supervising practitioner – notify Board within 14 days.

Storage of IV and Irrigation Solutions

Storage on the ambulances only (no CSR required):

- Due to size, these solutions may be stored outside of the kit.
- Solutions must be stored in ambulance at appropriate temperature.

Storage within the EMS station (CSR required):

- If additional supplies of solutions need to be stored within the EMS station, station must first obtain a CSR for this purpose.
- No alarm needed if only stocking fluids with no added drug in the building - 18VAC110-20-710.
- CSR issued for this purpose *does* require an inspection prior to issuance.

EMS Prepares and Restocks its Own Kits

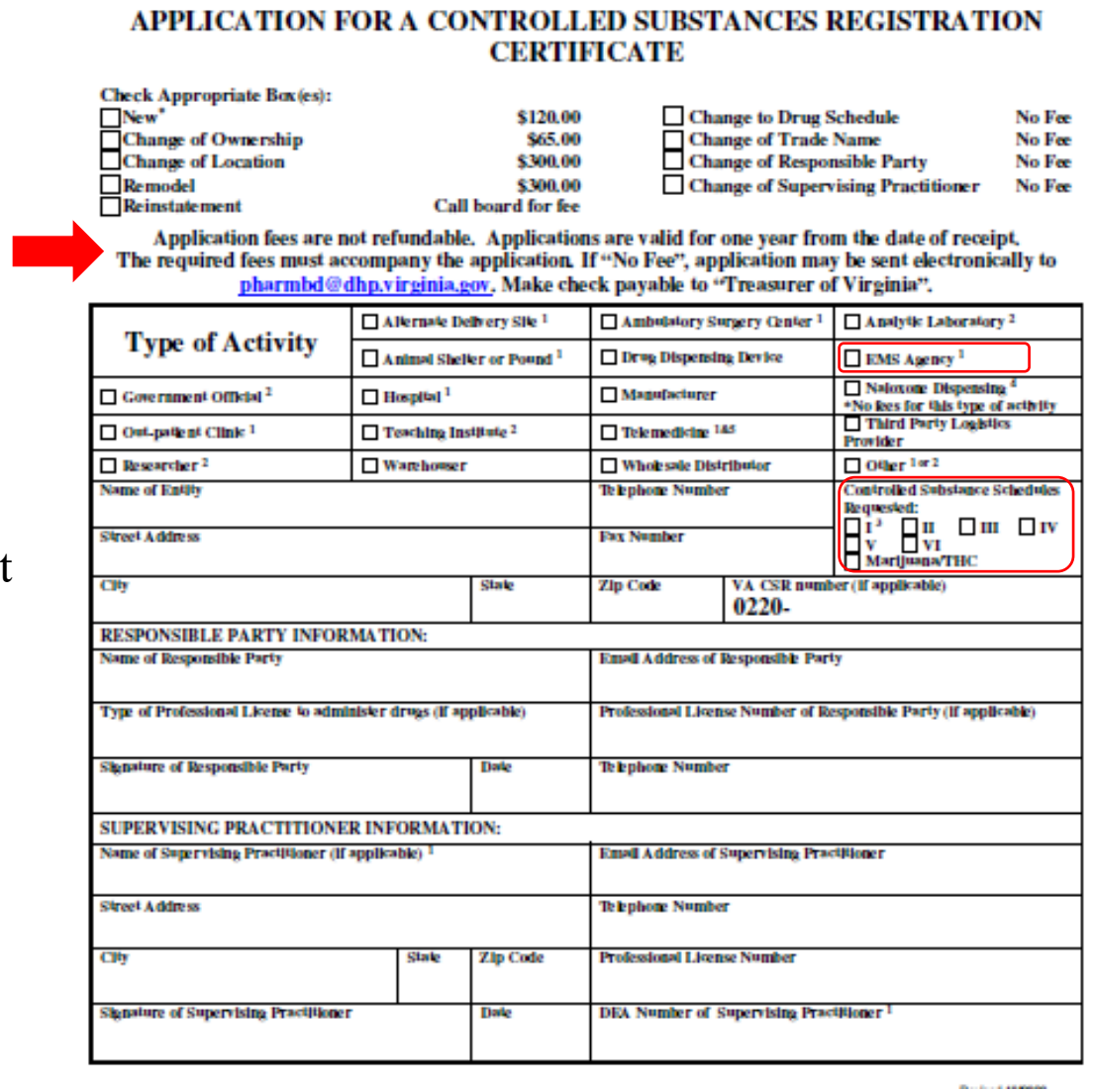
- Requires a CSR from the Board of Pharmacy.
- Two models:
  1) Each EMS station obtains its own CSR and DEA registration for purpose of ordering and stocking drugs for the preparation of that station's drug kits; or,
  2) EMS station obtains a CSR and DEA registration to order and stock drugs for preparation of drug kits for multiple stations within that one agency.
- Board inspection and alarm (monitored motion sensor, no cameras) required, unless staff on-site 24/7.
- EMS station solely responsible for securely storing drugs, preparing kits, and replacing drugs within kits when used for patient administration.
- EMS station responsible for reconciling accuracy of kit contents when kits have been unsealed, identifying and reporting thefts or losses to Board of Pharmacy, OEMS and DEA, and transferring drugs to someone authorized to possess and destroy unwanted drugs.

EMS Prepares and Restocks its Own Kits (cont.)

- Invoices from wholesale distributor must be maintained in accordance with §54.1-3404.
- Initial inventory of all drugs in Schedules II through V must be taken and then again at least every two years (not monthly).
- Prepared drug kits may not be stored in an EMS station other than the station listed on the CSR and DEA registration.
- If one station holds the CSR/DEA registrations to prepare kits for other stations within the agency, the ambulance must drive to the station preparing kits to exchange the opened kit for a new sealed kit.

Applying for a CSR to Stock Drugs for Preparing Own Drug Kits

- Type of activity – EMS agency
- Drug Schedules – check off any schedule of drug you may need for drug kits.
- Description of business practice - indicate that the EMS agency intends to order and store drugs for the preparation of its own drug kits or provide list of stations within the agency that it intends to provide kits for.
- Requirements of the Responsible Party – Must be someone authorized to administer drugs and able to provide daily oversight of drug security, recordkeeping, and compliance.
- Provide credentials for the responsible party.
- Supervising Practitioner – operational medical director (OMD).
- Report any changes to responsible party and/or supervising practitioner to board via application within 14 days of change.



APPLICATION FOR A CONTROLLED SUBSTANCES REGISTRATION CERTIFICATE

Check Appropriate Box(es):

☐ New*	$120.00	☐ Change to Drug Schedule	No Fee
☐ Change of Ownership	$65.00	☐ Change of Trade Name	No Fee
☐ Change of Location	$300.00	☐ Change of Responsible Party	No Fee
☐ Remodel	$300.00	☐ Change of Supervising Practitioner	No Fee
☐ Reinstatement	Call board for fee		

Application fees are not refundable. Applications are valid for one year from the date of receipt. The required fees must accompany the application. If "No Fee", application may be sent electronically to pharmbd@dhp.virginia.gov. Make check payable to "Treasurer of Virginia".

Type of Activity			
	☐ Alternate Delivery Site [1]	☐ Ambulatory Surgery Center [1]	☐ Analytic Laboratory [2]
	☐ Animal Shelter or Pound [1]	☐ Drug Dispensing Device	☐ EMS Agency [1]
☐ Government Official [2]	☐ Hospital [1]	☐ Manufacturer	☐ Naloxone Dispensing [4] *No fees for this type of activity
☐ Out-patient Clinic [1]	☐ Teaching Institute [2]	☐ Telemedicine [1&5]	☐ Third Party Logistics Provider
☐ Researcher [2]	☐ Warehouser	☐ Wholesale Distributor	☐ Other [1 or 2]
Name of Entity		Telephone Number	Controlled Substance Schedules Requested: ☐ I [3] ☐ II ☐ III ☐ IV ☐ V ☐ VI ☐ Marijuana/THC
Street Address		Fax Number	
City	State	Zip Code	VA CSR number (if applicable) 0220-

RESPONSIBLE PARTY INFORMATION:			
Name of Responsible Party			Email Address of Responsible Party
Type of Professional License to administer drugs (if applicable)			Professional License Number of Responsible Party (if applicable)
Signature of Responsible Party		Date	Telephone Number

SUPERVISING PRACTITIONER INFORMATION:			
Name of Supervising Practitioner (if applicable) [1]			Email Address of Supervising Practitioner
Street Address			Telephone Number
City	State	Zip Code	Professional License Number
Signature of Supervising Practitioner		Date	DEA Number of Supervising Practitioner [1]

Virginia Department of Health Professions

Inspections

- Inspection of drug storage location within building will be performed prior to issuance of CSR
  - Any deficiencies must be corrected before CSR may be issued.
- Alarm system requirements – if station is staffed 24/7 an alarm is not required.
- After issuance of the CSR, station may apply for DEA registration if stocking Schedules II-V.
- No drugs may be ordered or stored in station for this purpose prior to issuance of both CSR and DEA.
- Changes to approved drug storage location or security system require a CSR application for the change of location/remodel and an inspection. If moving to a new station or new drug storage area, drugs may not be relocated until the inspection is complete and area approved. DEA may also require an inspection prior to relocation.
- Routine unannounced board inspections occur approximately every 2 years.

QUESTIONS?

pharmbd@dhp.virginia.gov

804-367-4456

Attachment B

Quarterly Data Report

Virginia Department of Health

Office of Emergency Medical Services (OEMS)

Quarterly Report on EMS Incidents

Q3 2023

Office of Emergency Medical Services
1041 Technology Park Drive
Glen Allen, Virginia 23059
Phone: (804) 888-9100

This report is based on analyses requested by the Medical Direction Committee and performed by Office of EMS Epidemiology staff. The accuracy of the data within this report is limited by system performance and the accuracy of data submissions from EMS agencies.

Quarter 3 2023 data for this report was collected from the ESO Pre-hospital Data System (NEMSIS version 3.4) on December 6, 2023. Importantly, many records submitted by Virginia EMS agencies for incidents occurring during the third quarter of 2023 failed to pass established validation rules and are not counted in the dataset used for this report (see Table 1).

Table 1. Counts of Failed Records by Month, Third Quarter, 2023, Virginia

Month	Total Failed Records
July	4,231
August	4,558
September	4,302

Virginia EMS Call Summary, Third Quarter, 2023

EMS agencies in Virginia responded to a total of 435,697 EMS calls during the third quarter of 2023 (see Tables 2—5 and Figure 1).

Table 2. Number of EMS Incidents by Type of Service Requested and Disposition, Third Quarter, 2023, Virginia

Incident/ Patient Disposition	**Type of Service Requested**							**Total**
	911 Response (Scene)	Intercept/ Rendezvous	Interfacility Transport	Medical Transport	Mutual Aid	Public Assistance/ Not Listed	Standby	
Assist (Agency, Public, or Unit)	30,695	35	78	110	93	1,524	25	**32,560**
Canceled (Prior to Arrival at Scene or On Scene)	53,920	23	1,560	631	150	313	117	**56,714**
Patient Dead at Scene (with and without resucitation; with and without transport)	3,699	6	8	4	5	9	2	**3,733**
Patient Evaluated, No Treatment/Transport Required	3,770	2	22	18	5	59	20	**3,896**
Patient Refused Evaluation/Care (with or without transport)	25,686	42	46	56	18	70	31	**25,949**
Patient Treated, Released (AMA or per protocol)	17,872	31	8	18	21	115	66	**18,131**
Patient Treated, Transferred Care to Another EMS Unit	7,931	6	14	8	4	8	12	**7,983**
Patient Treated, Transported by Law Enforcement	448	0	0	0	0	5	0	**453**
Patient Treated, Transported by Private Vehicle	243	0	1	1	2	2	8	**257**
Patient Treated, Transported by this Unit	191,618	424	43,198	42,470	211	278	76	**278,275**
Standby (no services/support provided or public safety, fire, or EMS operational support provided)	5,791	2	7	64	44	148	1,317	**7,373**
Transport Non-Patient, Organs, etc.	0	0	24	236	1	78	0	**339**
Blank	3	0	9	20	0	2	0	**34**
Total	**341,676**	**571**	**44,975**	**43,636**	**554**	**2,611**	**1,674**	**435,697**

Table 3. Number of EMS Incidents by Type of Service Requested and Age Group, Third Quarter, 2023, Virginia

Type of Service Requested	Age Group							Total
	0-4 years	5-12 years	13-17 years	18-24 years	25-64 years	65 and older	Unknown	
911 Response (Scene)	4,678	4,257	5,850	15,965	114,692	111,419	84,815	**341,676**
Intercept/ Rendezvous	6	5	11	42	259	200	48	**571**
Interfacility Transport	813	708	937	1,084	14,974	25,394	1,065	**44,975**
Medical Transport	266	194	286	385	11,474	30,528	503	**43,636**
Mutual Aid	4	3	8	19	157	128	235	**554**
Public Assistance/ Other Not Listed	26	9	19	24	351	797	1,385	**2,611**
Standby	3	13	42	30	135	44	1,407	**1,674**
Total	**5,796**	**5,189**	**7,153**	**17,549**	**142,042**	**168,510**	**89,458**	**435,697**

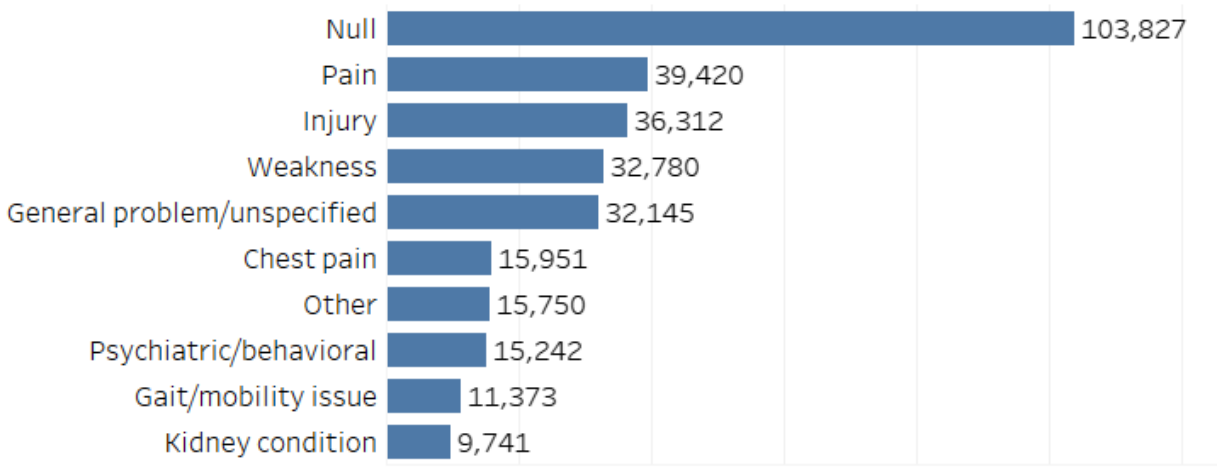
Table 4. Number of EMS Incidents by Patient Disposition and Age Group, Third Quarter, 2023, Virginia

Incident/ Patient Disposition	Age Group							Total
	0-4 years	5-12 years	13-17 years	18-24 years	25-64 years	65 and older	Unknown	
Assist (Agency, Public, or Unit)	140	100	103	324	2,892	4,598	24,403	**32,560**
Canceled (Prior to Arrival at Scene or On Scene)	26	18	43	86	796	968	54,777	**56,714**
Patient Dead at Scene (with and without resucitation; with and without transport)	10	5	30	104	1,606	1,896	82	**3,733**
Patient Evaluated, No Treatment/ Transport Required	180	146	165	383	1,611	1,408	3	**3,896**

Table 4 (continued). Number of EMS Incidents by Patient Disposition and Age Group, Third Quarter, 2023, Virginia

Incident/ Patient Disposition	Age Group							Total
	0-4 years	5-12 years	13-17 years	18-24 years	25-64 years	65 and older	Unknown	
Patient Refused Evaluation/Care (with or without transport)	822	663	960	2,280	10,777	7,783	2,664	**25,949**
Patient Treated, Released (AMA or per protocol)	513	633	712	1,785	8,760	5,714	14	**18,131**
Patient Treated, Transferred Care to Another EMS Unit	134	127	223	549	3,836	3,069	45	**7,983**
Patient Treated, Transported by Law Enforcement	2	11	18	59	337	22	4	**453**
Patient Treated, Transported by Private Vehicle	19	15	14	25	105	79	0	**257**
Patient Treated, Transported by this EMS Unit	3,906	3,455	4,865	11,927	111,093	142,784	245	**278,275**
Standby (no services/support provided or public safety, fire, or EMS operational support provided)	12	14	13	22	200	149	6,963	**7,373**
Transport Non-Patient, Organs, etc.	29	2	7	5	25	23	248	**339**
Blank	3	0	0	0	4	17	10	**34**
Total	**5,796**	**5,189**	**7,153**	**17,549**	**142,042**	**168,510**	**89,458**	**435,697**

Figure 1. All EMS Incidents by Top 10 Primary Impression Categories, Third Quarter, 2023, Virginia



Of the 435,697 total EMS calls that occurred during the third quarter of 2023, a total of 191,618 (44.0%) represented emergency response incidents (i.e., incidents with a Type of Service Requested equal to "911 Response (Scene)" and a Patient Disposition of "Patient Treated, Transported by this EMS Unit").

Figure 2. Emergency Responses by Top 10 Primary Impression Categories, Third Quarter, 2023, Virginia

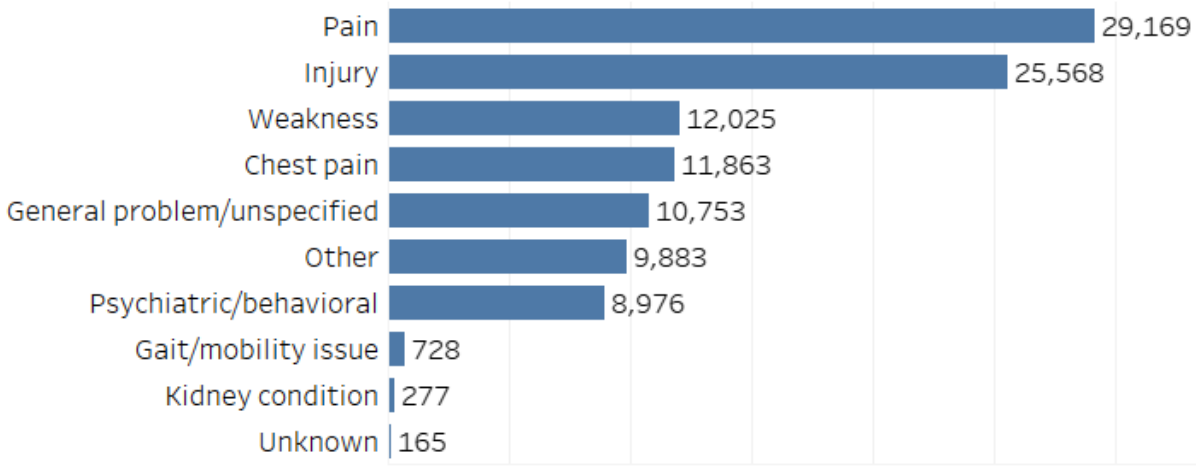


Table 5. Top 10 Primary Impressions for Emergency Responses by Patient Age Group, Third Quarter, 2023, Virginia

Provider Primary Impression	Age Group						
	0-4 years	**5-12 years**	**13-17 years**	**18-24 years**	**25-64 years**	**65 and older**	**Unknown**
1	Seizure/ convulsions	Injury	Injury	Injury	Pain	Pain	Obstetric condition
2	Injury	Pain	Psychiatric/ behavioral	Pain	Injury	Injury	General problem/ unspecified
3	General problem/ unspecified	Seizure/ convulsions	Pain	Psychiatric/ behavioral	Chest pain	Weakness	Injury
4	Fever	General problem/ unspecified	Seizure/ convulsions	Substance use/ effects of drug	Psychiatric/ behavioral	Other	Substance use/ effects of drug
5	Infection	Psychiatric/ behavioral	Substance use/ effects of drug	Seizure/ convulsions	Substance use/ effects of drug	General problem/ unspecified	Weakness
6	Fluid in/around the lungs	Allergic reaction	Syncope/near syncope	General problem/ unspecified	General problem/ unspecified	Chest pain	Other
7	Allergic reaction	Asthma	General problem/ unspecified	Chest pain	Weakness	Infection	Awareness/ consciousness problem
8	Other	Brain injury/ death	Allergic reaction	Nausea, vomiting, diarrhea	Other	Fluid in/around the lungs	Breathing abnormalities
9	Pain	Syncope/near syncope	Brain injury/ death	Syncope/near syncope	Seizures/ convulsions	Stroke/TIA	Cardiac arrest
10	Nausea, vomiting, diarrhea	Fluid in/around the lungs	Other	Obstetric condition	Nausea, vomiting, diarrhea	Nausea, vomiting, diarrhea	Fluid in/around the lungs

Chest Pain Emergency Responses

Importantly, a provider impression of "chest pain" can include multiple causes of chest pain, not specific or limited to chest pain of cardiac causes.

Non-Traumatic Chest Pain

Non-traumatic chest pain incidents are defined as those with a primary impression that includes the words "chest pain" and that do not have a response of "yes" in the possible injury (esituation.02) field. Twelve-lead acquisition is defined as ECG type (evitals.04) or Procedure (eprocedures.03) = 12 lead-left sided (normal), 12 lead-right sided, 15 lead, or 18 lead. Of the 191,618 emergency response incidents reported by EMS during the third quarter of 2023, 5,650 (2.9%) non-traumatic chest pain incidents were identified in patients 35 years of age and older. Of these, a total of 4,737 (83.8%) patients had 12-lead acquisition and 2,644 (46.8%) had aspirin administration documented in the record, either taken daily or administered by EMS.

Table 6. Emergency Responses Among Non-Traumatic Chest Pain Patients ≥ 35 Years of Age with 12-lead Acquisition by EMS Regional Council, Third Quarter 2023, Virginia

EMS Regional Council	Number Patients	Number of Patients with 12-Lead Acquisition	Percent With 12-Lead Acquisition Documented	Percent Without 12-Lead Acquisition Documented
Blue Ridge	376	350	93.1	6.9
Central Shenandoah	234	204	87.2	12.8
Lord Fairfax	85	71	83.5	16.5
Northern Virginia	586	300	51.2	48.8
Old Dominion	1,138	972	85.4	14.6
Peninsulas	447	399	89.3	10.7
Rappahannock	299	272	91.0	9.0
Southwest Virginia	550	442	80.4	19.6
Thomas Jefferson	133	114	85.7	14.3
Tidewater	1,136	1,026	90.3	9.7
Western Virginia	660	586	88.8	11.2
Out of State	6	1	16.7	83.3
Total	**5,650**	**4,737**	**83.8**	**16.2**

Table 7. Emergency Responses Among Non-Traumatic Chest Pain Patients ≥ 35 Years of Age with Aspirin Administration* by EMS Regional Council, Third Quarter 2023, Virginia

EMS Regional Council	Number Patients	Number of Patients with Aspirin Administration	Percent With Aspirin Administration Documented	Percent Without Aspirin Administration Documented
Blue Ridge	376	188	50.0	50.0
Central Shenandoah	234	134	57.3	42.7
Lord Fairfax	85	31	36.5	63.5
Northern Virginia	586	208	35.5	64.5
Old Dominion	1,138	604	53.1	46.9
Peninsulas	447	209	46.8	53.2
Rappahannock	299	145	48.5	51.5
Southwest Virginia	550	273	49.6	50.4
Thomas Jefferson	133	74	55.6	44.4
Tidewater	1,136	467	41.1	58.9
Western Virginia	660	310	47.0	53.0
Out of State	6	1	16.7	83.3
Total	**5,650**	**2,644**	**46.8**	**53.2**

*Includes documentation of medication administration or relevant pertinent negative.

Narrative Review

Of the 3,006 non-traumatic chest pain incidents occurring in patients ≥ 35 years of age without aspirin administration or a pertinent negative documented, 25 incidents were randomly selected for narrative review. Aspirin administration was documented in the narrative for 6 (24.0%) incidents. For all six incidents, aspirin was administered prior to arrival of EMS. A pertinent negative was documented in the narrative for 1 (4.0%) incident. The remaining 18 (72.0%) records did not have aspirin administration or a pertinent negative documented in the narrative.

STEMI Patients

STEMI incidents are defined as those with a documented:

- impression or symptom of myocardial infarction, or
- impression or symptom of unstable angina or angina pectoris and a cardiac rhythm of left bundle branch block, or
- cardiac rhythm of STEMI, or
- STEMI protocol used, or
- STEMI pre-arrival activation.

Time to receive an EKG is defined as the difference between the date/time the EMS clinician arrived at the patient and the date/time an EKG was performed. Of the 191,618 emergency response incidents reported by EMS during the third quarter of 2023, 1,037 (0.5%) STEMI incidents were identified. Of these, 785 (75.7%) patients had 12-lead acquisition, with 769 (98.0%) records containing information on the time between arrival at patient and when an EKG was performed. It took a median of 7 minutes and 0 seconds and an average of 10 minutes and 43 seconds for the 769 STEMI patients to receive an EKG.

Stroke Emergency Responses

Stroke incidents are defined as those with a documented primary/secondary impression of stroke, a positive stroke scale score, a destination activation for stroke, or a stroke/TIA protocol used by an EMS clinician. Of the 191,618 emergency response incidents reported by EMS during the third quarter of 2023, 5,131 (2.7%) stroke incidents were identified. Of the stroke incidents, 4,058 (79.1%) documented the performance of a stroke scale, 4,685 (91.3%) had a blood glucose or pertinent negative recorded, and 4,982 (97.1%) had the date/time the patient was last known well or the date/time of the patient's symptom onset recorded. For 1,134 (22.1%) patients, the interval between symptom onset and EMS clinician arrival at the patient was greater than 4.5 hours and less than 24 hours.

Table 8. Emergency Responses Among Stroke Patients by Destination Hospital Stroke Certification Level and EMS Regional Council, Third Quarter 2023, Virginia

EMS Regional Council	Number Stroke Patients	Number of Patients Transported to Out of State Facilities	Number (Percent) of Patients Not Transported to a Certified Facility	Number (Percent) of Patients Transported to Acute Stroke Ready Facilities	Number (Percent) of Patients Transported to Primary Stroke Centers	Number (Percent) of Patients Transported to Thrombectomy Capable Hospitals	Number (Percent) of Patients Transported to Comprehensive Stroke Centers
Blue Ridge	223	0 (0.0)	17 (7.6)	0 (0.0)	1 (0.4)	205 (91.9)	0 (0.0)
Central Shenandoah	206	0 (0.0)	25 (12.1)	0 (0.0)	179 (86.9)	0 (0.0)	2 (1.0)
Lord Fairfax	101	0 (0.0)	16 (15.8)	0 (0.0)	85 (84.2)	0 (0.0)	0 (0.0)
Northern Virginia	896	3 (0.3)	52 (5.8)	19 (2.1)	352 (39.3)	152 (17.0)	318 (35.5)
Old Dominion	1,011	0 (0.0)	82 (8.1)	2 (0.2)	365 (36.1)	2 (0.2)	560 (55.4)
Peninsulas	358	0 (0.0)	19 (5.3)	0 (0.0)	138 (38.5)	0 (0.0)	201 (56.1)
Rappahannock	359	0 (0.0)	42 (11.7)	0 (0.0)	304 (84.7)	0 (0.0)	13 (3.6)
Southwest Virginia	250	60 (24.0)	155 (62.0)	0 (0.0)	33 (13.2)	2 (0.8)	0 (0.0)
Thomas Jefferson	183	0 (0.0)	10 (5.5)	0 (0.0)	12 (6.6)	3 (1.6)	158 (86.3)
Tidewater	885	15 (1.7)	39 (4.4)	39 (4.4)	548 (61.9)	0 (0.0)	244 (27.6)
Western Virginia	639	16 (2.5)	132 (20.7)	37 (5.8)	226 (35.4)	227 (35.5)	1 (0.2)
Out of State	20	16 (80.0)	1 (5.0)	0 (0.0)	0 (0.0)	3 (15.0)	0 (0.0)
Total	**5,131**	**110 (2.1)**	**590 (11.5)**	**97 (1.9)**	**2,243 (43.7)**	**594 (11.6)**	**1,497 (29.2)**

Table 9. Emergency Responses Among Stroke Patients with Symptom Onset Between 4.5 and 24 Hours Prior to EMS Arrival by Destination Hospital Stroke Certification Level and EMS Regional Council, Third Quarter 2023, Virginia

EMS Regional Council	Number Stroke Patients	Number of Patients Transported to Out of State Facilities	Number (Percent) of Patients Not Transported to a Certified Facility	Number (Percent) of Patients Transported to Acute Stroke Ready Facilities	Number (Percent) of Patients Transported to Primary Stroke Centers	Number (Percent) of Patients Transported to Thrombectomy Capable Hospitals	Number (Percent) of Patients Transported to Comprehensive Stroke Centers
Blue Ridge	50	0 (0.0)	1 (2.0)	0 (0.0)	0 (0.0)	49 (98.0)	0 (0.0)
Central Shenandoah	44	0 (0.0)	4 (9.1)	0 (0.0)	40 (90.9)	0 (0.0)	0 (0.0)
Lord Fairfax	16	0 (0.0)	2 (12.5)	0 (0.0)	14 (87.5)	0 (0.0)	0 (0.0)
Northern Virginia	174	2 (1.1)	8 (4.6)	9 (5.2)	73 (42.0)	29 (16.7)	53 (30.5)
Old Dominion	241	0 (0.0)	28 (11.6)	0 (0.0)	88 (36.5)	0 (0.0)	125 (51.9)
Peninsulas	80	0 (0.0)	3 (3.8)	0 (0.0)	30 (37.5)	0 (0.0)	47 (58.8)
Rappahannock	84	0 (0.0)	8 (9.5)	0 (0.0)	76 (90.5)	0 (0.0)	0 (0.0)
Southwest Virginia	50	9 (18.0)	33 (66.0)	0 (0.0)	8 (16.0)	0 (0.0)	0 (0.0)
Thomas Jefferson	41	0 (0.0)	3 (7.3)	0 (0.0)	2 (4.9)	0 (0.0)	36 (87.8)
Tidewater	228	6 (2.6)	4 (1.8)	5 (2.2)	142 (62.3)	0 (0.0)	71 (31.1)
Western Virginia	123	5 (4.1)	27 (22.0)	7 (5.7)	27 (22.0)	57 (46.3)	0 (0.0)
Out of State	3	3 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Total	**1,134**	**25 (2.2)**	**121 (10.7)**	**21 (1.9)**	**500 (44.1)**	**135 (11.9)**	**332 (29.3)**

Trauma Emergency Responses

Trauma incidents are defined as those meeting the criteria outlined in the VDH Office of EMS quarterly report on trauma incidents. Step 1, 2, and 3 trauma incidents are defined as those meeting the Virginia Field Trauma Triage Decision Scheme. Of the 191,618 emergency response incidents reported by EMS during the third quarter of 2023, 27,374 (14.3%) trauma incidents were identified; 34 (0.1%) of the trauma patients were noted to be in cardiac arrest. Of the 27,340 patients not in cardiac arrest, a total of 2,058 (7.5%) Step 1 patients, 457 (1.7%) Step 2 patients, 598 (2.2%) Step 3 patients, and 24,227 (88.6%) patients not meeting step criteria were noted. Details on the transport of Step 1, 2, and 3 trauma patients who were not in cardiac arrest can be found in Tables 10—12.

Table 10. Emergency Responses Among Step 1 Trauma Patients Not in Cardiac Arrest Transported to a Level 1/Pediatric or Level 2 Trauma Center by EMS Regional Council, Third Quarter 2023, Virginia

EMS Regional Council	Number Trauma Patients	Number (Percent) of Patients Transported to Level 1 Trauma Center	Number (Percent) of Patients Transported to Level 2 Trauma Center
Blue Ridge	48	1 (2.1)	44 (91.7)
Central Shenandoah	59	1 (1.7)	0 (0.0)
Lord Fairfax	47	1 (2.1)	23 (48.9)
Northern Virginia	480	223 (46.5)	106 (22.1)
Old Dominion	400	205 (51.3)	25 (6.3)
Peninsulas	131	3 (2.3)	75 (57.3)
Rappahannock	143	13 (9.1)	71 (49.7)
Southwest Virginia	120	8 (6.7)	0 (0.0)
Thomas Jefferson	74	56 (75.7)	2 (2.7)
Tidewater	336	158 (47.0)	8 (2.4)
Western Virginia	212	96 (45.3)	24 (11.3)
Out of State	8	5 (62.5)	1 (12.5)
Total	**2,058**	**770 (37.4)**	**379 (18.4)**

Table 11. Emergency Responses Among Step 2 Trauma Patients Not in Cardiac Arrest Transported to a Level 1/Pediatric or Level 2 Trauma Center by EMS Regional Council, Third Quarter 2023, Virginia

EMS Regional Council	Number Trauma Patients	Number (Percent) of Patients Transported to Level 1 Trauma Center	Number (Percent) of Patients Transported to Level 2 Trauma Center
Blue Ridge	3	0 (0.0)	3 (100.0)
Central Shenandoah	5	0 (0.0)	0 (0.0)
Lord Fairfax	1	0 (0.0)	0 (0.0)
Northern Virginia	77	47 (61.0)	21 (27.3)
Old Dominion	123	94 (76.4)	8 (6.5)
Peninsulas	34	0 (0.0)	33 (97.1)
Rappahannock	17	2 (11.8)	14 (82.4)
Southwest Virginia	17	3 (17.6)	0 (0.0)
Thomas Jefferson	16	14 (87.5)	1 (6.3)
Tidewater	110	80 (72.7)	5 (4.5)
Western Virginia	50	26 (52.0)	4 (8.0)
Out of State	4	4 (100.0)	0 (0.0)
Total	**457**	**270 (59.1)**	**89 (19.5)**

Table 12. Emergency Responses Among Step 3 Trauma Patients Not in Cardiac Arrest Transported to a Level 1/Pediatric, Level 2, or Level 3 Trauma Center by EMS Regional Council, Third Quarter 2023, Virginia

EMS Regional Council	Number Trauma Patients	Number (Percent) of Patients Transported to Level 1 Trauma Center	Number (Percent) of Patients Transported to Level 2 Trauma Center	Number (Percent) of Patients Transported to Level 3 Trauma Center
Blue Ridge	13	3 (23.1)	10 (76.9)	0 (0.0)
Central Shenandoah	20	1 (5.0)	0 (0.0)	0 (0.0)
Lord Fairfax	19	0 (0.0)	4 (21.1)	0 (0.0)
Northern Virginia	118	66 (55.9)	27 (22.9)	17 (14.4)
Old Dominion	87	58 (66.7)	6 (6.9)	17 (19.5)
Peninsulas	39	2 (5.1)	36 (92.3)	0 (0.0)
Rappahannock	26	3 (11.5)	19 (73.1)	0 (0.0)
Southwest Virginia	36	3 (8.3)	1 (2.8)	8 (22.2)
Thomas Jefferson	26	24 (92.3)	1 (3.8)	0 (0.0)
Tidewater	159	100 (62.9)	10 (6.3)	43 (27.0)
Western Virginia	52	16 (30.8)	3 (5.8)	14 (26.9)
Out of State	3	3 (100.0)	0 (0.0)	0 (0.0)
Total	**598**	**279 (46.7)**	**117 (19.6)**	**99 (16.6)**

Pain Emergency Responses

Pain incidents are defined as those with documented pain scale scores between 4 and 10.

Pain Scale Score 4—6

Of the 191,618 emergency response incidents reported by EMS during the third quarter of 2023, 25,277 (13.2%) incidents occurred among patients with a pain score of 4—6, with 2,198 (8.7%) patients receiving an analgesic (additional details provided in Tables 13—15). By age group, 107 (0.4%) incidents occurred among patients younger than 5 years of age, 403 (1.6%) incidents occurred among patients 5—12 years of age, 608 (2.4%) incidents occurred among patients 13—17 years of age, 1,724 (6.8%) incidents occurred among patients 18—24 years of age, 12,084 (47.8%) incidents occurred among patients 25—64 years of age, 10,349 (40.9%) incidents occurred among patients 65 years of age and older, and 2 (<0.1%) incidents occurred in patients whose age was not documented.

Narrative Review (Pain Scale Score 4—6)

Of the 23,079 incidents occurring among patients with a pain score of 4—6 without analgesic administration or a pertinent negative documented, 25 incidents were randomly selected for narrative review. Zero incidents had analgesic administration or a pertinent negative documented in the narrative.

Table 13. Emergency Responses Among Patients with Pain Score of 4—6 and Analgesic Administration* by Age Group, Third Quarter 2023, Virginia

Age Group	Number Pain Patients	Number of Patients Receiving an Analgesic	Percent With Analgesic Administration Documented	Percent Without Analgesic Administration Documented
0-4 years	107	8	7.5	92.5
5–12 years	403	51	12.7	87.3
13–17 years	608	96	15.8	84.2
18—24 years	1,724	159	9.2	90.8
25—64 years	12,084	1,068	8.8	91.2
65 years and older	10,349	816	7.9	92.1
Unknown	2	0	0.0	100.0
Total	**25,277**	**2,198**	**8.7**	**91.3**

*Includes documentation of medication administration or relevant pertinent negative.

Table 14. Emergency Responses Among Patients with Pain Score of 4—6 and Analgesic Administration* by EMS Regional Council, Third Quarter 2023, Virginia

EMS Regional Council,	Number Pain Patients	Number of Patients Receiving an Analgesic	Percent With Analgesic Administration Documented	Percent Without Analgesic Administration Documented
Blue Ridge	1,364	144	10.6	89.4
Central Shenandoah	1,028	117	11.4	88.6
Lord Fairfax	493	24	4.9	95.1
Northern Virginia	4,766	362	7.6	92.4
Old Dominion	4,561	271	5.9	94.1
Peninsulas	2,100	157	7.5	92.5
Rappahannock	1,690	236	14.0	86.0
Southwest Virginia	1,705	186	10.9	89.1
Thomas Jefferson	787	134	17.0	83.0
Tidewater	3,983	290	7.3	92.7
Western Virginia	2,776	264	9.5	90.5
Out of State	24	13	54.2	45.8
Total	**25,277**	**2,198**	**8.7**	**91.3**

*Includes documentation of medication administration or relevant pertinent negative.

Table 15. Analgesics Administered to Patients with Pain Score of 4—6, Third Quarter 2023, Virginia

Analgesic Administered	Number Analgesic Administrations†	Percent of Analgesics Administered
Acetaminophen	50	2.2
Dilaudid/Hydromorphone	1	<0.1
Fentanyl	1,770	77.0
Ibuprofen/Motrin	8	0.3
Ketamine	82	3.6
Ketorolac/Toradol	159	6.9
Morphine	228	9.9
Tylenol	0	0.0
Total	**2,298**	**100.0**

†The number of analgesic administrations is higher than the number of patients receiving an analgesic, as patients may receive more than one medication during an incident.

Pain scale score 7—10

During the third quarter of 2023, 34,960 incidents occurred among patients with a pain score between 7 and 10, with 4,667 (13.3%) patients receiving an analgesic (additional details provided in Tables 16—18). By age group, 86 (0.2%) incidents occurred among patients younger than 5 years of age, 342 (1.0%) incidents occurred among patients 5—12 years of age, 665 (1.9%) incidents occurred among patients 13—17 years of age, 2,144 (6.1%) incidents occurred among patients 18—24 years of age, 19,741 (56.5%) incidents occurred among patients 25—64 years of age, 11,977 (34.3%) incidents occurred among patients 65 years of age and older, and 5 (<0.1%) incidents occurred in patients whose age was not documented.

Narrative Review (Pain Scale Score 7—10)

Of the 30,293 incidents occurring among patients with a pain score of 7—10 without analgesic administration or a pertinent negative documented, 25 incidents were randomly selected for narrative review. A pertinent negative was documented in the narrative for 1 (4.0%) incident. The remaining 24 (96.0%) records did not have analgesic administration or a pertinent negative documented in the narrative.

Table 16. Emergency Responses Among Patients with Pain Score of 7—10 and Analgesic Administration* by Age Group, Third Quarter 2023, Virginia

Age Group	Number Pain Patients	Number of Patients Receiving an Analgesic	Percent With Analgesic Administration Documented	Percent Without Analgesic Administration Documented
0—4 years	86	22	25.6	74.4
5–12 years	342	97	28.4	71.6
13–17 years	665	165	24.8	75.2
18—24 years	2,144	309	14.4	85.6
25—64 years	19,741	2,534	12.8	87.2
65 years and older	11,977	1,540	12.9	87.1
Unknown	5	0	0.0	100.0
Total	**34,960**	**4,667**	**13.3**	**86.7**

*Includes documentation of medication administration or relevant pertinent negative.

Table 17. Emergency Responses Among Patients with Pain Score of 7—10 and Analgesic Administration* by EMS Regional Council, Third Quarter 2023, Virginia

EMS Regional Council	Number Pain Patients	Number of Patients Receiving an Analgesic	Percent With Analgesic Administration Documented	Percent Without Analgesic Administration Documented
Blue Ridge	1,369	249	18.2	81.8
Central Shenandoah	1,435	248	17.3	82.7
Lord Fairfax	987	68	6.9	93.1
Northern Virginia	5,654	924	16.3	83.7
Old Dominion	8,014	562	7.0	93.0
Peninsulas	3,306	394	11.9	88.1
Rappahannock	1,901	538	28.3	71.7
Southwest Virginia	1,794	264	14.7	85.3
Thomas Jefferson	1,132	251	22.2	77.8
Tidewater	5,562	616	11.1	88.9
Western Virginia	3,777	535	14.2	85.8
Out of State	29	18	62.1	37.9
Total	**34,960**	**4,667**	**13.3**	**86.7**

*Includes documentation of medication administration or relevant pertinent negative.

Table 18. Analgesics Administered to Patients with Pain Score of 7—10, Third Quarter 2023, Virginia

Analgesic Administered	Number Analgesic Administrations†	Percent of Analgesics Administered
Acetaminophen	70	1.4
Dilaudid/Hydromorphone	12	0.2
Fentanyl	3,796	78.0
Ibuprofen/Motrin	15	0.3
Ketamine	189	3.9
Ketorolac/Toradol	362	7.4
Morphine	419	8.6
Tylenol	2	<0.1
Total	**4,865**	**100.0**

†The number of analgesic administrations is higher than the number of patients receiving an analgesic, as patients may receive more than one medication during an incident.

Pediatric (<15 Years) Pain Emergency Responses

During the third quarter of 2023, 1,197 incidents with a recorded pain score between 4 and 10 were identified among patients younger than 15 years of age, with 186 (15.5%) patients receiving an analgesic (additional details provided in Tables 19—20).

Table 19. Emergency Responses Among Pediatric Patients with Pain Score of 4—10 and Analgesic Administration* by EMS Regional Council, Third Quarter 2023, Virginia

EMS Regional Council	Number Pediatric Pain Patients	Number of Patients Receiving an Analgesic	Percent With Analgesic Administration Documented	Percent Without Analgesic Administration Documented
Blue Ridge	40	6	15.0	85.0
Central Shenandoah	47	8	17.0	83.0
Lord Fairfax	27	4	14.8	85.2
Northern Virginia	316	53	16.8	83.2
Old Dominion	247	25	10.1	89.9
Peninsulas	95	9	9.5	90.5
Rappahannock	92	19	20.7	79.3
Southwest Virginia	57	12	21.1	78.9
Thomas Jefferson	44	8	18.2	81.8
Tidewater	142	28	19.7	80.3
Western Virginia	89	13	14.6	85.4
Out of State	1	1	100.0	0.0
Total	**1,197**	**186**	**15.5**	**84.5**

*Includes documentation of medication administration or relevant pertinent negative.

Table 20. Analgesics Administered to Pediatric Patients with Pain Score of 4—10, Third Quarter 2023, Virginia

Analgesic Administered	Number Analgesic Administrations†	Percent of Analgesics Administered
Acetaminophen	5	2.6
Dilaudid/Hydromorphone	0	0.0
Fentanyl	163	84.5
Ibuprofen/Motrin	0	0.0
Ketamine	9	4.7
Ketorolac/Toradol	6	3.1
Morphine	10	5.2
Tylenol	0	0.0
Total	**193**	**100.0**

†The number of analgesic administrations is higher than the number of patients receiving an analgesic, as patients may receive more than one medication during an incident.

Asthma Emergency Responses

Asthma incidents are defined as those with a primary impression that includes the words "asthma" or "reactive airway" or with a protocol that includes the word "asthma". Patients with a primary impression of chronic obstructive pulmonary disease are excluded. Of the 191,618 emergency response incidents reported by EMS during the third quarter of 2023, 2,153 (1.1%) asthma incidents were identified. By age group, 53 (2.5%) incidents occurred among patients younger than two years of age, 203 (9.4%) incidents occurred among patients 2 – 17 years of age, 1,896 (88.1%) incidents occurred among patients older than 18 years of age, and 1 occurred among a patient of unknown age. A total of 1,084 (50.3%) incidents had no steroid, magnesium, or Albuterol/ipratopium administration documented, while 1,069 (49.7%) incidents reported administration of at least one of the three medications or had a pertinent negative documented.

Narrative Review

Of the 1,084 asthma incidents occurring among patients without steroid, magnesium, or Albuterol/ipratropium administration or a pertinent negative documented, 25 incidents were randomly selected for narrative review. Medication administration was documented in the narrative for 9 (36.0%) incidents. Of these nine:

- In three instances, use of an inhaler or nebulizer prior to EMS arrival was noted in the narrative, with no detail provided on what medication was administered.
- In three instances, Albuterol was administered by EMS. Of these, 2 patients were also given a steroid by EMS.
- In two instances, Albuterol was administered prior to arrival of EMS. Of these, one patient was given a steroid prior to arrival of EMS and one patient was given a steroid by EMS.
- In one instance, a steroid was administered prior to arrival of EMS.

The remaining 16 (64.0%) records did not have medication administration or a pertinent negative documented in the narrative.

Table 21. Emergency Responses Among Asthma Patients with Albuterol/Ipratropium Administration* by Age Group, Third Quarter 2023, Virginia

Age Group	Number Asthma Patients	Number of Patients Receiving Albuterol/ Ipratropium	Percent With Albuterol/ Ipratropium Administration Documented	Percent Without Albuterol/Ipratropium Administration Documented
< 2 years	53	10	18.9	81.1
2 – 17 years	203	115	56.7	43.3
18 and older	1,896	916	48.3	51.7
Unknown	1	0	0.0	100.0
Total	**2,153**	**1,041**	**48.4**	**51.6**

*Includes documentation of medication administration or relevant pertinent negative.

Table 22. Emergency Responses Among Asthma Patients with Albuterol/Ipratropium Administration* by EMS Regional Council, Third Quarter 2023, Virginia

EMS Regional Council	Number Asthma Patients	Number of Patients Receiving Albuterol/ Ipratropium	Percent With Albuterol/ Ipratropium Administration Documented	Percent Without Albuterol/ Ipratropium Administration Documented
Blue Ridge	57	31	54.4	45.6
Central Shenandoah	55	23	41.8	58.2
Lord Fairfax	25	11	44.0	56.0
Northern Virginia	148	100	67.6	32.4
Old Dominion	299	162	54.2	45.8
Peninsulas	201	111	55.2	44.8
Rappahannock	211	87	41.2	58.8
Southwest Virginia	267	104	39.0	61.0
Thomas Jefferson	42	24	57.1	42.9
Tidewater	528	265	50.2	49.8
Western Virginia	320	123	38.4	61.6
Out of State	0	0	---	---
Total	**2,153**	**1,041**	**48.4**	**51.6**

*Includes documentation of medication administration or relevant pertinent negative.

Table 23. Emergency Responses Among Asthma Patients with Steroid Administration* by Age Group, Third Quarter 2023, Virginia

Age Group	Number Asthma Patients	Number Patients Receiving a Steroid	Percent With Steroid Administration Documented	Percent Without Steroid Administration Documented
< 2 years	53	0	0.0	100.0
2 – 17 years	203	10	4.9	95.1
18 and older	1,896	303	16.0	84.0
Unknown	1	0	0.0	100.0
Total	**2,153**	**313**	**14.5**	**85.5**

*Includes documentation of medication administration or relevant pertinent negative.

Table 24. Emergency Responses Among Asthma Patients with Steroid Administration* by EMS Regional Council, Third Quarter 2023, Virginia

EMS Regional Council	Number Asthma Patients	Number Patients Receiving a Steroid	Percent With Steroid Administration Documented	Percent Without Steroid Administration Documented
Blue Ridge	57	18	31.6	68.4
Central Shenandoah	55	9	16.4	83.6
Lord Fairfax	25	8	32.0	68.0
Northern Virginia	148	35	23.6	76.4
Old Dominion	299	26	8.7	91.3
Peninsulas	201	60	29.9	70.1
Rappahannock	211	22	10.4	89.6
Southwest Virginia	267	39	14.6	85.4
Thomas Jefferson	42	3	7.1	92.9
Tidewater	528	47	8.9	91.1
Western Virginia	320	46	14.4	85.6
Out of State	0	0	---	---
Total	**2,153**	**313**	**14.5**	**85.5**

*Includes documentation of medication administration or relevant pertinent negative.

Table 25. Emergency Responses Among Asthma Patients with Magnesium Administration* by Age Group, Third Quarter 2023, Virginia

Age Group	Number Asthma Patients	Number of Patients Receiving Magnesium	Percent With Magnesium Administration Documented	Percent Without Magnesium Administration Documented
< 2 years	53	0	0.0	100.0
2 – 17 years	203	3	1.5	98.5
18 and older	1,896	79	4.2	95.8
Unknown	1	0	0.0	100.0
Total	**2,153**	**82**	**3.8**	**96.2**

*Includes documentation of medication administration or relevant pertinent negative.

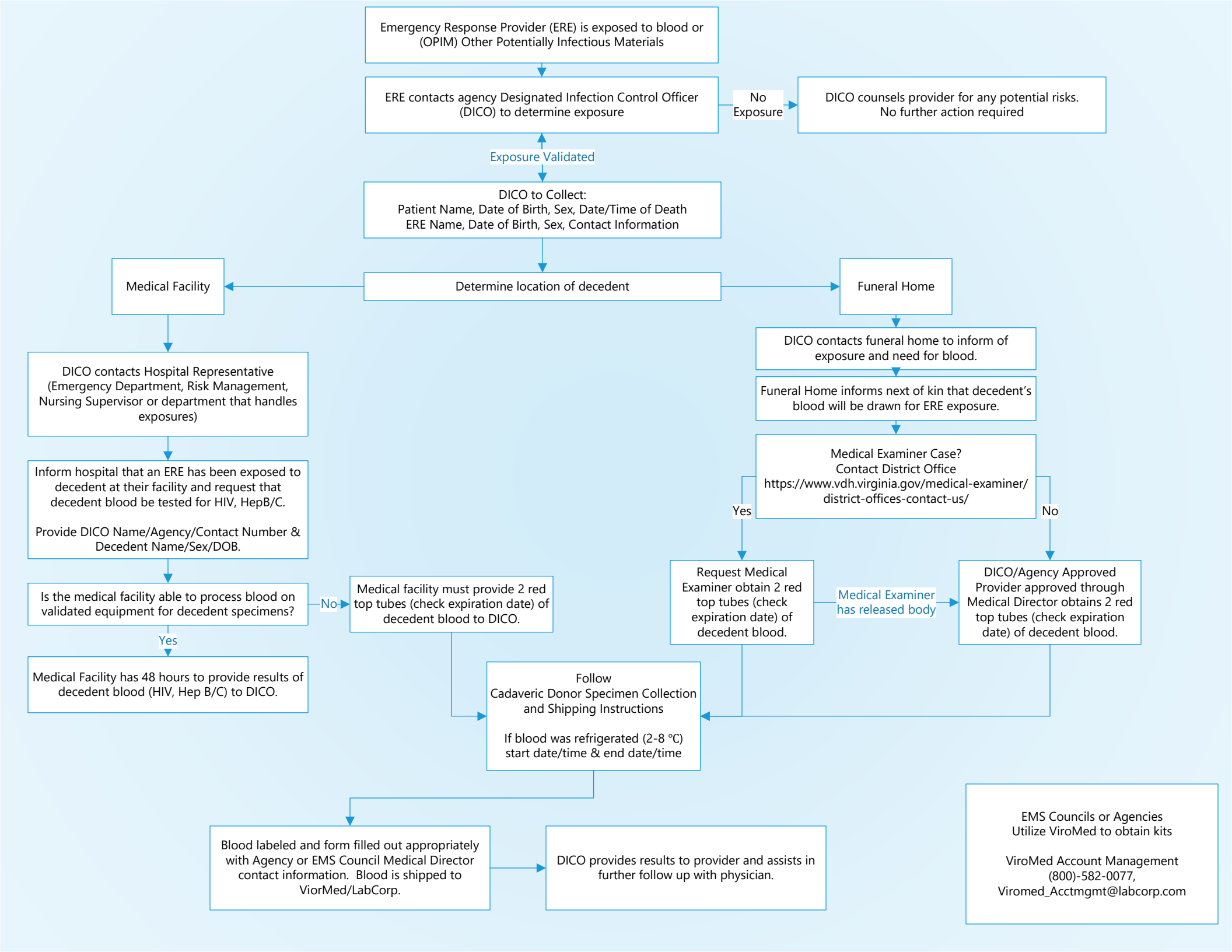
Table 26. Emergency Responses Among Asthma Patients with Magnesium Administration* by EMS Regional Council, Third Quarter 2023, Virginia

EMS Regional Council	Number Asthma Patients	Number of Patients Receiving Magnesium	Percent With Magnesium Administration Documented	Percent Without Magnesium Administration Documented
Blue Ridge	57	8	14.0	86.0
Central Shenandoah	55	0	0.0	100.0
Lord Fairfax	25	0	0.0	100.0
Northern Virginia	148	5	3.4	96.6
Old Dominion	299	6	2.0	98.0
Peninsulas	201	16	8.0	92.0
Rappahannock	211	3	1.4	98.6
Southwest Virginia	267	1	0.4	99.6
Thomas Jefferson	42	1	2.4	97.6
Tidewater	528	32	6.1	93.9
Western Virginia	320	10	3.1	96.9
Out of State	0	0	---	---
Total	**2,153**	**82**	**3.8**	**96.2**

*Includes documentation of medication administration or relevant pertinent negative.

Attachment C

Decedent Exposure Presentation


Emergency Response Provider (ERE) is exposed to blood or (OPIM) Other Potentially Infectious Materials
ERE contacts agency Designated Infection Control Officer (DICO) to determine exposure
No Exposure
DICO counsels provider for any potential risks. No further action required
Exposure Validated
DICO to Collect:
Patient Name, Date of Birth, Sex, Date/Time of Death
ERE Name, Date of Birth, Sex, Contact Information
Determine location of decedent
Medical Facility
Funeral Home
DICO contacts Hospital Representative (Emergency Department, Risk Management, Nursing Supervisor or department that handles exposures)
Inform hospital that an ERE has been exposed to decedent at their facility and request that decedent blood be tested for HIV, HepB/C.
Provide DICO Name/Agency/Contact Number & Decedent Name/Sex/DOB.
Is the medical facility able to process blood on validated equipment for decedent specimens?
No
Medical facility must provide 2 red top tubes (check expiration date) of decedent blood to DICO.
Yes
Medical Facility has 48 hours to provide results of decedent blood (HIV, Hep B/C) to DICO.
DICO contacts funeral home to inform of exposure and need for blood.
Funeral Home informs next of kin that decedent's blood will be drawn for ERE exposure.
Medical Examiner Case?
Contact District Office
https://www.vdh.virginia.gov/medical-examiner/district-offices-contact-us/
Yes
No
Request Medical Examiner obtain 2 red top tubes (check expiration date) of decedent blood.
Medical Examiner has released body
DICO/Agency Approved Provider approved through Medical Director obtains 2 red top tubes (check expiration date) of decedent blood.
Follow
Cadaveric Donor Specimen Collection and Shipping Instructions
If blood was refrigerated (2-8 ℃) start date/time & end date/time
Blood labeled and form filled out appropriately with Agency or EMS Council Medical Director contact information. Blood is shipped to ViorMed/LabCorp.
DICO provides results to provider and assists in further follow up with physician.
EMS Councils or Agencies
Utilize ViroMed to obtain kits
ViroMed Account Management
(800)-582-0077,
Viromed_Acctmgmt@labcorp.com

Attachment D

Cadaver Specimen Instructions

Cadaveric Donor Specimen Collection and Shipping Instructions

Components

- Specimen transport box
- Foam interior cooler
- Biohazard leak proof bag
- (2) 10 mL red-top tube
- Absorbent pouch
- Gel pack
- (3) Sealing tape
- FedEx Express Clinical Pak (large)
- FedEd Express billable stamp
- FedEx Saturday delivery sticker
- Specimen collection and shipping instruction

Collection Information:

- Create a unique identifier for the Donor ID (Suggestion: PPCR #)
- Check the expiration date to verify that the enclosed tubes have not expired
- Collect blood by venipuncture and if possible, centrifuge prior to shipment to ViroMed
- Label all tubes with 2 identifiers (patient name, DOB) and Donor ID
- Ensure both identifiers are on the test request form (2 identifiers much match)
- Ensure collection date and time is documented on the test request form.

Filling out the Cadeveric Donor Testing (ViroMed) form

- Use sticky labels from VIROMED form an affix to two Red Top tubes and place a third label on outside of foam cooler
- Check box - 'Account Bill'
- Under Donor ID - come up with a Unique Patient Identifier (not patient name).
    - Incident number or PPCR number could be used as identifier
    - This 'Donor ID' what will be used to notify you of results.
- Enter 'Collection Date'
- Enter 'Collection Time'
- Check box 'SST (Serum)'
- Check box 'Cadaveric' under Collection Status
- Contact should be name of DICO with contact number
- Enter Refrigerated 2-8 ℃ - 'Start Date/Time' & 'End Date/Time'
- Enter 'Packaged & Shipped Date/Time'
- {The goal is to clearly indicate on the test request form that appropriate temperatures have been maintained between the draw time/date and the ship time/date}
- Check Box 'Donor Panel 139730' under Research Panels

Specimen Packing and Transport Instructions

1. Clearly indicate on the test request form that appropriate temperatures have been maintained between the draw time/date and the ship time/date.
2. Remove foam interior cooler from ViroMed specimen transport box.
3. Place labeled tubes in sleeves of absorbent pouch
4. Place absorbent pouch in biohazard leak proof bag and seal completely.
5. Place test request form in outer pouch of biohazard bag.
6. Wrap the gel pack around the biohazard bag with tubes and place in foam cooler.
7. Place top of foam cooler and seal with 2 strips of sealing tape and then reinsert foam cooler into specimen transport box.

8. Close transport box and seal with remaining strip of sealing tape.
9. Place box in FedEx Express Clinical Pak.

Shipping Instructions

1. Complete “From” section in the upper left-hand corner of FedEx Express billable stamp.
2. Peel off removable label on right-hand side of billable stamp and attach to outside of FedEx Express Clinical Pak. Keep left-hand side of billable stamp for your records, it bears the shipment tracking number. Email FedEx tracking number to Viromed_shipment_notifications@labcorp.com
3. If it is a Friday, attach Saturday delivery sticker to FedEx Express Clinical Pak directly above the billable stamp.
4. Call FedEx at 800-463-3339 prior to FedEx deadline for specimen pick-up-generally 2:00 PM in most areas.
5. If specimen is drawn too late for FedEx pick up that day, contact ViroMed Laboratories at 800-582-0077 for special processing instructions.
6. Never place the shipment in a FedEx drop box.

Questions:

ViroMed Account Management – (800)-582-0077, Viromed_Acctmgmt@labcorp.com

CADAVERIC DONOR TESTING (VIROMED)

3450.12

REQUESTED BY

ViroMed LABORATORIES
LabCorp Specialty Testing Group
800-582-0077

VDH VA State Anantomical Program
400 E Jackson St
RICHMOND VA 23219
804-371-2143 VAR

45871570-1
EXK45871570

EXK45871570 EXK45871570 EXK45871570

CHECK ONE
03 LV ACCOUNT BILL

Donor ID or Patient's Legal Name (Last, First, MI)

Collection Date			Collection Time		Date of Birth		
MO	DAY	YR		AM PM	MO	DAY	YR
X			X				

Sex: ☐ M ☐ F Specimen Type: ☑ SST (Serum) ☐ EDTA (Plasma)

Collection Status: ☑ Cadaveric ☐ Pre-Mortem

Contact: Phone#

☒ Packaged & Shipped Date: MM / DD / YYYY Time: : AM PM

IF SPECIMEN REFRIGERATED OR FROZEN

Centrifuge / Pour Off Date: MM / DD / YYYY Time: : AM PM

Refrigerated 2-8 °C
Stored Refrigerated: (Start) Date / Time MM / DD / YYYY : AM PM
(End) Date / Time MM / DD / YYYY : AM PM

Temperature: °C
Stored Frozen: (Start) Date / Time MM / DD / YYYY : AM PM
(End) Date / Time MM / DD / YYYY : AM PM

Time Zone: ☑ EST ☐ CST ☐ MST ☐ PST

INDIVIDUAL COMPONENTS OF TEST COMBINATIONS / PROFILES LISTED IN THE SECTION ABOVE CAN BE ORDERED BELOW.

DONOR SCREENING TESTS

139530		HBcAb Total
139532		HBcAb Total w/reflex to IgM
139535		HBsAg
139540		HBsAg with reflex
139543		HCV Ab
139795		HIV/HCV/HBV NAT
139550		HIV-1/HIV-2 Plus O
139544		HIV-1/HIV-2 Plus O w/reflex to HIV-1 WB
139412		HTLV-I/II Ab
139414		HTLV-I/II Ab w/reflex to Immunoblot
139761		Syphilis (T. pallidum)
139819		West Nile Virus NAT

ADDITIONAL / CONFIRMATORY TESTS

139682		ABO/Rh
138820		HBsAg Neutralization
138981		HIV-1 Western Blot
138121		HIV-2 Immunoblot
138984		HTLV-I/II Immunoblot
016881		Hepatitis B core IgM

DONOR SCREENING PANELS

Syphilis *(T pallidum IgG)*

139732		Donor Panel 139732
139737		Donor Panel 139737
139739		Donor Panel 139739
139744		Donor Panel 139744
139230		Donor Panel 139230

RESEARCH PANELS

139715		Donor Panel 139715
139729		Donor Panel 139729
139730	X	Donor Panel 139730

OTHER TESTS / INDIVIDUAL PROFILE COMPONENTS

TEST # | TEST NAMES

VML USE ONLY

Specimens Received:

Red-Top _____ Serum _____
EDTA _____ Plasma _____ Other _____

Opened by: _____ Initial / Date

Package Information: (Circle all applicable choices)

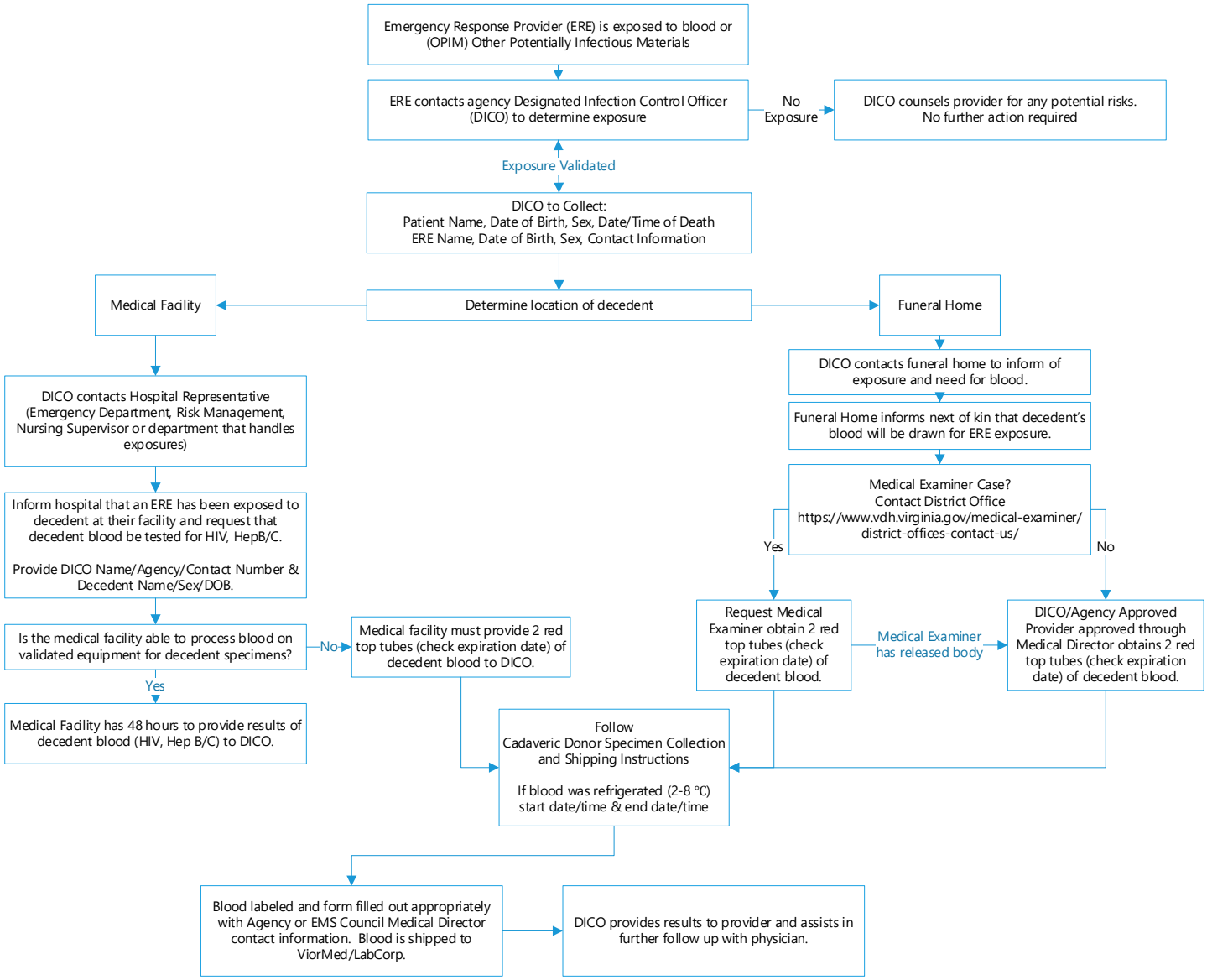
Frozen Refrigerated Ambient
NanoCool Shipper Gold/White Shipper Other

Other Comments: _____

PLEASE PRINT

PLEASE PRINT

ORIGINAL-LABORATORY / COPY-CLIENT


Emergency Response Provider (ERE) is exposed to blood or (OPIM) Other Potentially Infectious Materials
ERE contacts agency Designated Infection Control Officer (DICO) to determine exposure
No Exposure
DICO counsels provider for any potential risks. No further action required
Exposure Validated
DICO to Collect:
Patient Name, Date of Birth, Sex, Date/Time of Death
ERE Name, Date of Birth, Sex, Contact Information
Determine location of decedent
Medical Facility
Funeral Home
DICO contacts Hospital Representative (Emergency Department, Risk Management, Nursing Supervisor or department that handles exposures)
Inform hospital that an ERE has been exposed to decedent at their facility and request that decedent blood be tested for HIV, HepB/C.
Provide DICO Name/Agency/Contact Number & Decedent Name/Sex/DOB.
Is the medical facility able to process blood on validated equipment for decedent specimens?
No
Medical facility must provide 2 red top tubes (check expiration date) of decedent blood to DICO.
Yes
Medical Facility has 48 hours to provide results of decedent blood (HIV, Hep B/C) to DICO.
DICO contacts funeral home to inform of exposure and need for blood.
Funeral Home informs next of kin that decedent's blood will be drawn for ERE exposure.
Medical Examiner Case?
Contact District Office
https://www.vdh.virginia.gov/medical-examiner/district-offices-contact-us/
Yes
No
Request Medical Examiner obtain 2 red top tubes (check expiration date) of decedent blood.
Medical Examiner has released body
DICO/Agency Approved Provider approved through Medical Director obtains 2 red top tubes (check expiration date) of decedent blood.
Follow
Cadaveric Donor Specimen Collection and Shipping Instructions
If blood was refrigerated (2-8 ℃) start date/time & end date/time
Blood labeled and form filled out appropriately with Agency or EMS Council Medical Director contact information. Blood is shipped to ViorMed/LabCorp.
DICO provides results to provider and assists in further follow up with physician.

Attachment E

EMSSP Report

Virginia EMS Scholarship Program

Second Quarter Report

Virginia Department of Health

Office of Emergency Medical Services | January 2024

VDH VIRGINIA DEPARTMENT OF HEALTH

Virginia OFFICE OF EMERGENCY MEDICAL SERVICES

Background

The Virginia EMS Scholarship Program is managed by the Virginia Office of Emergency Medical Services providing scholarship awards to current Virginia EMS Providers and those seeking to become EMS providers in the Commonwealth.

The scholarship program supports students who are accepted into an eligible Virginia approved initial certification program–EMR, EMT, Advanced EMT and Paramedic.

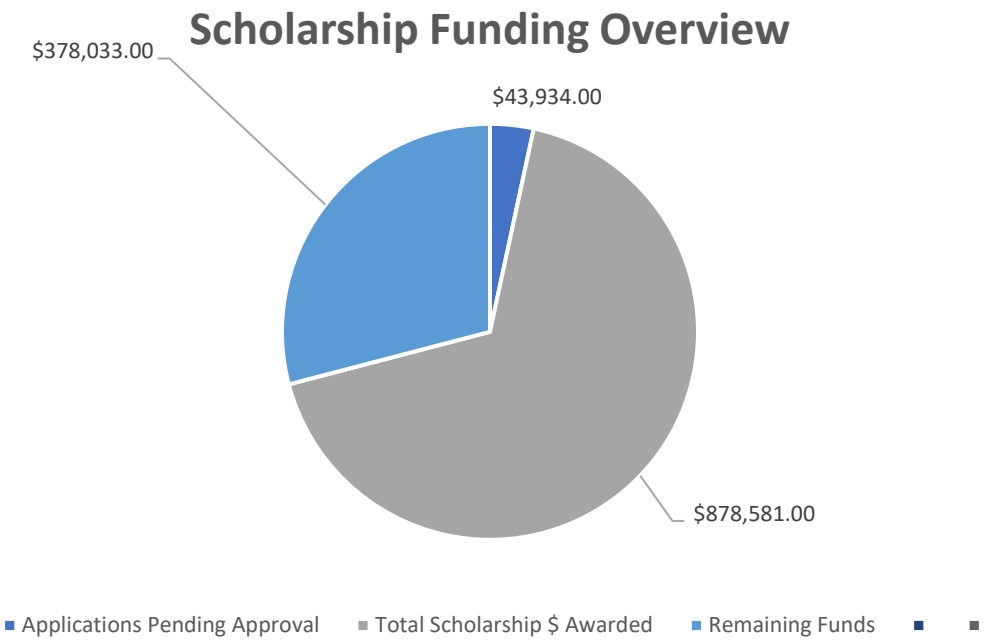
The scholarship program is not designed to provide 100% funding for a training program.

FY24 Scholarship Budget

The FY24 budget for the Virginia EMS Scholarship Program is $1,300,000.00. The following chart shows a breakdown of funding based on three (3) categories:

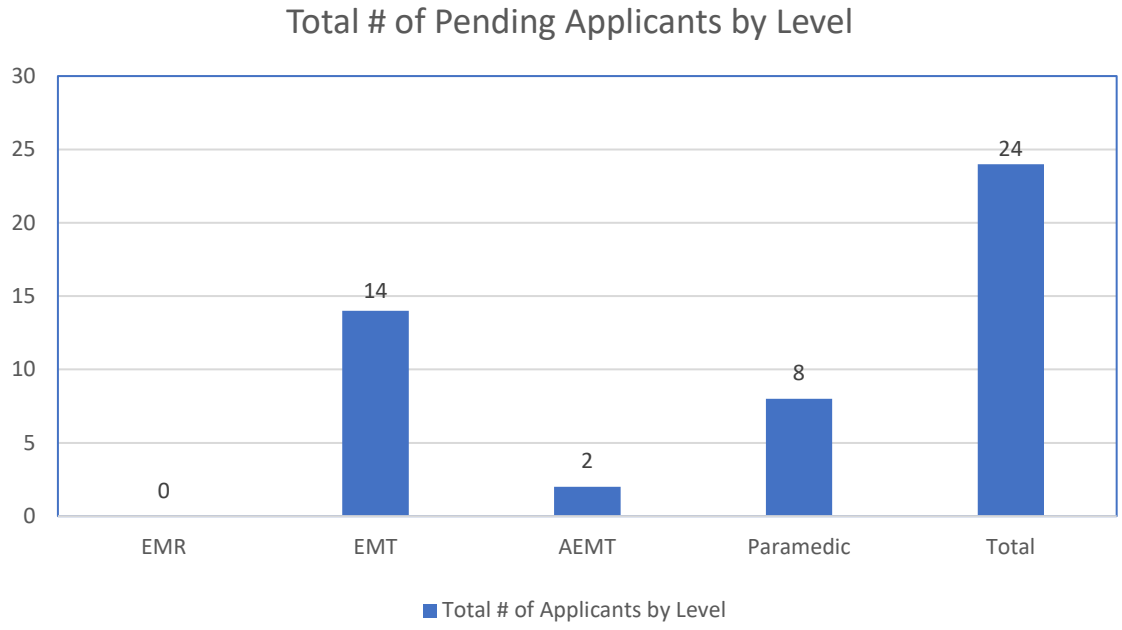
1) Applications Pending Approval
2) Total Scholarship $ Awarded
3) Remaining Funds

- **Application Pending Approval** – this category includes the total dollar value for all applications received through December 31, 2023. This covers Q2.
- **Total Scholarship $ Awarded** – this category is the total dollar value for all scholarship applications which have been approved and are in the process of being paid. Since the Virginia EMS Scholarship module is new, OEMS staff have only approved a small group of test applications as we work through the payment processes with the VDH Office of Financial Management.
- **Remaining Funds** – this category is the total dollar value of funds remaining in the scholarship program and available for to students for the remainder of the fiscal year.

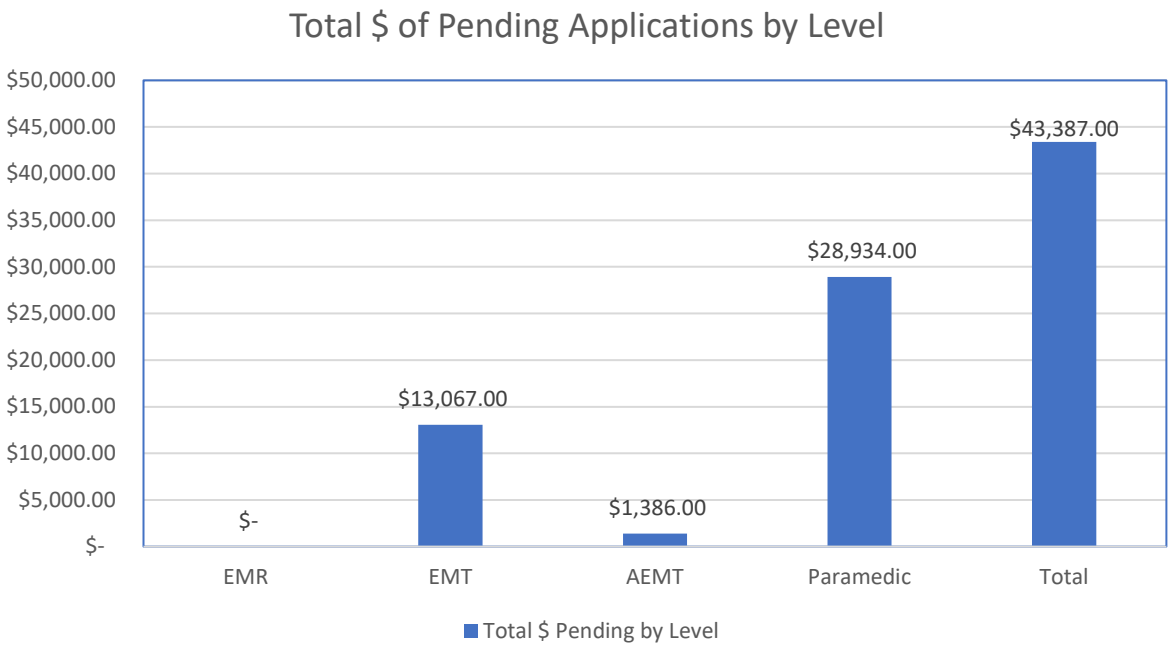


Breakdown of Pending Applications

The following chart show of pending scholarship applications by training level. This includes all pending applications for students enrolled in eligible initial certification courses from June 1, 2023 through December 31, 2023.

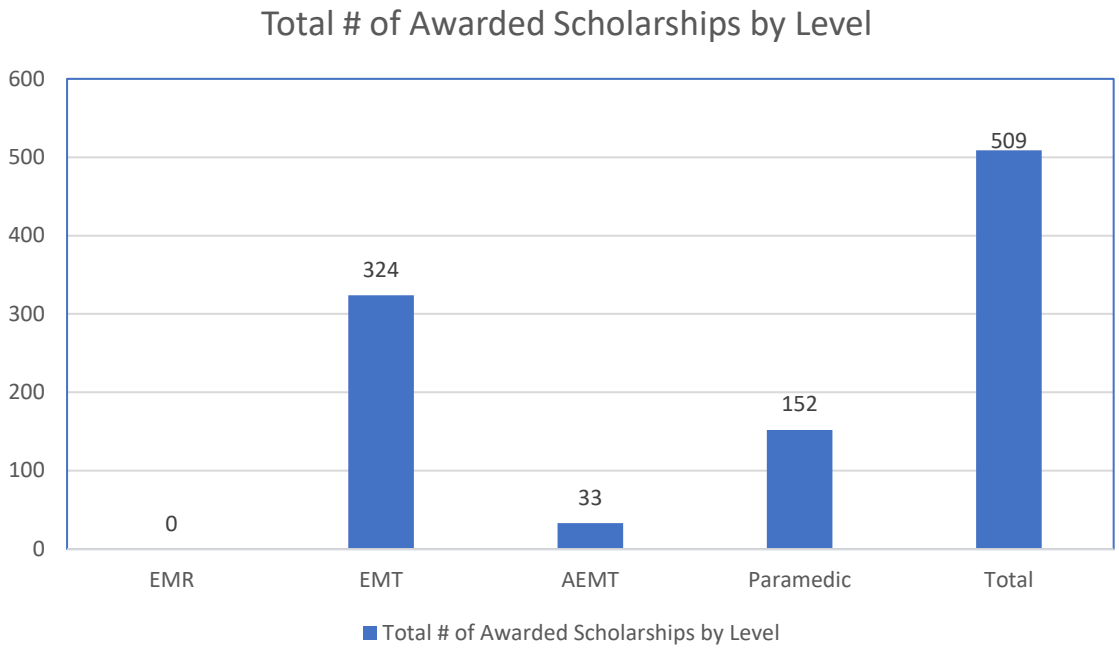


The following chart show of pending scholarship applications by training level. This includes all pending applications for students enrolled in eligible initial certification courses from June 1, 2023 through December 31, 2023.

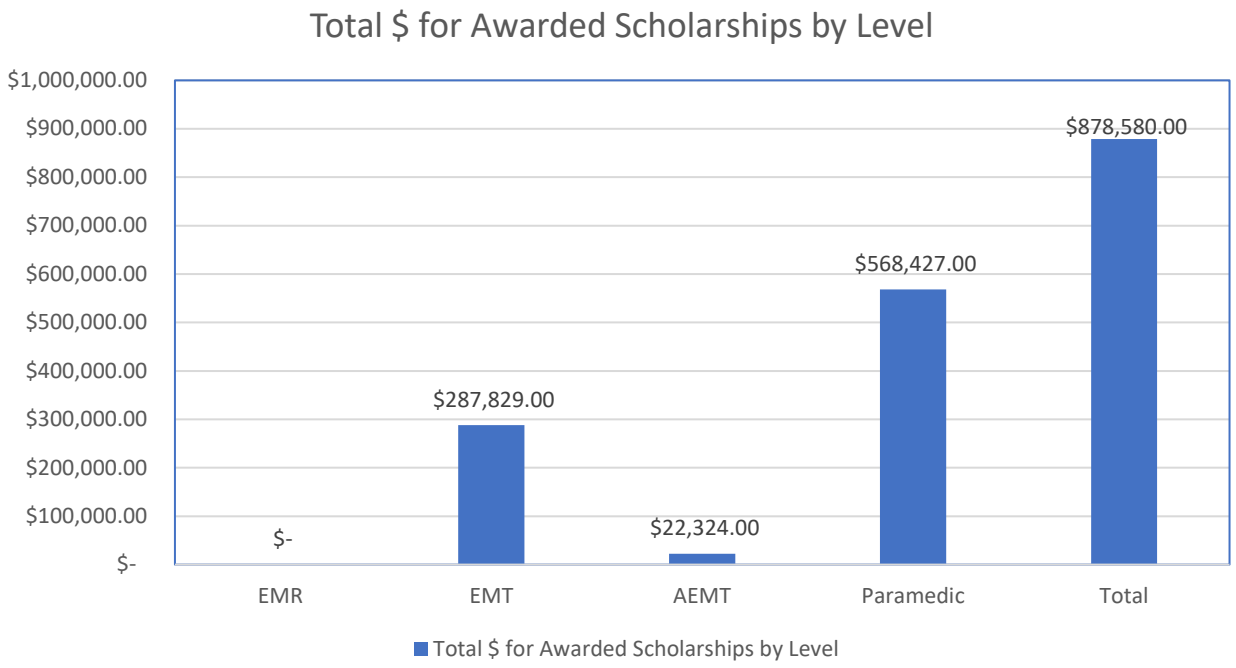


Breakdown of Awarded Scholarships

The following chart shows data for all scholarship applications which have been awarded by training level. This includes all awarded applications for students enrolled in eligible initial certification courses from June 1, 2023 through December 31, 2023.



The following chart shows data for all scholarship applications which have been awarded by training level. This includes all pending applications for students enrolled in eligible initial certification courses from June 1, 2023 through December 31, 2023.



Published by the:

Virginia Office of Emergency Medical Services
Division of Accreditation, Certification & Education
1041 Technology Park Drive
Glen Allen, VA 23059

VDH VIRGINIA DEPARTMENT OF HEALTH

Attachment F

Accreditation Report

Accredited Training Site Directory

As of January 1, 2024

Virginia
OFFICE OF EMERGENCY MEDICAL SERVICES
Virginia Department of Health

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Accredited Paramedic Training Programs in the Commonwealth

Site Name	Site Number	BLS Accredited	# of Alternate Sites	Accreditation Status	Expiration Date
Blue Ridge Community College	79005	Yes	--	CoAEMSP - LOR	
Brightpoint Community College	04115	Yes	--	CoAEMSP - Initial	CoAEMSP
Central Virginia Community College	68006	Yes	--	CoAEMSP – Continuing	CoAEMSP
Chesterfield Fire and EMS	04103	Yes	--	CoAEMSP – LOR	
ECPI University	70017	Yes	--	CoAEMSP – Initial	CoAEMSP
Germanna Community College	13720	Yes	--	CoAEMSP – LOR	
Hanover Fire EMS Training	08533	Yes	--	CoAEMSP - LOR	
Henrico County Division of Fire	08718	Yes	--	CoAEMSP – LOR	
J. Sargeant Reynolds Community College	08709	No	--	CoAEMSP – Continuing	CoAEMSP
Laurel Ridge Community College	06903	Yes	--	CoAEMSP – Continuing	CoAEMSP
Loudoun County Fire & Rescue	10704	Yes	--	CoAEMSP – Continuing	CoAEMSP
Newport News Fire Department	600975	Yes	--	CoAEMP – LOR	
Northern Virginia Community College	05906	Yes	--	CoAEMSP – Continuing	CoAEMSP
Patrick and Henry Community College	08908	No	--	CoAEMSP – Continuing	CoAEMSP
Piedmont Virginia Community College	54006	Yes	--	CoAEMSP – Continuing	CoAEMSP
Prince William County Dept. of Fire and Rescue	15312	Yes	--	CoAEMSP – Inactive	CoAEMSP
Radford University Carilion	77007	Yes	---	CoAEMSP – Continuing	CoAEMSP
Rappahannock Community College	11903	Yes	--	CoAEMSP – Initial	CoAEMSP
Southside Virginia Community College	18507	Yes	--	CoAEMSP – Continuing	CoAEMSP
Southwest Virginia Community College	11709	Yes	3	CoAEMSP – Continuing	CoAEMSP
Stafford County & Associates in Emergency Care	15319	Yes	11	CoAEMSP – Continuing	CoAEMSP
Tidewater Community College	81016	Yes	--	CoAEMSP – Continuing	CoAEMSP
VCU Health System Authority	76011	Yes	**7**	CoAEMSP – Continuing	CoAEMSP
Virginia Peninsula Community College	83012	Yes	2	CoAEMSP – Initial	

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

Radford University Carilion CoAEMSP Reaccreditation Site Visit is scheduled for February 8th and 9th and will be conducted virtually.
Rappahannock Community College CoAEMSP Reaccreditation Site Visit is schedule for April 4th and 5th.

Accredited AEMT Training Programs in the Commonwealth

Site Name	Site Number	BLS Accredited	# of Alternate Sites	Accreditation Status	Expiration Date
Accomack County Dept. of Public Safety	00121	No	--	State – LOR	December 31, 2024
Augusta County Fire and Rescue	01521	Yes	--	State – LOR	December 31, 2024
City of Virginia Beach Department of EMS	81004	Yes	--	State – LOR	December 31, 2024
Danville Training Center	69009	No	--	State – Full	December 31, 2024
Fauquier County Fire & Rescue – Warrenton	06125	Yes	--	State – LOR	December 31, 2024
Frederick County Fire & Rescue	06906	Yes	--	State – Full	December 31, 2024
Hampton Fire & EMS	83002	No	--	State – Full	December 31, 2024
Hampton Roads Regional EMS Academy (HRREMSA)	74039	Yes	--	State – LOR	December 31, 2024
James City County Fire Rescue	83002	Yes	--	State – Full	December 31, 2024
King George Fire, Rescue and Emergency Services	09910	No	--	State – LOR	December 31, 2024
Norfolk Fire and Rescue	71008	Yes	--	State – Full	December 31, 2024
Northern Neck Advanced EMS Education Alliance	19318	No	--	State – LOR	December 31, 2024
Paul D. Camp Community College	62003	Yes	--	State – Full	December 31, 2024
Richmond Ambulance Authority	76031	No	--	State – LOR	December 31, 2024
Rockingham County Fire and Rescue	16536	Yes	--	State – LOR	December 31, 2024
Southwest Virginia EMS Council	52003	Yes	--	State – Full	December 31, 2024
UVA Prehospital Program	54008	Yes	--	State – Full	December 31, 2024
WVEMS – New River Valley Training Center	75004	No	--	State – Full	December 31, 2024

Rockbridge County VRS has submitted a self-study for consideration of issuance of a Letter of Review.
Prince Edward VRS has submitted a self-study for consideration of issuance of a Letter of Review.

Accredited EMT Training Programs in the Commonwealth

Site Name	*Site Number*	*# of Alternate Sites*	*Accreditation Status*	*Expiration Date*
Albemarle Co Dept of Fire	54013	--	State – Letter of Review	December 31, 2024
Arlington County Fire Training	01305	--	State – Letter of Review	December 31, 2024
Fairfax County Fire & Rescue Dept.	05918	--	State – Letter of Review	December 31, 2024
Gloucester Volunteer Fire & Rescue	07302	--	State – Letter of Review	December 31, 2024
Navy Region Mid-Atlantic Fire EMS	71006	--	State – Full	December 31, 2024
Roanoke Valley Regional Fire/EMS Training	77505	--	State – Letter of Review	December 31, 2024
Spotsylvania County Fire & Rescue	63010	--	State – Letter of Review	December 31, 2024