MEDICAL DIRECTION COMMITTEE
Public Safety Training Center, 7093 Broad Neck Road, Hanover, VA 23069
April 6, 2017
10:30 AM

Members Present:	Members Absent:	Staff:	Others:
Marilyn McLeod, M. D. - Chair	Asher Brand, M.D.	Gary Brown	Gary Critzer
Forrest Calland, M.D.	Theresa Guins, M.D.	Scott Winston	Chad Blosser
Charles Lane, M.D.	Stewart Martin, M.D.	Michael Berg	Ron Passmore
George Lindbeck, MD	Paul Phillips, M.D.	Cam Crittenden	Tom Calogrides
Cheryl Lawson, M.D.	Christopher Turnbull, M.D.	Warren Short	James Gould
John Morgan, M.D.		Greg Neiman	Randall Geldreich, M.D.
Tania White, M.D.		Debbie Akers	Chris Christensen
Scott Weir, M.D.		Chuck Faison	Cathy Cockrell
Allen Yee, M.D.			Tracie Henriques
Chief Eddie Ferguson			Alix Paget-Brown
			Melissa Assalone

Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
I. Welcome	The meeting was called to order by Dr. McLeod at 10:42 a.m.	
II. Introductions	Introductions were made, Attendance as per sign-in roster	
III. Approval of Agenda		**Approved by consensus**
IV. Approval of Minutes	Approval of minutes from January 5, 2017	**Approved by consensus**
V. Drug Enforcement Administration (DEA) & Board of Pharmacy (BOP) Compliance Issues		
VI. Old Business	None	
VII. New Business		
A Training & Certification Committee Report – Dr. Charles Lane	1. Stated the committee met on April 5, 2017. Lively discussion concerning the future of EMSTF. Supported the motion from the workgroup concerning the Accreditation Program Internal Psychomotor Testing proposal. Will be moving to the state EMS Advisory Board in May. 2. Additional information from the TCC meeting will be presented by OEMS staff in their reports.	

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Topic/Subject		Discussion	Recommendations, Action/Follow-up; Responsible Person
B	Trauma Committee Report – Dr. Forrest Calland	3. Reported the taskforce working on Trauma System Consultation Report is ongoing to develop an organized and efficiently led statewide trauma system. Looking at how to sort out care of the injured from the myriad of incidences and find direct reporting line of this information. There is a desire to increase representation from Traumatologists from across the Commonwealth. 4. Report from Trauma Advisory Committee a. Stated they are discovering it is nearly impossible to follow the guidelines of the many plans in place across the Commonwealth b. Discussed draft 2016 annual report that was distributed. Stated a new report will be distributed in the near future sorted by EMS region and by EMS agency on the percentage of transport to a Tier 1 trauma center based on the criteria. Discussion by committee concerning how this information was being evaluated. Dr. Weir made recommendation to consider injury criteria and a missing vital signs before determining need for Level 1 trauma center transport. Committee requested verification that the data will be blinded and Dr. Calland offered verification.	
C	Expanding the AEMT Scope of Practice – Dr. Marilyn McLeod	Dr. McLeod presented to the committee a discussion she had with Chief David Hoback concerning the possibility for an expanded Scope of Practice for the AEMT, specifically in the area of cardiac care. Gary Critzer offered insight from the meeting that was held in Richmond with the Virginia Fire Chief's Association representatives. Dr. Lane presented information from the 2005 EMS Agenda for the Future and key points from those documents. Discussion by the committee. After motion died, committee agreed to review the information as it is presented from the new EMS Agenda committee that was recently formed in reference to the future Scope of Practice for the AEMT.	**Motion by Dr. Allen Yee that MDC consider the addition of cardiology care module to the AEMT level. No second received, motion died.**
D	DNR/POST – Dr. Scott Weir	Brought up discussion of whether an electronic or digital care record of a DNR is acceptable in lieu of physical paper copy. Michael Berg asked for clarification that this would be a Durable DNR and not a hospital issued DNR form. Prior to any change in policy, OEMS will request guidance from Amanda Lavin, Assistant Attorney General at Office of the Attorney General of VA. Clarification is needed to make sure recognizing an electronic or digital representation of a DDNR form does not conflict with existing statutory or regulatory language.	**Dr. Scott Weir made motion that electronic copies of DDNR be consistent with regulatory requirements and acceptable in lieu of physical copy. Seconded by Dr. John Morgan. Motion carried.**
VIII. Research Requests		None	
Committee Lunch Break – 12:10 – 12:45			

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IX. State OMD – George Lindbeck, MD			
A.	State Stroke Plan and CARES Registry	Code language requires that the Board of Health develop and maintain a component of the Statewide EMS Plan, a statewide prehospital and interhospital Stroke Triage Plan. Stroke Triage Plan was distributed by email. Stated 3 levels were added. Offered clarification and information about the document. Virginia Stroke System Task Force (VSSTF) asked for grid that was put together. AHA stroke guideline included as a reference. Dr. Weir offered information concerning recent information from JACHO and was there any validation for the stroke plan transport requirement to an acute stroke ready hospital rather than a designated primary stroke center. In depth discussion by committee. Information presented by Cam Crittenden, Trauma Division Manager for OEMS concerning criteria for determination. Requested opinion on the document. Information offered by committee and clarification sought.	
B	Scope of Practice – POC Testing in Field	Brought to the committee the question concerning point of care testing in the field. Discussion by committee. Offered guidance and direction to Dr. Lindbeck to update the Scope of Practice.	**Dr. Lindbeck will update Scope of Practice and will send to committee for review.**
C	Opiate Overdose Guidelines	Dr. Marilyn McLeod presented a PowerPoint draft concerning MDC Response to Opiod Overdoses. Dr. Lindbeck then offered information concerning document that was distributed to the committee. Discussion by committee concerning care of the overdose patient. Discussion concerning how post event education could benefit the patient. Will be discussed further at next quarterly meeting. 'Attachment A'	**Attachment 'A'**
D	Critical Care Transport	Addressed critical care transports. Long discussion by committee concerning changes needed to the Scope of Practice and clearer definition. Balloon pumps, and ECMO need to be defined in the Scope of Practice as outside the scope of the Paramedic. The committee discussed concerns on the scope of practice and how it related to critical care transports. The discussion led to the conclusion of the need to add exclusions to the scope of practice.	**Motion by Dr. Lindbeck that the Scope of Practice be revised to state that Balloon Pumps and ECMO be defined as outside the scope of practice for a Paramedic. Seconded by Dr. Lawson. Unanimously passed. Dr. McLeod to establish a workgroup to review critical care transports.**
E	EMS Agency Licensure	Dr. Lindbeck presented generic information concerning an EMS agency that has committed such egregious errors that the Medical Director immediately resigned. He advised the committee to be aware of EMS agency representatives requesting a new medical director because their previous medical director resigned.	
F	Scope of Practice	Brought to the committee's attention that the ability of the EMR to administer Narcan and the route had not been addressed in the Scope of Practice. Brought up discussion concerning the allowance of Intermediates to titrate administration of Propophol during transport. PCA Pumps – can an Intermediate transport a patient on a PCA pump that is preset at the facility? Patients on LVADs – could an EMT transport that patient?	**Motion by Dr. Allen Yee to modify the Scope of Practice procedures to allow an EMR to administer medications nasally and that the Scope of Practice formulary be amended**

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			to allow the administration of Narcan. Seconded by Dr. Charles Lane. Motion carried.
Office of EMS Reports			
Division of Educational Development Staff			
A	BLS Training Specialist – Greg Neiman (Given by Debbie Akers)	1. EC Institute a. Last Institute under the old process b. Written Exam Deadline is April 23rd, candidates taking the exam at the office over the next few days c. Psychomotor Exam is May 6th d. Next Institute is June 24-28 and will be held in the Richmond area e. New EC process has been approved and will be implemented when all of the mechanisms are in place for the new model 2. Updates a. The DED Division will stay on the road for 2017. i. Saturday Updates were held in ODEMSA in February and TJEMS in March. ii. Next Update is in LFEMSC on Saturday, April 22nd, 2017 b. See the latest schedule on the OEMS webpage: http://www.vdh.virginia.gov/OEMS/Training/EMS_InstructorSchedule.htm	
B	ALS Training Specialist – Debbie Akers	1. 2012/2016 New CE Requirements a. E-mail went out on Tuesday, April 4th regarding the transition to the 2016 National Continued Competency Program (NCCP) b. The Office completed the conversion in the Training database on Monday, April 3rd c. EMS Educators should announce new courses to capture these changes. d. With redistribution, 60 people who had recertified after 10/1/16 have gained recertification eligibility. New hour allocations mean they no longer meet the 2016 requirements. OEMS will contact EMS providers affected by this change to determine how they wish to proceed. e. Identified some issues with EMS providers and CE timelines. OEMS will follow up. 2. NR Stats (**ATTACHMENT: B**) a. State results now match National Registry b. Remediation i. Continue to have EMS Educators sending people to take general CE to remediate ii. EMS Educators should review their students test results and design a focused remediation plan for each student requiring it. iii. Upon completion a letter must be sent to National Registry 3. Accreditation (**ATTACHMENT: C**) i. Report distributed ii. No significant changes	**See Attachment 'B'** **See Attachment 'C'**

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C	Training and Development Specialist – Chuck Faison	1. EMSTF – Chuck Faison a. Remains on hold in order to comply with State Procurement Laws b. Special Initiative has been re-opened for courses that starts January 1-June 30, 2017 i. Application Deadline is April 25 c. For FY18 Funding Distribution Model - Plan for implementation July 1, 2017 i. Looking at a scholarship model ii. Establishing a partnership with the Office of Health Equity for the application process d. CE Funding i. Establishing agreements with the Regional EMS Councils for funding distribution ii. Contracts have been approved by DGS iii. Will be reaching out and working with the Councils on the process Committee asked for clarification concerning eligibility, how the funding would be distributed, what defines need. Warren Short offered further clarification and stated that when the final document is available, information will be provided to all.	
D	Division of Educational Development Training Manager – Warren Short	1. EMS Symposium is scheduled a. Thanks to all who stepped up to teach at Symposium b. 359 Classes for 2017 Symposium	
Other OEMS Staff			
E	Regulation and Compliance Manager – Michael Berg	1. NOIRA a. Awaiting Governor's signature b. Will be published and Town Halls will be held (www.townhall.virginia.gov) 2. HB 2153 a. Allows Reciprocity for out of state DDNR. Effective July 1, 2017. Regulatory update to follow. 3. Documentation Policy – See Attachment 'D' a. Updated Policy Regarding when a Call Report needs to be created and reported b. If an EMS resource is utilized, a call report must be generated and submitted c. The policy will go into effect July 1 4. Guidelines for the Safe Transportation of Children a. NASEMSO approved – working with Dave Edwards to develop communications plan for distribution to EMS agencies – recommendations only. 5. VDH Sponsored Vaccination Events a. OEMS to participate in 15 events for 2017. See Attachment 'E'	**Attachment 'D'** **Attachment 'E'**
F	Executive Director – Gary Brown	1. REPLICA a. Have had 8th and 9th state pass, those being Wyoming and Mississippi b. Georgia has passed the bill and sitting on Governor's desk; they will be the 10th state 2. Stated that any comments concerning the use of the Public Safety Training Center for	
G	Assistant Director – Scott Winston	1. General Assembly a. SB1244 - Possession and Administration of Glucagon	**Dr. McLeod will work with committee**

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		i. Bill placed in subcommittee ii. Instead of going legislative route, patron agreed to have the EMS Advisory Board weigh in. iii. Bill was passed directing VDH to study this and OEMS has been tasked to review the referenced subject matter in the bill. iv. Response to the Senate Committee is due by November 1. b. HB1728 i. Introduced by a delegate at the request of a patron who utilized an air medical service and received a significant bill ii. Legislation introduced in Montana (SB444) and by a congressman from Ohio addressing the alleviation of the patient from paying the balance of the bill not covered by insurance. Bill intended to prevent surprise billing. iii. VDH has formed a Workgroup to review the rules, regulations and protocols governing the use of air medical services and develop recommendations for changes that address differences in dispatch and billing practices. iv. Report back to House Committee by November 1 v. OEMS is in the process of identifying individuals to serve on the workgroup to begin looking at the study requirements.	**members to provide a recommendation by the July meeting.**
H	Trauma Systems Director – Cam Crittenden	1. Has hired a Trauma System Coordinator – Comes from Ohio and will bring some insight from outside of Virginia.	
PUBLIC COMMENT			
For The Good Of The Order			
Future Meeting Dates for 2017		July 6, 2017, October 5, 2017	
Adjournment		2:18 pm	

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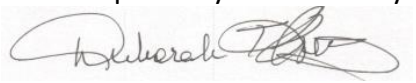
Respectfully submitted by:



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Deborah T. Akers
OEMS Staff Liaison
April 6, 2017

Attachment A

Opiod PowerPoint and Handouts

MDC Response to Opioid Epidemic

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The Problem

- By the end of 2016, the numbers of fatal opioid deaths had increased about 77 % from 2011
- In 2014, for the first time in Virginia, more people died from opioid overdoses than car accidents

- “As physicians, we are on the front lines of an opioid epidemic that is crippling communities across the country. We must accept and embrace our professional responsibility to treat our patient’s pain without worsening the current crisis.” Steven Stack, MD
- As EMS physicians, we have even more insight to our patients battles with opioids.

Limiting Opioids in EMS

- Opioids are inherently dangerous, highly addictive drugs with significant abuse potential
- They should be avoided whenever possible, and in most cases, initiated only after other modalities of pain control have been trailed

- Opioid alternatives should be used to manage patients whenever possible
- As Emergency Departments limit opioid use, EMS must follow suit

- EMS providers should be experts in evaluating the scene and home for evidence of drug abuse
- EMS should have a mechanism for offering materials for patients that desire treatment
- EMS should be able to distribute methods to access resources

- EMS providers should have a through understanding of Alternatives to Opioids(ALTO) protocols
- EMS Medical Directors should develop appropriate protocols with Alternatives to Opioids Medications

- EMS physicians and providers are encouraged to participate in an interdisciplinary pain management team that includes clinicians, nurses, pharmacists, social workers, and case managers

Harm Reduction

- Patients who abuse opioids should be managed without judgment; addiction is a medical condition and not a moral failure
- Empathy should be the response to these patients
- Patients who inject drugs should receive education on safe practices

- EMS patients that overdose, but refuse transport should be offered resources to help obtain naloxone
- Overdose patients should receive materials with appropriate resources should they desire help

- The vast majority of those who become addicted to opioids, both prescription and illicit, receive their first dose from a physician

- Patients that receive emergency care for opioid intoxication should receive ready to use naloxone

- EMS Medical Directors and providers should have a system in place for disposing of opioids

Protect our own

- MDC, Legislative and Planning, and Provider Health and Safety are initiating a joint project to develop a system to protect and treat any provider with an addiction problem

REVIVE

- Training system for police and other stakeholders to recognize and treat opioid overdose

BREMS REGION

- Developing a system with law enforcement and hospice to appropriately dispose of opioids after a patients death
- Working with mental health to have pamphlets to leave with patients and families after an opioid misadventure on resources for treatment of opioid addiction
- Developing cards with resources for obtaining naloxone

- Serving on the multidisciplinary committee for frequent ED visitors
- Distributing harm reduction information
- Working with CentraHealth to further develop our ATLO protocols – BREMS already utilizes Ketamine, Ketorolac, and Acetaminophen
- Working on obtaining funds to distribute naloxone to our high risk patients

REVIVE!
OPIOID OVERDOSE AND NALOXONE EDUCATION FOR VIRGINIA

REVIVE! Training Guide

I. Welcome and Introductions

Sign in and complete registration forms if needed.

Training Objectives

- Understand the REVIVE! program, including lay administration of naloxone, protection from civil liability, and the safe reporting of overdoses law
- Understand how opioid overdose emergencies happen and how to recognize them
- Understand how naloxone works
- Identify risk factors that may make someone more susceptible to an opioid overdose emergency
- Dispel common myths about how to reverse an opioid overdose
- Learn how to respond to an opioid overdose emergency with the administration of naloxone

II. Background and development of the REVIVE! Program

In 2013, the Virginia General Assembly passed House Bill 1672, directing the Virginia Department of Behavioral Health and Developmental Services (DBHDS), in conjunction with the Virginia Department of Health, the Virginia Department of Health Professions, law enforcement and the recovery community, to conduct a pilot project on the administration of naloxone to counteract the effects of an opioid overdose emergency. In 2015, the General Assembly passed House Bill 1458, which expanded REVIVE! to a statewide program; broadened immunity from civil liability to include anyone who prescribes, dispenses, or administers naloxone; allowed for an oral, written, or standing order that would allow an individual to obtain naloxone from a pharmacy without a prescription; and explicitly allowed law enforcement officers and fire fighters to carry and administer naloxone. Virginia is one of more than 25 states (plus the District of Columbia) that has enacted laws to allow for some form of naloxone access.

The 2015 General Assembly also passed House Bill 1500 and Senate Bill 892 which allow for the safe reporting of overdoses. These bills allow a person to assert an affirmative defense against the following charges:

- unlawful purchase, possession, or consumption of alcohol pursuant to § 4.1-305
- possession of a controlled substance pursuant to § 18.2-250
- possession of marijuana pursuant to § 18.2-250.1
- intoxication in public pursuant to § 18.2-388, or
- possession of controlled paraphernalia pursuant to § 54.1-3466.

An affirmative defense is a defense that alleges additional facts that defeats or mitigates the legal consequences of otherwise unlawful activity. You can still be charged with these crimes, but you can assert an affirmative defense against them if you are responding to an overdose emergency. To be able to assert an affirmative defense, ALL of the following criteria must be met:

1. You must in good faith seek or obtain medical attention for yourself or someone else experiencing an overdose emergency by reporting the event to a firefighter, emergency medical services personnel, a law enforcement officer, or an emergency 911 system;
2. You must remain at the scene of the overdose or an alternate location which you or the person who suffered the overdose has been transported until a law enforcement official responds to the reported overdose. If no law enforcement officer responds, you must cooperate with law enforcement as indicated and described in the other sections;
3. You must identify yourself to the law enforcement officer who responds;
4. If requested by a law enforcement officer, you must substantially cooperate in any investigation of any criminal offense reasonably related to the controlled substance or alcohol that led to the overdose; and
5. The evidence for the prosecution of an offense was obtained as a result of the individual seeking or obtaining emergency medical attention.

Finally, an affirmative defense may not be asserted if you sought or obtained emergency medical attention during the execution of a search warrant or during a lawful search or arrest.

III. Understanding and Identifying Opioid Overdose Emergencies

An opioid overdose emergency happens when an excessive amount of an opioid, or a combination of opioids and other substances overwhelms the body and causes it to shut down. Drugs such as heroin and prescription pain medications cause the central nervous system to become depressed, leading to breathing and heart rate slowing down and eventually ceasing entirely. Opioids include heroin as well as prescription pain medications that have generic, trade, and slang or street names:

Generic	Trade	Street
Hydrocodone	Lortab, Vicodin	Hydro, Norco, Vikes,Watsons
Oxycodone	Oxycontin,	Ox, Oxys. Oxycotton, Kicker, Hillbilly Heroin
Morphine	Kadian, MSContin	M, Miss Emma, Monkey, White Stuff
Codeine	Tylenol #3	Schoolboy, T-3s
Fentanyl	Duragesic	Apache, China Girl, China White, Goodfella, TNT
Hydromorphone	Dilaudid	Dill, Dust, Footballs, D, Big-D, M-2, M-80s, Crazy 8s, Super 8s
Oxymorphone	Opana	Blue Heaven, Octagons, Oranges, Pink, Pink Heaven, Stop Signs
Meperidine	Demerol	Dillies, D, Juice
Methadone	Dolophine, Methadose	Meth, Junk, Fizzies, Dolls, Jungle Juice
Heroin	N/A	Dope, Smack, Big H, Black Tar
Buprenorphine	Bunavail, Suboxone, Subutex,	Sobos, Bupe, Stops, Stop Signs, Oranges

The main difference between someone who is high and someone who is overdosing is that someone who is overdosing is **UNRESPONSIVE**. Other differences:

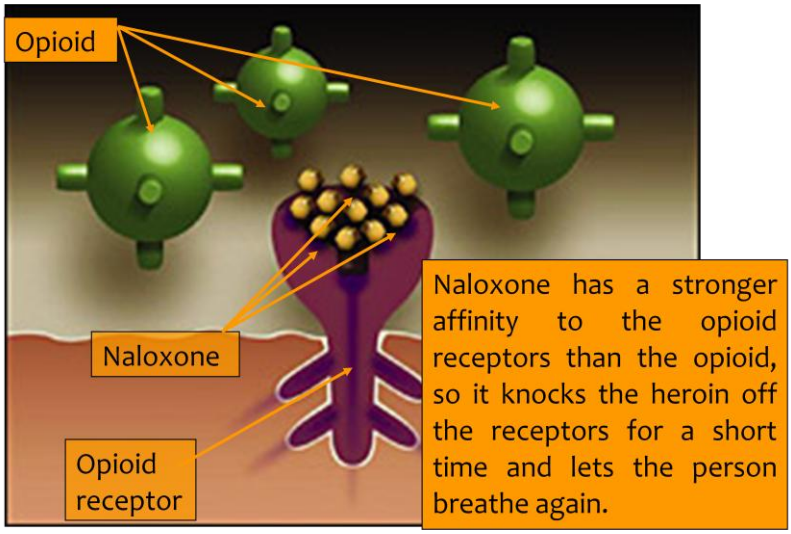
REALLY HIGH	OVERDOSED
Muscles become relaxed	Pale, clammy skin
Speech is slowed or slurred	Breathing is infrequent or has stopped
Sleepy-looking	Deep snoring or gurgling (death rattle)
Responsive to shouting, ear lobe pinch or sternal rub	Unresponsive to any stimuli
Normal heart rate and/or pulse	Slow or no heart rate and/or pulse
Normal skin tone	Blue lips and/or fingertips

Keys to look for if you suspect someone has overdosed:

- Unresponsiveness to verbal or physical stimulation, such as pinching their ear lobe or rubbing your knuckles up and down the person's sternum. Whether or not they respond to this stimulation effectively draws the line between being really high versus overdosed.
- Slow, shallow, or no breathing
- Turning pale, blue or gray (especially lips and fingernails)
- Snoring, gurgling or choking sounds
- Very limp body
- Vomiting

If the person shows any of these symptoms, especially lack of response to stimulus or no breathing/pulse, the person may be experiencing an opioid overdose emergency. Today you will learn how you can use naloxone to respond to an opioid overdose emergency and save someone's life. It is important to remember that naloxone will only work to reverse an overdose emergency that is the result of opioid use. It will have no impact on someone that has overdosed on alcohol, cocaine, benzodiazepines (such as Valium, Klonopin, or Ativan), or methamphetamine.

IV. How does naloxone work?



V. Risk Factors for Opioid Overdose Emergency

There are a number of factors that can place someone at increased risk for an opioid overdose emergency. These include:

- Prior overdose
- Reduced tolerance – previous users who have stopped using due to abstinence, illness, treatment, incarceration, etc.
- Mixing drugs – combining opioids with other drugs, including alcohol, stimulants or depressants. Combining stimulants and depressants DO NOT CANCEL EACH OTHER OUT.
- Using alone
- Variations in strength/quantity or changing formulations (e.g., switching from quick acting to long lasting/extended release)
- Medical conditions such as chronic lung disease or kidney or liver problems

VI. What NOT to do During an Opioid Overdose Emergency

There are many myths about actions you can take to respond to an opioid overdose emergency. Here are some, and why you should NOT DO THEM.

- DO NOT put the individual in a bath. They could drown.
- DO NOT induce vomiting or give the individual something to eat or drink. They could choke.
- DO NOT put the person in an ice bath or put ice in their clothing or in any bodily orifices. Cooling down the core temperature of an individual who is experiencing an opioid overdose emergency is dangerous because it can further depress their heart rate.
- DO NOT try and stimulate the individual in a way that could cause harm, such as shaking them, slapping them hard, kicking them, or other more aggressive actions that may cause long-term physical damage.
- DO NOT inject the individual with any foreign substances (e.g., salt water or milk) or other drugs. It will not help reverse the overdose and may expose the individual to bacterial or viral infection, abscesses, endocarditis, cellulitis, etc.

VII. Responding to a Suspected Opioid Overdose Emergency

1. Check for responsiveness and administer initial rescue breaths if person is not breathing.
2. Call 911.*
3. Continue rescue breathing if person is not breathing on their own.
4. Administer naloxone.
5. Resume rescue breathing if the person is not breathing on their own yet.
6. Conduct follow-up and administer a second dose of naloxone if no response after three minutes.

* If you are by yourself and have to leave the person alone to call 911, put the person in the recovery position (described below).

VIII. Responding to an Opioid Overdose Emergency

1. **Check for responsiveness and administer rescue breaths if person is not breathing.**

   a. Try to stimulate them. You can shout their name, tap their shoulder, or pinch their ear lobe.
   b. Give a sternal rub. Make a fist and rake your knuckles hard up and down the front of the person's sternum (breast bone). This is sometimes enough to wake the person up.
   c. Check for breathing. Put your ear to the person's mouth and nose so that you can also watch their chest. Feel for breath and watch to see if the person's chest rises and falls.
   d. If the person does not respond or is not breathing, proceed with the steps listed below.
   e. Put on latex-free gloves from the REVIVE! kit.
   f. Check the person's airway for obstructions and remove any obstructions that can be seen or felt. Clear any obstructions with a sweeping (not poking or stabbing) motion.
   g. Tilt the person's forehead back and lift their chin (see diagram below).
   h. Place breathing mask on person's face, covering their mouth and nose. Ensure that the plastic piece is in the person's mouth. The mask has a nose printed on it to guide proper placement.
   i. Pinch the person's nose and give normal breaths – not quick or overly powerful breaths.
   j. Give three breaths, one breath every five seconds.

Image courtesy of the Chicago Recovery Alliance

2. **Call 911** [If you have to leave the person alone to call 911, put the person in the recovery position – see details below].

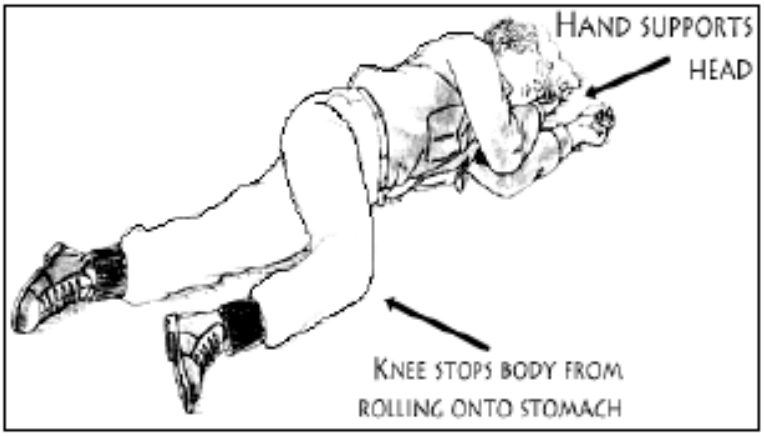
   a. Quiet down the scene, or move to a quieter location. Speak calmly and clearly. State that someone is unresponsive and is not breathing.
   b. You DO NOT have to mention drugs or overdose when calling 911 unless specifically asked by the 911 dispatcher.

c. Give the exact address and location. If you're outside, use an intersection or landmark.
d. When first responders arrive, tell them it is an overdose and what drugs the person may have used, and what you have done so far to respond.

PLEASE NOTE: Complications may arise during or as a result of opioid overdose emergencies. Also, naloxone only works on opioids, and the person may have overdosed on something else, e.g., alcohol or benzodiazepines. **Calling 911 to request Emergency medical services is critical.**

* If you have to leave the person while they are still unresponsive, put the person in the **recovery position**.

a. If necessary, place the overdose victim flat on their back.
b. Roll the person over slightly onto their side.
c. Bend their top knee.
d. Put the person's top hand under their head for support.
e. This position should keep the person from rolling onto their stomach or back and prevent them from asphyxiation in case of vomiting.
f. Make sure the person is accessible and visible to first responders; don't close or lock doors that would keep first responders from being able to find or access the person.



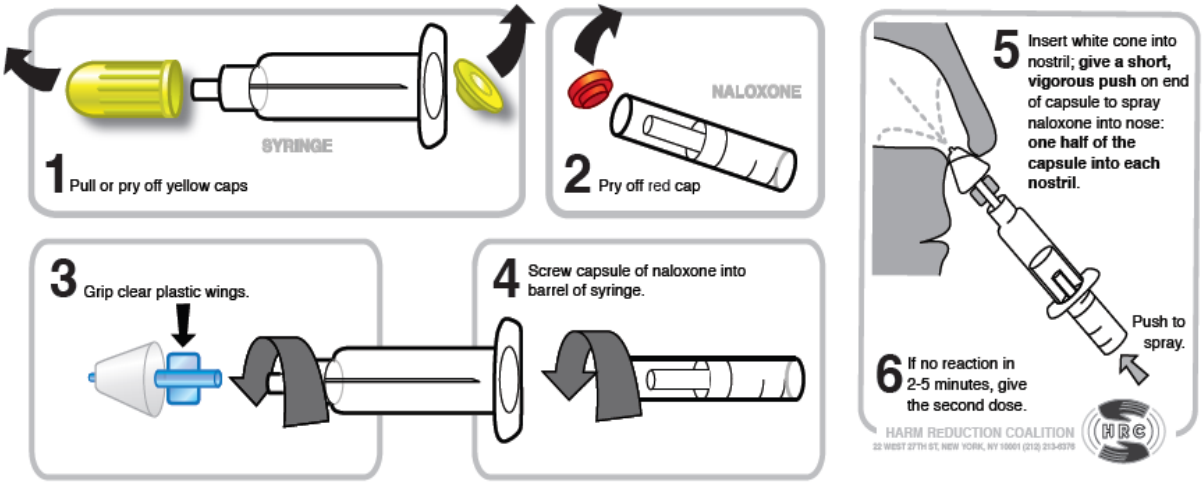
3. **Continue rescue breathing** if the person is not breathing on their own.

a. Tilt the person's forehead back and lift chin (see diagram above, page five)
b. Place breathing mask back on person's face, covering their mouth and nose. Ensure that the plastic piece is in the person's mouth. You can still do mouth-to-mouth rescue breathing if a mask is not available.
c. Pinch the person's nose and give normal breaths – not quick or overly powerful breaths.
d. Give one breath every five seconds for approximately 30 seconds

4. **Administer naloxone**.

INTRANASAL

a. Pull the yellow caps off the syringe.
b. Pull the purple (may also be red or gray) cap off the naloxone capsule.
c. Screw the atomizer, which looks like a white cone, onto the threaded end of the syringe.
d. Gently screw the naloxone capsule into the syringe, open end first, until you feel it catch.
e. Put the tip of the spray device into one nostril and push on the capsule to spray half of the naloxone into the nostril; immediately switch to the other nostril and spray the other half of the naloxone into the nostril (see diagram below). The capsule has gradient marks to indicate when you have sprayed half of the medication.



EVZIO

EVZIO is designed to be easy to use for patients, their family members, and other caregivers. It contains the Intellijet®Prompt System (IPS™) with visual and voice instructions that help guide the user through the injection process. You should use EVZIO exactly as prescribed by your healthcare provider. Each EVZIO auto-injector contains only one dose of medicine. Caregivers should pinch the thigh muscle when injecting EVZIO into a child under the age of one.

Pull EVZIO from the outer case.

Do not go to Step 2 (Do not remove the **red** safety guard.) until you are ready to use EVZIO. **If you are not ready to use EVZIO, put it back in the outer case for later use.**

Pull off the red safety guard.

To reduce the chance of an accidental injection, do not touch the **black** base of the auto-injector, which is where the needle comes out. If an accidental injection happens, get medical help right away.

Note: The **red** safety guard is made to fit tightly. **Pull firmly to remove. Do not replace the red safety guard after it is removed.**

Place the black end against the middle of the outer thigh, through clothing (pants, jeans, etc) if necessary, then press firmly and hold in place for 5 seconds.

If you give EVZIO to an infant less than 1 year old, pinch the middle of the outer thigh before you give EVZIO and continue to pinch while you give EVZIO.

Note: EVZIO makes a distinct sound (click and hiss) when it is pressed against the thigh. This is normal and means that EVZIO is working correctly. Keep EVZIO firmly pressed on the thigh for 5 seconds after you hear the click and hiss sound. The needle will inject and then retract back up into the EVZIO auto-injector and is not visible after use.

5. **Resume rescue breathing** if the person has not started breathing on their own.

PLEASE NOTE - Brain damage can occur after three to five minutes without oxygen. Rescue breathing gets oxygen to the brain quickly. Once you give naloxone, it may take some time for it to be take effect, so the person may not start breathing on their own right away. Continue rescue breathing for them until the naloxone takes effect or until emergency medical services arrive.

6. **Assessment and response**

Most individuals will recover after a single dose of naloxone is administered. When this occurs, the person will be in withdrawal, which may include abrupt waking up, vomiting, diarrhea, sweating, and nausea. They may not remember overdosing. In rare cases, the person may recover into acute withdrawal, which in addition to the above, may include aggressive, combative, or violent behavior. In this case, the Lay Rescuer needs to ensure their own safety. The chart below describes the different outcomes possible after administering the first dose of naloxone.

Assessment and Response after First Administration of Naloxone		
If person recovers, monitor until emergency medical services arrive	If person does not recover within three minutes, return to step four and administer second dose of naloxone	If person recovers but relapses into overdose after 30-45 minutes, recheck for responsiveness, then perform rescue breathing and naloxone administration as appropriate

If person recovers after the first dose of naloxone, continue to monitor them until emergency medical services arrive.

- Do what you can to calm and soothe them
- They may be agitated and will want to take more drugs
- Do not allow them to take more drugs or eat or drink anything
- Emphasize the importance of waiting for emergency medical services to arrive so they can be assessed
- Tell them that opioid withdrawal is not life-threatening and that naloxone will wear off in 30-45 minutes
- Depending on what substances they were taking, they could relapse into overdose once the first dose of naloxone wears off

There are **two cases** in which you may need to administer a second dose of naloxone:

SITUATION A: If the individual has not responded to the initial dose within three minutes

SITUATION B: If the individual has relapsed into an overdose again after having previously recovered with the initial dose.

SITUATION A: The individual has not responded to the initial dose within three minutes

When this occurs:

- Naloxone should take effect within 30-45 seconds but may take longer
- Wait three minutes (continue rescue breathing during this time)
- At three minutes, administer second dose of naloxone

If person remains unresponsive after the second dose is administered, continue rescue breathing until emergency medical services arrives.

SITUATION B: The individual has relapsed into an overdose again after having previously recovered with the initial dose.

Naloxone has a very short half life – 30-45 minutes. In some cases, there is so much opioid in the system that the person can relapse back into overdose after the naloxone has worn off.

When this occurs:

- Recheck person for responsiveness as described in Step 1 above.
- If unresponsive, administer second dose of naloxone
- Continue rescue breathing until person recovers or until emergency medical services arrives.

NALOXONE ADMINISTRATION PROTOCOL SUMMARY

- Ensure the person is experiencing an opioid overdose emergency before calling 911 or administering naloxone.
- Calling 911 before administering naloxone is vital. An individual who has overdosed needs to be assessed by medical professionals.
- The administration of naloxone to an individual **is not the last step in responding to an opioid overdose emergency**. Further attention and action are necessary.
- Withdrawal is awful but not life-threatening. Try to keep them calm, let them know what happened, and explain that help is coming and they need to wait for emergency medical personnel to respond.
- Monitor the individual to see that they start to breathe and become responsive.
- Resume rescue breathing if the person has not started breathing on their own.
- Naloxone takes several minutes to kick in and wears off in 30-45 minutes. The person may relapse into an opioid overdose emergency after the naloxone wears off. Therefore, it is STRONGLY RECOMMENDED that you watch the person for at least an hour or until emergency medical services arrive.
- Do not let them ingest food, drinks, or more drugs.
- Apply the "I've Received Naloxone" sticker from the REVIVE! kit somewhere visible on the person which can let first responders know that the person has experienced an overdose and received naloxone. If the person is in withdrawal, their skin may be sweaty or clammy. To ensure it stays, apply the sticker to the person's clothing or hair.

REPORT THE OVERDOSE REVERSAL

It is important that you report the reversal of an opioid overdose with the administration of naloxone. Information about how many lives have been saved with naloxone can be used to obtain future funding that will continue to expand the availability of naloxone in Virginia.

You can anonymously and securely report an opioid overdose reversal online or on your mobile device here:

https://www.surveymonkey.com/s/REVIVEVA

This link uses a secure connection that encrypts all information provided. Additionally, this link captures no identifying information such as your name, contact information, or the IP of the computer or device from which you are submitting the information. You are free to provide as much or as little information as you like, and all your information will be kept anonymous and only reported in aggregate, non-identifiable ways.

IX. Hands-On Training

X. Video Presentation

How to Prepare Naloxone for Administration: https://www.youtube.com/watch?v=Uq6AxrEY3Vk

XI. Complete Evaluation and receive REVIVE! Kit

Thank you for attending this REVIVE! Training!

ACKNOWLEDGEMENTS:

REVIVE! would not be possible without the help of many public and private partners, who DBHDS would like to acknowledge for their invaluable assistance.

Boston Public Health Commission
Bureau of Justice Assistance
Chicago Recovery Alliance
Delegate John O'Bannon, R-73
Joanna Eller
Harm Reduction Coalition
Kaléo
The McShin Foundation
Massachusetts Department of Public Health
Multnomah County (OR) Health Department
New York City Department of Mental Health and Hygiene
New York State Division of Criminal Justice Services
Ed Ohlinger
One Care of Southwest Virginia
Project Lazarus
SAARA Recovery Center of Virginia
San Francisco Department of Health/DOPE Project
University of Washington Alcohol and Drug Abuse Institute
Virginia Department of Criminal Justice Services
Virginia Department of Health
Virginia Department of Health Professions

HARM REDUCTION FACT SHEET

Avoid using alone - Drug users should inject in the presence of others for safety.

Always carry naloxone – Naloxone has saved more than 26,000 lives since 1996.

Try tester shots – Variation in drug potency are common. When trying a new product, patients should use a small test dose.

Avoid sharing equipment. HIV, Hepatitis B and C can spread easily when needles are shared.

Practice good hygiene – Drug users should wash their hands and clean their skin prior to injecting drugs.

Use sterile equipment – Communicable diseases can be avoided by not sharing needles. Reusing equipment increases the risk of bacterial contamination.

Use sterile water to prepare the product – Many infections stem from unsafe water supplies. Bottled water is not sterile!

Protect your veins – Patients should use the highest gauge or smallest needle possible, rotate injection sites, and start using at distal site.

Attachment B

EMT Statistics

EMT Statistics
As of 04/04/2017

Virginia:

Report Date:	4/4/2017 5:20:51 PM
Report Type:	State Report (VA)
Registration Level:	EMT
Course Completion Date:	1st Quarter 2015 to 2nd Quarter 2017
Training Program:	All

View Legend | Printer-Friendly Version

Show All | Show Only Percentages | Show Only Numbers

The results of your report request are as follows:

Attempted The Exam	First Attempt Pass	Cumulative Pass Within 3 Attempts	Cumulative Pass Within 6 Attempts	Failed All 6 Attempts	Eligible For Retest	Did Not Complete Within 2 Years
5440	68% (3676)	79% (4285)	79% (4301)	0% (2)	18% (983)	3% (155)

National Registry Statistics:

Report Date:	4/4/2017 5:24:05 PM
Report Type:	National Report
Registration Level:	EMT
Course Completion Date:	1st Quarter 2015 to 2nd Quarter 2017
Training Program:	All

View Legend | Printer-Friendly Version

Show All | Show Only Percentages | Show Only Numbers

The results of your report request are as follows:

Attempted The Exam	First Attempt Pass	Cumulative Pass Within 3 Attempts	Cumulative Pass Within 6 Attempts	Failed All 6 Attempts	Eligible For Retest	Did Not Complete Within 2 Years
150511	68% (102329)	79% (119619)	80% (120512)	0% (82)	18% (27042)	2% (2894)

Individual Instructor Statistics are available on the OEMS webpage at the following link: http://www.vdh.virginia.gov/content/uploads/sites/23/2017/01/01-10-2017-16th-Percentile-EMT.pdf

Attachment C

Accreditation Report

Accredited Training Site Directory

As of April 4, 2017

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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	CoAEMSP
J. Sargeant Reynolds Community College	08709	No	3	National – Continuing	CoAEMSP
Jefferson College of Health Sciences	77007	Yes	---	National – Continuing	CoAEMSP
John Tyler Community College	04115	Yes	--	CoAEMSP - LOR	
Lord Fairfax Community College	06903	No	--	National – Initial	CoAEMSP
Loudoun County Fire & Rescue	10704	No	--	National – Continuing	CoAEMSP
Northern Virginia Community College	05906	No	1	National – Continuing	CoAEMSP
Patrick Henry Community College	08908	No	--	CoAEMSP – Initial	CoAEMSP
Piedmont Virginia Community College	54006	Yes	--	National – Continuing	CoAEMSP
Prince William County Dept of Fire and Rescue	15312	Yes	--	CoAEMSP – Initial	CoAEMSP
Rappahannock Community College	11903	Yes	--	CoAEMSP – LOR	
Southside Virginia Community College	18507	No	1	National – Continuing	CoAEMSP
Southwest Virginia Community College	11709	Yes	4	National – Continuing	CoAEMSP
Stafford County & Associates in Emergency Care	15319	Yes	1	National – Continuing	CoAEMSP
Tidewater Community College	81016	Yes	3	National – Continuing	CoAEMSP
VCU School of Medicine Paramedic Program	76011	Yes	5	National – Continuing	CoAEMSP

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

- Rappahannock Community College had their site visit in November, 2017. Awaiting final decision by CAAHEP.
- John Tyler Community College under Letter of Review. Completing self-study for submission to CoAEMSP.
- ECPI University has received their Letter of Review to conduct their first cohort class.

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Accredited Intermediate[1] Training Programs in the Commonwealth

Site Name	Site Number	BLS Accredited	# of Alternate Sites	Accreditation Status	Expiration Date
Central Shenandoah EMS Council	79001	Yes	4*	State – Full	May 31, 2017
Dabney S. Lancaster Community College	00502	No	--	State – Full	July 31, 2017
Danville Area Training Center	69009	No	--	State – Full	July 31, 2019
Hampton Fire & EMS	83002	Yes	--	State – Full	February 28, 2018
Henrico County Fire Training	08718	No	--	State – Full	August 31, 2020
James City County Fire Rescue	83002	No	--	State – Full	February 28, 2019
Norfolk Fire Department	71008	No	--	State – Full	July 31, 2021
Paul D. Camp Community College	62003	No	--	State – Full	May 31, 2021
Southwest Virginia EMS Council	52003	No	--	State – Full	March 31, 2019
UVA Prehospital Program	54008	No	--	State – Full	July 31, 2019
WVEMS – New River Valley Training Center	75004	No	--	State – Full	June 30, 2017

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

- WVEMS – New River Valley Training Center reaccreditation self-study submitted and assigned to site team. Site visit to be conducted in May, 2017.

Accredited AEMT Training Programs in the Commonwealth

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

Accredited EMT Training Programs in the Commonwealth

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

Attachment D

Patient Care Documentation and Data Submission

Marissa J. Levine, MD, MPH, FAAFP
State Health Commissioner

Gary R. Brown
Director

P. Scott Winston
Assistant Director

COMMONWEALTH of VIRGINIA
Department of Health

Office of Emergency Medical Services
1041 Technology Park Drive
Glen Allen, VA 23059-4500

1-800-523-6019 (VA only)
804-888-9100 (Main Office)
804-888-9120 (Training Office)
FAX: 804-371-3108

April 17, 2017

TO: Virginia Emergency Medical Services (EMS) agencies
Regional EMS Councils

From: Michael D. Berg, BS, NRP
Manager, Regulation and Compliance

Cam Crittenden, RN
Manager, Trauma and Critical Care

SUBJECT: Patient Care Documentation

Please find attached a revised agency policy regarding the completion of a patient care report for Virginia EMS agencies. This policy is effective July 1, 2017 and remains in effect until acted on by the Office of Emergency Medical Services.

This policy applies to all categories of Virginia EMS agencies (911, non-emergency, ground, air, etc.). Please direct any questions to the appropriate program manager.

Virginia Office of Emergency Medical Services

Patient Care Report Documentation and Data Submission

I. Purpose

§32.1-116.1 of the *Code of Virginia* (*Code*) mandates that each licensed Emergency Medical Services (EMS) agency submit data to the Office of Emergency Medical Services (OEMS) on a prescribed format as approved by the Board of Health (http://law.lis.virginia.gov/vacode/32.1-116.1/ . The *Virginia Emergency Medical Services Regulations* (*Regulations*) 12VAC5-31-560 also identifies the need for Emergency Medical Services (EMS) agencies to report patient care data to OEMS (http://law.lis.virginia.gov/admincode/title12/agency5/chapter31/section560/ .

The policy exists to provide a consistent standard for OEMS staff and Emergency Medical Services agencies as to when a patient care report is to be completed and data transmitted to OEMS.

II. Scope

Incident documentation involves the recording of all patient assessment and treatment performed by licensed EMS agencies providing prehospital emergency medical services, inter-facility transport or pre-scheduled patient transport. Data submission involves transmitting the required data set that is collected through incident documentation to the OEMS. This policy applies to all EMS agencies licensed to operate within the Commonwealth of Virginia.

III. Definitions

Medical care facility – means (as defined by § 32.1-102.1 of the *Code* and 12VAC5-31-10 of the *Regulations*) any institution, place, building or agency, whether or not licensed or required to be licensed by the Board of Health or the Department of Behavioral Health and Developmental Services, whether operated for profit or nonprofit and whether privately owned or privately operated or owned or operated by a local governmental unit, (i) by or in which health services are furnished, conducted, operated or offered for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, whether medical or surgical, of two or more nonrelated persons who are injured or physically sick or have mental illness, or for the care of two or more nonrelated

persons requiring or receiving medical, surgical or nursing attention or services as acute, chronic, convalescent, aged, physically disabled or crippled or (ii) which is the recipient of reimbursements from third-party health insurance programs or prepaid medical service plans.

IV. Requirements

A. Whenever an EMS agency is requested (scheduled, unscheduled, emergent or non-emergent) to provide patient care for a real or potential patient, a patient care report shall be completed and the data shall be submitted to OEMS as per the *Code of Virginia* §32.1116.1 (http://law.lis.virginia.gov/vacode/32.1-116.1/).

All licensed EMS agencies shall document and submit data on all EMS incidents including but not limited to:

1. Cancelled calls (by Public Safety Answering Point – 911 center)

2. Standby's (fire assist, law enforcement assist), pubic events such as recreational events (football games, large gatherings)

3. Patient refusals (care and/or transportation – established patient provider relationship)

4. Patient transfers.

Documentation and data to be submitted includes:

1. Any transport to or from a physician's office, clinic or health care facility that is for prescheduled testing, evaluation or treatment.

2. Discharges from a medical care facility.

3. Scheduled admissions to a medical care facility whether from a private residence or another medical care facility.

B. This applies to all EMS agencies including surface and air agencies.

C. In the event multiple permitted vehicles are involved in the same incident, only one report per patient is required unless a mass casualty event has been declared.

D. In a multi-agency response to an incident, one patient care report documenting the incident and the EMS agency response will suffice providing no patient care has been rendered or a patient is transported to a medical care facility by the responding EMS agency.

    1. In the event a mass casualty event has been declared, the use of triage tags will suffice in lieu of individual patient care reports. One main patient care report shall be completed by the primary (lead) EMS agency identifying the event and the number of patients involved in the incident.

E. For EMS agencies who provide large event staffing, scheduled or as part of their "mission"(i.e. Kings Dominion, Busch Gardens, concert venue, etc.): If no patient is transported or transferred to a transport agency as a result of assessment and treatment, then only a patient care report noting "standby only" is required and submitted. Any patient transfer or transport must be documented and the data transmitted to OEMS.

F. Data related to the use of permitted vehicles performing administrative, training or maintenance functions can be documented for agency use; however, it should NOT be submitted to the Office of EMS.

V. Conditions

This policy will remain in effect until revised or terminated by OEMS.

VI. Effective Date: July 1, 2017

Attachment E

EMS Vaccination Program Update

Marissa J. Levine, MD, MPH
State Health Commissioner

Gary R. Brown
Director

P. Scott Winston
Assistant Director

COMMONWEALTH of VIRGINIA
Department of Health

Office of Emergency Medical Services
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EMS Vaccination Program Update

- Agencies and operational medical directors should work together to determine participation in local VDH sponsored vaccination events. Participation in any vaccination events is voluntary. However, if an agency/provider wishes to participate, the training and skills verification is mandatory.

- Working to finalize access to online training through VaTrain. This training is CDC based and required for any provider participating in a vaccination event (exercise or real-time incident)

- On-the-job skills verification will need to occur prior to participation in a VDH sponsored vaccination clinic or real-world incident. This can either be documented by the Operational Medical Director or by the clinician on-site prior to the vaccination event (currently done pre-event for MRC members)

- The Office of EMS will have a Train SuperUser that is able to verify online course completion

- The Office will provide information to agencies on VDH sponsored vaccination events that they can participate in.