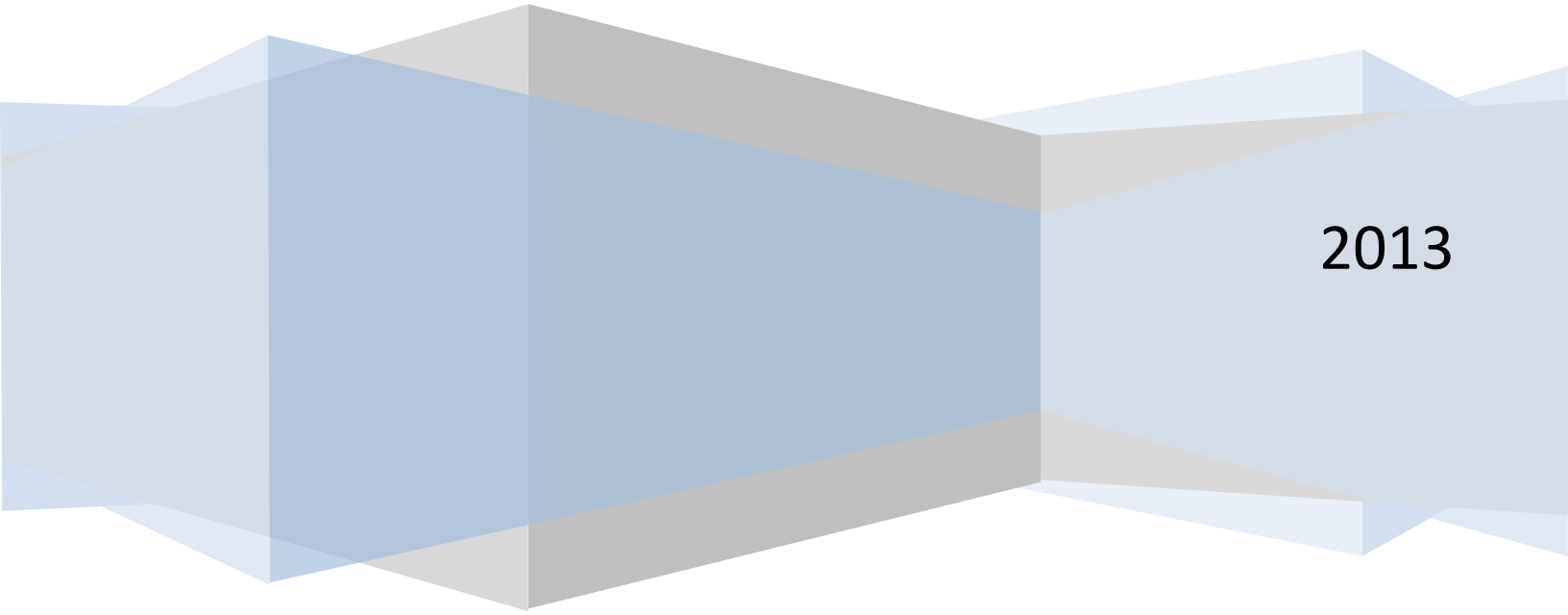
Virginia Department of Health – Office of Emergency Medical Services

Report on the Progress in Meeting the Requirements of HB1856

Presented to the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health



2013

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HB1856: CHAPTER 429

An Act to require the State Board of Health to develop certain policies related to statewide emergency medical services.

[H 1856]
Approved March 16, 2013

Be it enacted by the General Assembly of Virginia:

1. *§ 1. That the Board of Health shall direct the State Emergency Medical Services Advisory Board to, by July 1, 2014, develop and facilitate the implementation of (i) a process whereby an emergency medical services provider who is certified by the Office of Emergency Medical Services pursuant to § 32.1-111.5 and who has received an adverse decision related to his authority to provide emergency medical care on behalf of an emergency medical services agency under the authority of an agency operational medical director shall be informed of the appeals process and (ii) a standard operating procedure template to be used in the development of local protocols for emergency medical services personnel for basic life support services provided by emergency medical services personnel. The Board, in cooperation with the State Emergency Medical Services Advisory Board, shall also review the training for emergency medical services personnel throughout the state to identify and address disparities in the delivery of training to and the availability of training for emergency medical services personnel. The Board shall report on its progress in meeting the requirements of this act to the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health no later than December 1, 2013.*

Virginia EMS Advisory Board Recommendations for Training

Section of HB1856 Addressed by the Training and Certification Committee of the EMS Advisory Board

I. The Board, in cooperation with the State Emergency Medical Services Advisory Board, shall also review the training for emergency medical services personnel throughout the state to identify and address disparities in the delivery of training to and the availability of training for emergency medical services personnel.

Motion approved by the EMS Advisory Board

The EMS Advisory Board recommends the following actions to address HB1856 that pertains to the section addressing that "The Board, in cooperation with the State Emergency Medical Services Advisory Board, shall also review the training for emergency medical services personnel throughout the state to identify and address disparities in the delivery of training to and the availability of training for emergency medical services personnel" and to develop a process to identify the need for and complete a program(s) with the intent of attracting and recruiting volunteers for EMT certification, utilizing various resources including but not limited to EMS Regional Councils, no later than the June 30, 2015. The details of such activity will be developed in association with the EMS Regional Councils as follows.

1. Present this proposal to TCC for action on October 9, 2013.
2. Present this proposal to EMS Advisory Board Executive Committee for action on October 10, 2013.
3. Present this proposal to the Commissioner of Health by October 16, 2013.
4. OEMS develop the program goal(s).
5. OEMS in association with the EMS Regional Councils identify in their respective council areas if and where a volunteer oriented program may be needed by February 15, 2014.
6. Based upon the goal, the Regional Councils shall develop a plan as they determine necessary to achieve specified goals by May 2014.
7. Implement identified programs by September 15, 2014.

Summary of the EMS Advisory Board's Recommendations Pertaining to Training.

Abstract

The Virginia Office of EMS (OEMS) Advisory Board's Training and Certification Committee (TCC) designated a workgroup to address the component of HB1856 dealing with the Training Disparities, Delivery and Availability of Training. The workgroup formulated and executed a plan. The workgroup requested the OEMS schedule a meeting with Delegate Orrock to present their finding and assist with his views on the direction they should take.

Conclusion

The workgroup requested the Office of EMS schedule a meeting with Delegate Orrock to review their information and provide guidance to address his concerns. .

Overview

During the 2013 General Assembly, HB1856 was passed (Attachment A). A summary of that bill reads:

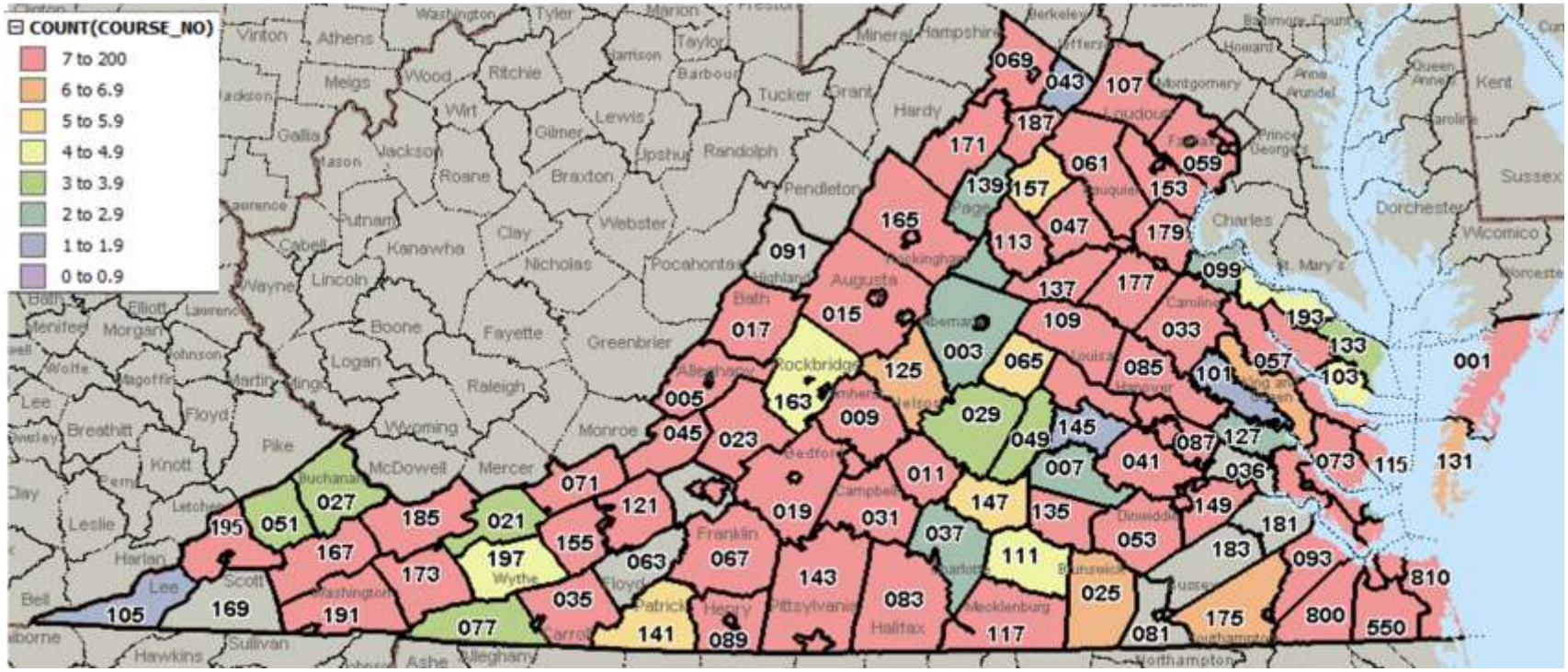
> **Emergency medical services; procedures and practice.** Requires the Board of Health to direct the State Emergency Medical Services Advisory Board to develop and facilitate implementation of (i) a process for informing an emergency medical services provider who has received an adverse decision relating to his authority to provide emergency medical care on behalf of an agency of the process for appealing that decision and (ii) a standard operating procedure template to be used in the development of local protocols for emergency medical services personnel for basic life support services. The bill also requires the Board, in cooperation with the State Emergency Medical Services Advisory Board, to review training for emergency medical services personnel and address disparities in the delivery of training to and availability of training for emergency medical services personnel. The Board shall report on its progress no later than December 1, 2013.

In response to the bill, the Virginia Office of EMS Advisory Board assigned to their Training and Certification Committee a charge to investigate and provide recommendations addressing the HB1856 component "to review training for emergency medical services personnel and address disparities in the delivery of training to and availability of training for emergency medical services personnel". The TCC appointed a workgroup (Attachment B) to report back at the October 9, 2013 TCC meeting any recommendations as an action item for the Advisory Board. In addition, the recommendations from the Advisory Board are to be presented to the Health Commissioner by October 16, 2013.

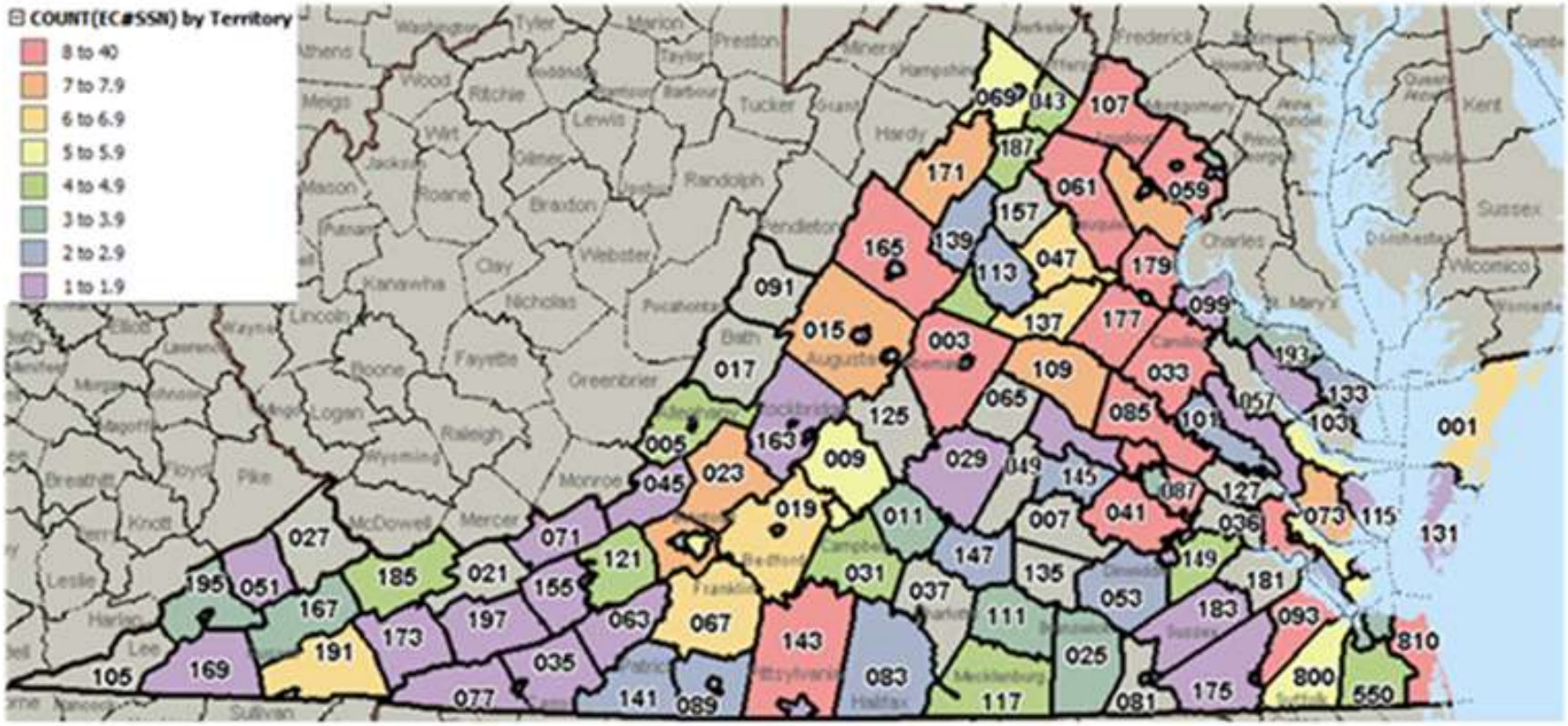
The workgroup had several webinars and compiled information useful for addressing the issues raised in HB1856. Findings and recommendations from a similar study conducted in 2000 based upon HJR 164 were also reviewed. (Attachment C). The workgroup felt that the recommendations from the 2000 study were no longer appropriate due to the variation in needs across the Commonwealth. The workgroup requested the Office of EMS schedule a meeting with Delegate Orrock to review their information and provide guidance to address his concerns.

Course and Instructor Data From TCC Presented to Del. Orrock

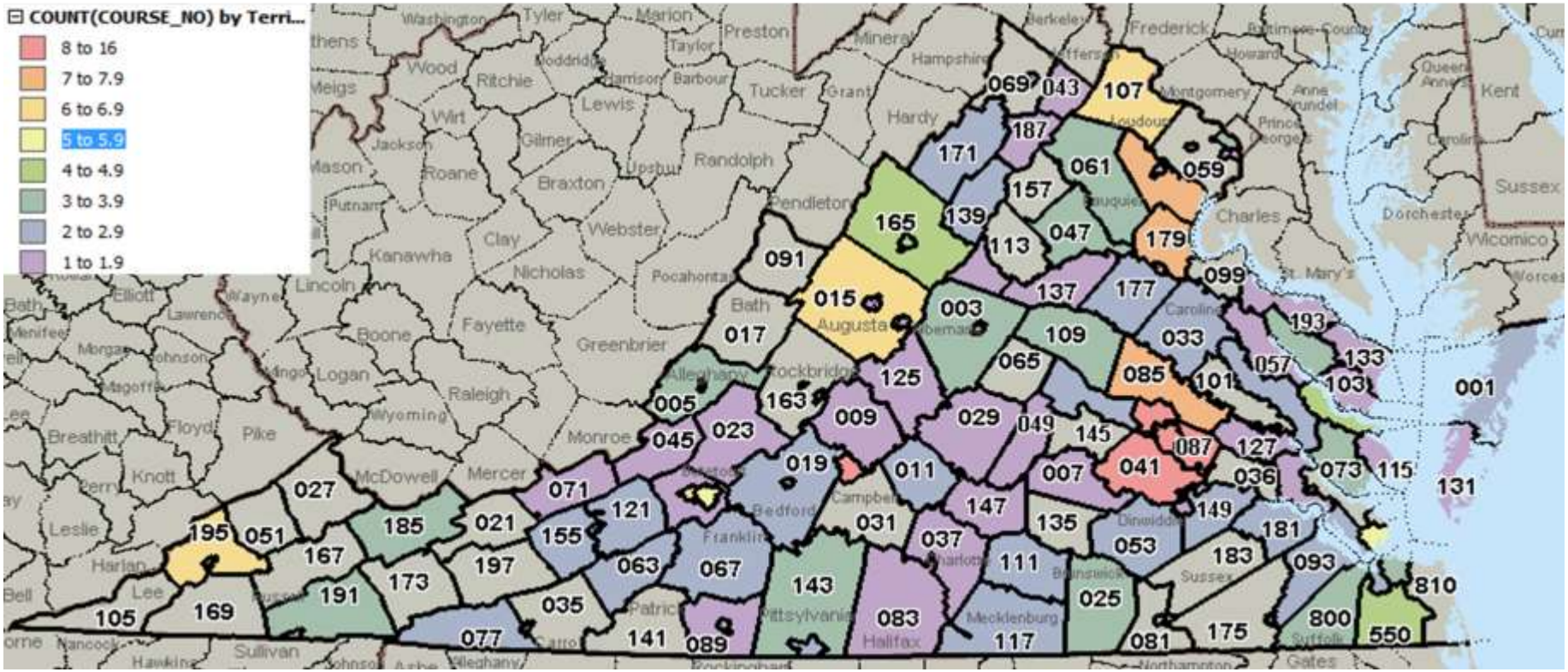
FY 11-12 EMSTF Courses by Location



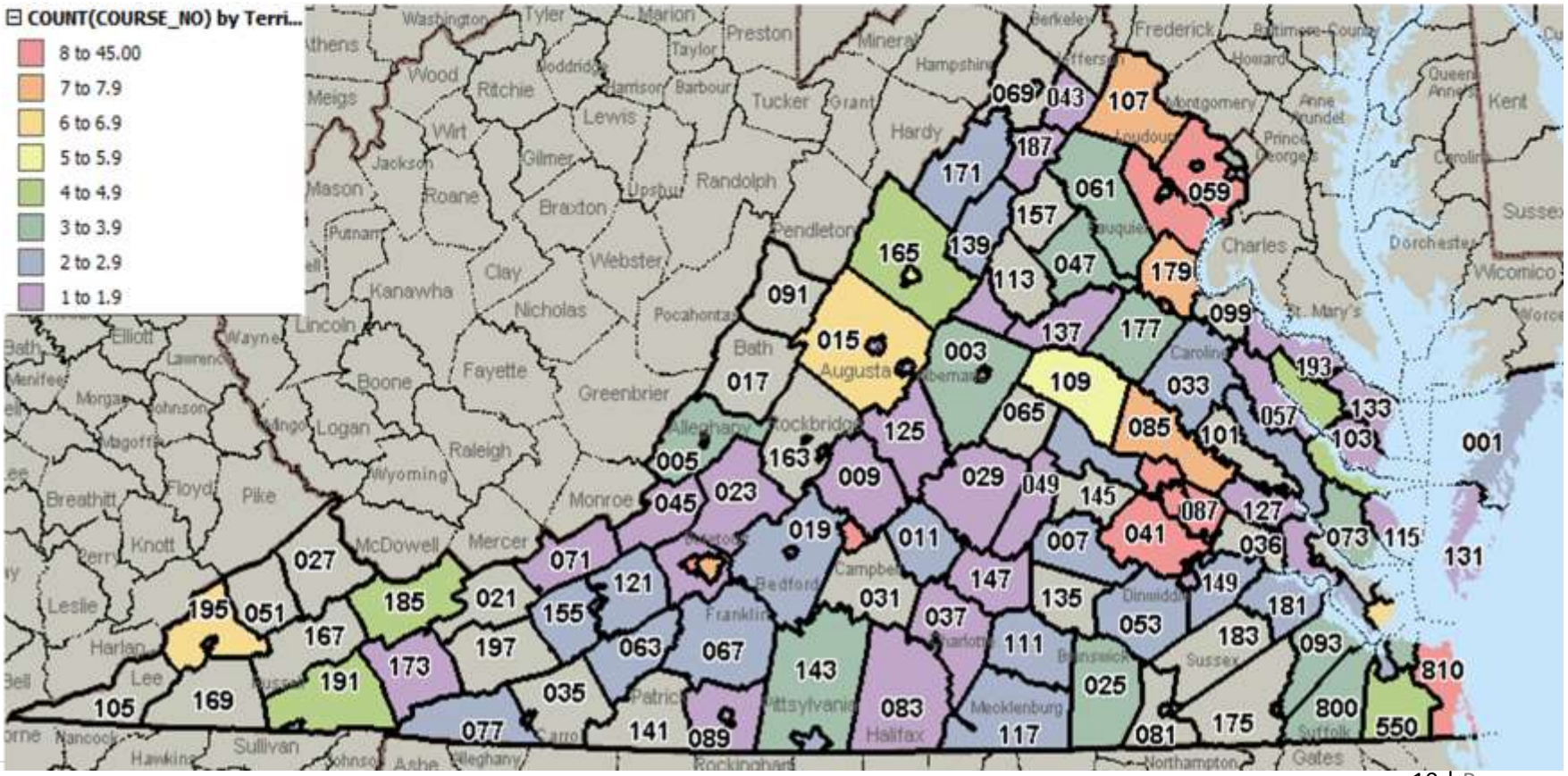
Education Coordinator by Location 05-2013



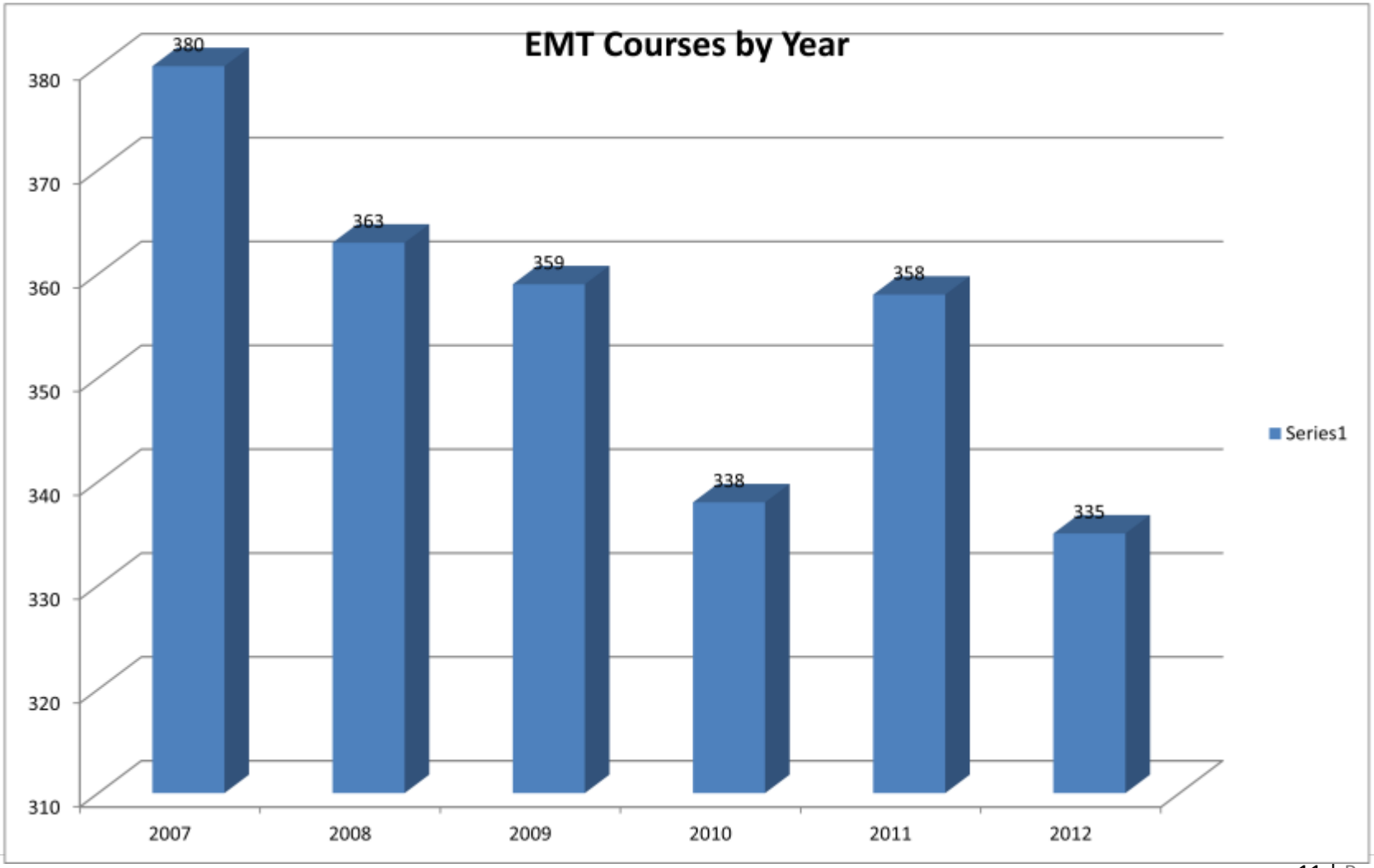
EMT EMSTF by Location FY 12-13



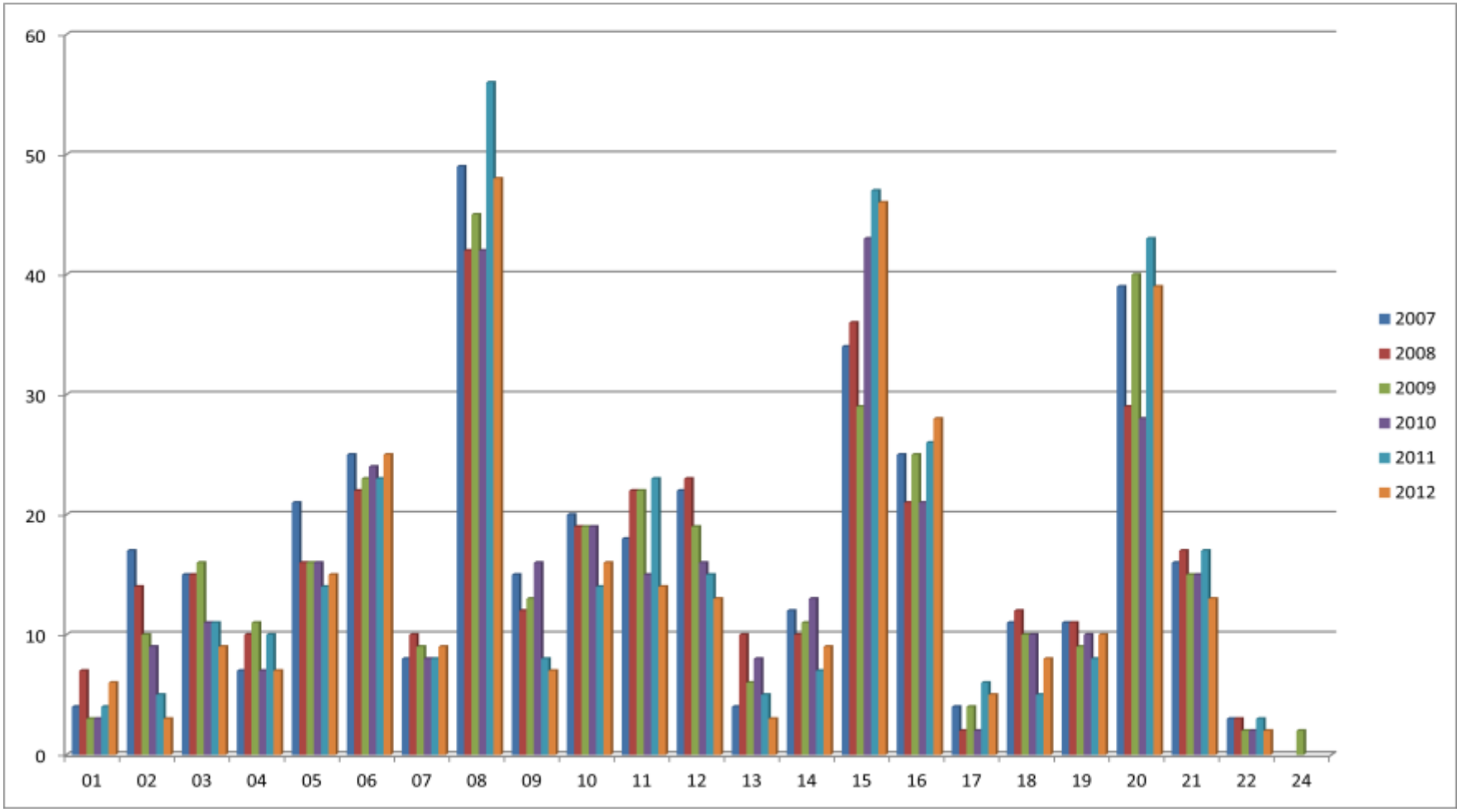
VEMSES Courses by Location 05-2013



Number of EMT Courses by Year

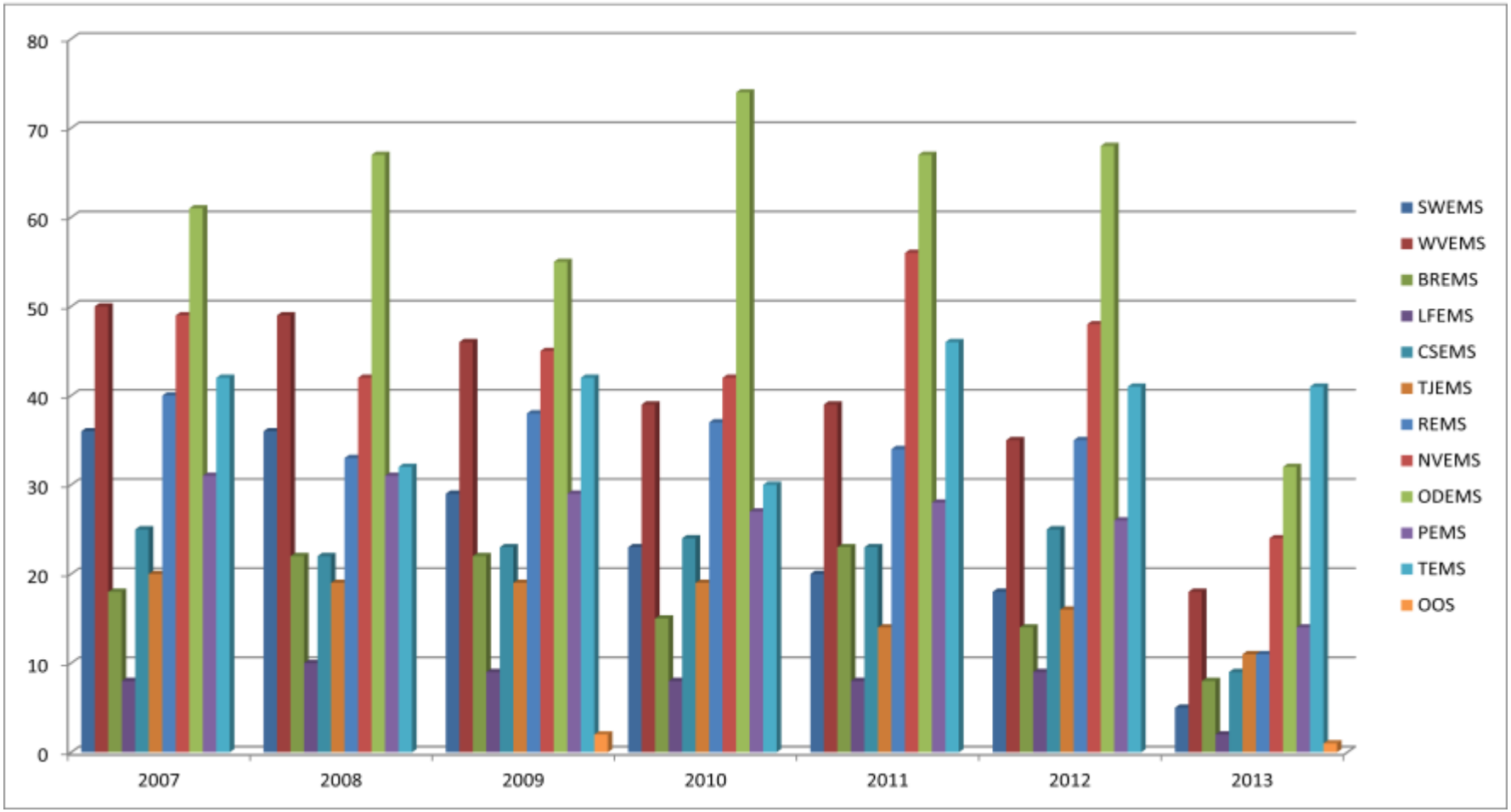


EMT Course Per PD by Year

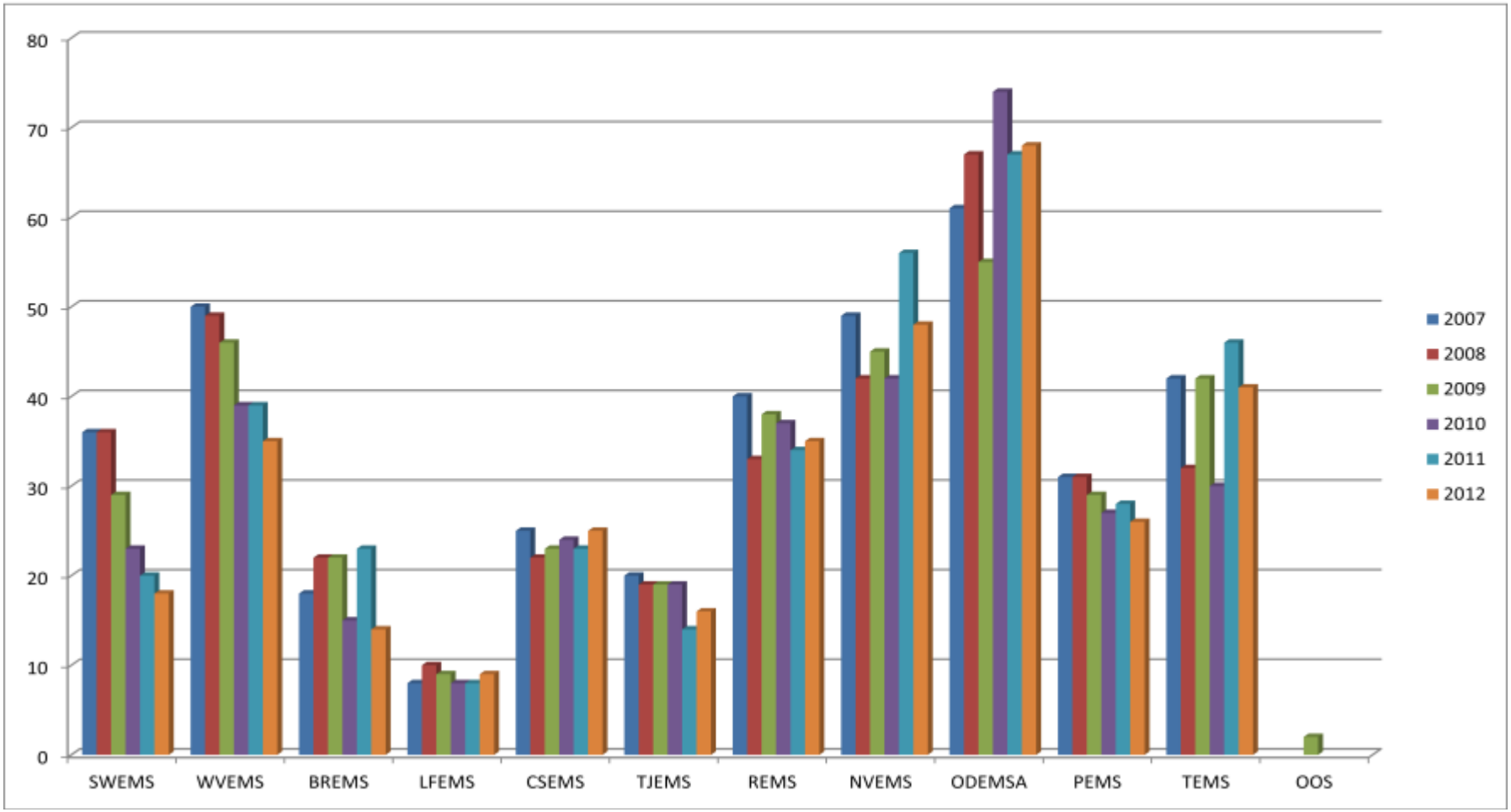


EMT Courses Per Year by Council

2013 is incomplete data.



EMT Courses Per Council by Year



Survey of EMT Instructors

Va. EMS Advisory Board Training and Certification Committee Training Survey

SurveyMonkey

In what Regional Council Area do your teach?

	Response Percent	Response Count
Southwest Virginia EMS Council	7.9%	22
Western Virginia EMS Council	16.8%	47
Blue Ridge EMS Council	5.0%	14
Thomas Jefferson EMS Council	3.9%	11
Central Shenandoah EMS Council	2.9%	8
Lord Fairfax EMS Council	2.5%	7
Northern Virginia EMS Council	8.6%	24
Rappahannock EMS Council	7.2%	20
Old Dominion EMS Alliance	**22.6%**	**63**
Peninsulas EMS Council	13.3%	37
Tidewater EMS Council	9.3%	26
	answered question	**279**
	skipped question	**0**

Survey of EMT Instructors

Va. EMS Advisory Board Training and Certification Committee Training Survey

SurveyMonkey

Where do you teach? Select all that apply.

	Response Percent	Response Count
Volunteer Rescue Squad	**62.2%**	**173**
Volunteer Fire Station	30.6%	85
High School	14.0%	39
College	34.9%	97
Municipal Agency (Fire - Fire/EMS - EMS)	52.9%	147
Private Company	24.1%	67
Other (please specify)		25
answered question		**278**
skipped question		**1**

Survey of EMT Instructors

Va. EMS Advisory Board Training and Certification Committee Training Survey

SurveyMonkey

Which of the following do you require for class?

Requirement

	Yes	No	Response Count
EMT Book	**92.1% (199)**	7.9% (17)	216
EMT Workbook	48.1% (87)	**51.9% (94)**	181
Uniform Shirt	**57.1% (100)**	42.9% (75)	175
Uniform Pants	44.7% (76)	**55.3% (94)**	170
Safety Shoes	38.5% (65)	**61.5% (104)**	169
Own B/P Cuff and Stethoscope	30.8% (52)	**69.2% (117)**	169
Fee for EVOC Classes	19.7% (31)	**80.3% (126)**	157
Fee for Vehicle Rescue Awareness and OPS Class	11.2% (17)	**88.8% (135)**	152
Fee for Hazardous Materials Awareness Class	8.6% (13)	**91.4% (139)**	152
Fee for Written Test	36.4% (64)	**63.6% (112)**	176
Fee for practical Test	**57.3% (102)**	42.7% (76)	178

Survey of EMT Instructors

Do you use on line testing for students	**55.4% (102)**	44.6% (82)	184
Do you use on line tacking or rosters for tracking student progress.	**53.2% (99)**	46.8% (87)	186

Costs

	$0 to $25	$26 to $50	$51 to $75	$76 to $100	$101 to $125	$126 to $150	Greater than $150	Response Count
EMT Book	6.1% (10)	6.1% (10)	17.0% (28)	**40.0% (66)**	19.4% (32)	5.5% (9)	6.1% (10)	165
EMT Workbook	19.4% (13)	**38.8% (26)**	31.3% (21)	10.4% (7)	0.0% (0)	0.0% (0)	0.0% (0)	67
Uniform Shirt	**55.4% (46)**	38.6% (32)	4.8% (4)	1.2% (1)	0.0% (0)	0.0% (0)	0.0% (0)	83
Uniform Pants	31.7% (19)	**56.7% (34)**	11.7% (7)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	60
Safety Shoes	23.9% (11)	23.9% (11)	17.4% (8)	**28.3% (13)**	4.3% (2)	2.2% (1)	0.0% (0)	46
Own B/P Cuff and Stethoscope	**52.2% (24)**	39.1% (18)	4.3% (2)	2.2% (1)	2.2% (1)	0.0% (0)	0.0% (0)	46
Fee for EVOC Classes	**71.9% (23)**	12.5% (4)	9.4% (3)	6.3% (2)	0.0% (0)	0.0% (0)	0.0% (0)	32
Fee for Vehicle Rescue Awareness and OPS Class	**72.7% (16)**	18.2% (4)	4.5% (1)	0.0% (0)	4.5% (1)	0.0% (0)	0.0% (0)	22
Fee for Hazardous Materials Awareness Class	**76.5% (13)**	11.8% (2)	5.9% (1)	0.0% (0)	5.9% (1)	0.0% (0)	0.0% (0)	17
Fee for Written Test	20.8% (11)	22.6% (12)	**26.4% (14)**	13.2% (7)	13.2% (7)	1.9% (1)	1.9% (1)	53
Fee for practical Test	20.0% (17)	**57.6% (49)**	14.1% (12)	1.2% (1)	0.0% (0)	1.2% (1)	5.9% (5)	85
Do you use on line testing for students	**61.7% (37)**	21.7% (13)	8.3% (5)	8.3% (5)	0.0% (0)	0.0% (0)	0.0% (0)	60

Survey of EMT Instructors

Do you use on line tacking or rosters for tracking student progress.	**65.3% (32)**	6.1% (3)	12.2% (6)	16.3% (8)	0.0% (0)	0.0% (0)	0.0% (0)	49
							Other (please specify)	27
							answered question	**222**
							skipped question	**57**

Survey of EMT Instructors

Va. EMS Advisory Board Training and Certification Committee Training Survey

SurveyMonkey

Do you charge for your EMT Class?

		Response Percent	Response Count
Yes		50.8%	125
No		49.2%	121
		answered question	246
		skipped question	33

Survey of EMT Instructors

Va. EMS Advisory Board Training and Certification Committee Training Survey

SurveyMonkey

Is the cost of books and course materials included?

		Response Percent	Response Count
Yes		52.4%	66
No		47.6%	60
		answered question	126
		skipped question	153

Survey of EMT Instructors

Va. EMS Advisory Board Training and Certification Committee Training Survey

SurveyMonkey

Do you require your students to have uniforms?

		Response Percent	Response Count
Yes		38.4%	88
No		61.6%	141
		answered question	229
		skipped question	50

Survey of EMT Instructors

Va. EMS Advisory Board Training and Certification Committee Training Survey

SurveyMonkey

Who pays for the uniform?

	Yes	No	Rating Count
Students	**75.0% (60)**	25.0% (20)	80
Sponsor	**64.9% (50)**	36.4% (28)	77
You the instructor	1.4% (1)	**98.6% (69)**	70
		answered question	**88**
		skipped question	**191**

Survey of EMT Instructors

Va. EMS Advisory Board Training and Certification Committee Training Survey

SurveyMonkey

What are you charging for the EMT class?

Charge

	$0	$1 to $100	$101 to $200	$201 to $300	$301 to $400	$401 to $500	$501 to $600	$601 to $700	$701 to $800	$801 to $900	$901 to $1000	$1001 to $2000	$2001 to $3000	$3001 to $4000	$4001 to $5000	Great than $5000
Cost	43.0% (95)	5.0% (11)	9.0% (20)	7.2% (16)	7.7% (17)	4.5% (10)	2.3% (5)	1.8% (4)	2.7% (6)	1.4% (3)	3.2% (7)	6.8% (15)	1.4% (3)	0.5% (1)	0.0% (0)	3.6% (8)

answered question

skipped question

Survey of EMT Instructors

Va. EMS Advisory Board Training and Certification Committee Training Survey

SurveyMonkey

Do you use EMS Training Funds to cover the program cost?

		Response Percent	Response Count
Yes		49.8%	115
No		50.2%	116
		answered question	231
		skipped question	48

Survey of EMT Instructors

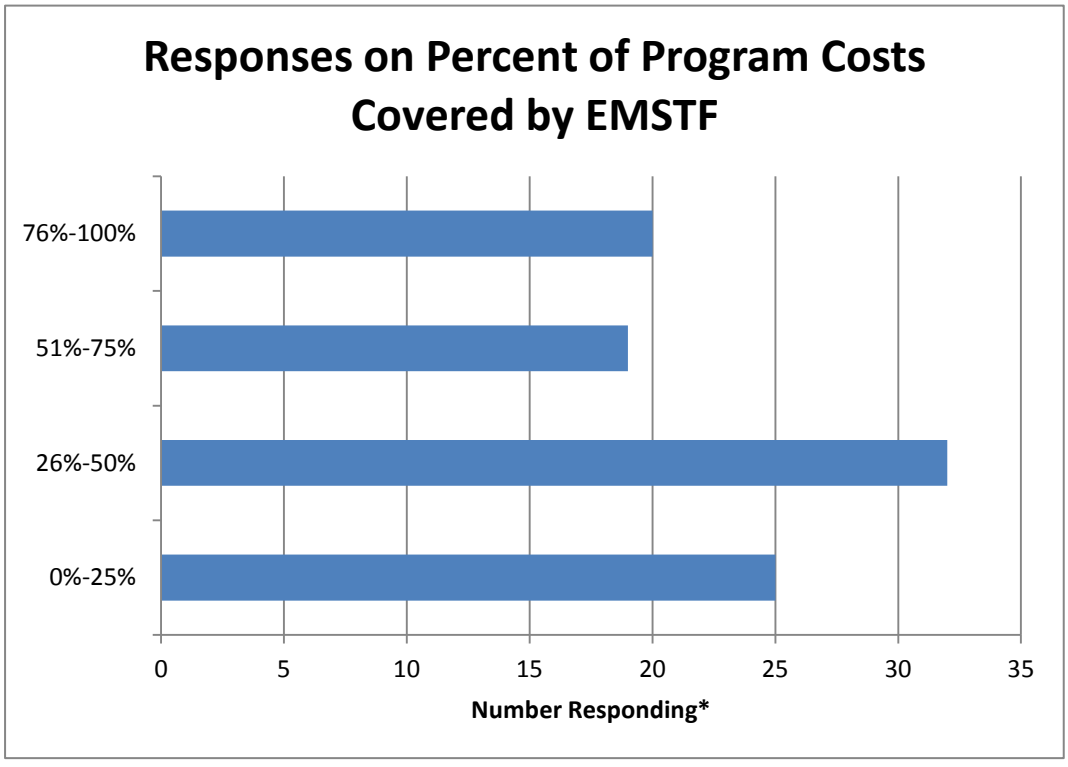
Survey of EMT Instructors

Va. EMS Advisory Board Training and Certification Committee Training Survey

SurveyMonkey

If you use EMS Training Funds, approximately what percent of programs cost is covered?

	Response Count
	110
answered question	110
skipped question	169



*Total does not equal 110 as some responses gave no numerical value.

Survey of EMT Instructors

Va. EMS Advisory Board Training and Certification Committee Training Survey

SurveyMonkey

Have you ever been refused Training Funds?

		Response Percent	Response Count
Yes		10.8%	24
No		89.2%	198
		answered question	222
		skipped question	57

Attachment A

CHAPTER 429

An Act to require the State Board of Health to develop certain policies related to statewide emergency medical services.

[H 1856]
Approved March 16, 2013

Be it enacted by the General Assembly of Virginia:

1. *§ 1. That the Board of Health shall direct the State Emergency Medical Services Advisory Board to, by July 1, 2014, develop and facilitate the implementation of (i) a process whereby an emergency medical services provider who is certified by the Office of Emergency Medical Services pursuant to § 32.1-111.5 and who has received an adverse decision related to his authority to provide emergency medical care on behalf of an emergency medical services agency under the authority of an agency operational medical director shall be informed of the appeals process and (ii) a standard operating procedure template to be used in the development of local protocols for emergency medical services personnel for basic life support services provided by emergency medical services personnel. The Board, in cooperation with the State Emergency Medical Services Advisory Board, shall also review the training for emergency medical services personnel throughout the state to identify and address disparities in the delivery of training to and the availability of training for emergency medical services personnel. The Board shall report on its progress in meeting the requirements of this act to the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health no later than December 1, 2013.*

Attachment B

HB1856 – Training Disparities, Delivery and Availability of Training Workgroup

Name	Organization Represented	EMS System Participant
Mike Garnett, Chair	-Training and Certification Committee -Western Va. EMS Region	Education Coordinator Paramedic
Kathy Eubank	-Virginia Association of Volunteer Rescue Squads -Training and Certification Committee -Old Dominion EMS Region	EMT Instructor Paramedic
Charles Lane, MD	-Medical Direction Committee -Training and Certification Committee -Western Va. EMS Region	Operational Medical Director
Pat Pope	-Lord Fairfax EMS Region	Paramedic Education Coordinator
James Gower	-Peninsulas EMS Region	Paramedic
James Larounis	-Rappahannock EMS Region	Enhanced

Attachment C

The Impact of Training and Certification Time and Cost Requirements On the Ability to Fund and Recruit EMS Volunteers in Virginia

Executive Summary

Background

A significant amount of EMS education and training takes place annually in Virginia by a variety of sources. Recently, concerns have been raised by volunteer EMS agencies regarding the availability of training programs, the cost of training, the number of miles that must be driven to obtain training and the type and availability of clinical experiences offered. Most volunteers must obtain initial training and continuing education while devoting much of their efforts toward another full-time occupation. These competing demands on the time and effort of volunteers make access to training a high priority for volunteer EMS agencies.

During the 2000 Virginia General Assembly, House Joint Resolution (HJR) 164 was introduced to direct the Joint Legislative Audit and Review Commission (JLARC) to study the regional emergency medical services (EMS) council offices' policies regarding compensation for training expenses, the location of clinical training and the impact of such policies on the ability of local volunteer EMS agencies to recruit volunteers. Although HJR 164 was not reported, the House Rules committee believed that the issues raised in HJR 164 were appropriate for the Office of EMS (OEMS) to review. OEMS concurred and initiated a process to address the issues. A copy of HJR 164 is included as Attachment A.

Methodology

In an effort to obtain more comprehensive data on the real costs of EMS training, OEMS contracted with Ms. Carolyn Rinaca to develop, administer and tabulate a survey of recent EMS students, licensed EMS agencies, certified Emergency Medical Technician (EMT) Instructors, Advance Life Support (ALS) Coordinators, Regional EMS Councils and Clinical sites. Ms. Rinaca is a Nationally Registered Paramedic with EMS research experience from George Washington University. She has published several national EMS studies.

The OEMS assisted in the development of the surveys and met with Delegate Albert Pollard, the patron of House Joint Resolution (HJR) 164 to discuss the questions. Delegate Pollard reviewed the questions and made suggestions, including the addition of some questions. After incorporating his suggestions and additions, OEMS mailed the surveys to individuals and organizations directly involved in EMS training, operations and recruitment.

OEMS contracted with Bob Bailey, Inc., an EMS consulting firm, to work with OEMS to analyze the data and develop a report discussing the findings and any appropriate recommendations. Mr. Bailey, President of Bob Bailey, Inc., is the principal investigator for this report and has over thirty years experience in local, state and national EMS issues. He is a past president of the National Association of State EMS Directors and served as a member of the steering committee of the '*EMS Agenda for the Future'* project. In June 2000, he completed an analysis of an opinion survey of all fifty state EMS directors for the federal Office of Rural Health Policy on the challenges facing rural EMS organizations.

The return rate for the Virginia surveys varied from 15.5% for EMS agencies to 100 percent for EMS Regional Councils. Additionally, responses to individual questions varied significantly.

Findings and Recommendations

There are significant resources being utilized in the Commonwealth of Virginia to offer EMS education and training. According to the survey responses initial and recertification courses, continuing education courses and bridge courses are being offered in every EMS region in Virginia. EMS agencies, regional EMS councils,

community colleges, OEMS and individual instructors are all engaged in providing and/or coordinating this service.

An analysis of the survey responses indicates that there is a wide variance in the cost of EMS education and training throughout Virginia. The variation in costs was not considered a barrier to recruitment of volunteers by the respondents. However, additional information and analysis beyond the scope of this survey is needed to determine the reasons for such variances and if cost efficient measures, alternatives (such as distance learning), or both, can be better utilized to reduce the overall cost to students.

There are additional resources available in Virginia that historically have not been used to provide EMS education, training and clinical experiences. The Virginia system of higher education is the 11th largest in the United States with over 100 colleges and universities. There are 15 public four-year colleges and universities, 23 community colleges and one two-year institution. Many of these institutions, including community colleges and vocational schools, have not participated in EMS education and training programs. Arranging for their participation in EMS education and training presents an unrealized opportunity.

The low number of survey respondents and even lower number of responses to individual questions makes it difficult to draw specific conclusions regarding the availability and cost of training. With the small number of responses, more information and detailed analysis is necessary to determine the magnitude of the costs, availability of training, travel time and clinical sites in impacting the recruitment and retention of EMS personnel. While complaints were presented in some survey responses, and some appeared valid, the number of complaints was minimal compared to the number of students receiving training.

Finally, OEMS, regional EMS councils and other EMS agencies should a) consider the motivation and dedication behind individual decisions to volunteer as EMS providers when developing recruitment and retention programs; and b) should realize that, as in any sector of the economy, there is an unavoidable structural element to personnel turnover and that some number of volunteers will choose to leave EMS service during any period despite efforts to retain them.

The following recommendations are offered as suggestions for increasing the availability of EMS training and clinical sites and reducing travel time and out-of-pocket costs to students.

1. Opportunities should be explored with the State Council of Higher Education for Virginia, the Virginia Community College System and other organizations to broaden the number of locations offering EMS education and training in order to have courses more locally available and at more convenient times.

2. Opportunities should be explored to provide clinical experiences at physician offices, urgent care centers, community health centers, mental health clinics, and other appropriate facilities to reduce travel time of students to receive clinical experiences. The result would be increased access to clinical experiences and the availability of a variety of clinical experiences, as well as fostering a strong partnership between the local health care providers and EMS system.

3. An in-depth study of the wide variances of the cost of instruction should be undertaken and solutions or alternatives developed to ensure educational costs are efficient, fair and consistent throughout the Commonwealth.

Summary of the EMS Advisory Board's Recommendations Pertaining to EMS Provider Appeals Process

Section of HB1856 Addressing EMS Provider Appeals

II. The State Emergency Medical Services Advisory Board to, by July 1, 2014, develop and facilitate the implementation of (i) a process whereby an emergency medical services provider who is certified by the Office of Emergency Medical Services pursuant to § 32.1-111.5 and who has received an adverse decision related to his authority to provide emergency medical care on behalf of an emergency medical services agency under the authority of an agency operational medical director shall be informed of the appeals process.

EMS Provider Appeals Process Introduction

The integral involvement of physician medical directors in EMS has been recognized as part of the foundation on which a successful pre-hospital emergency patient care system is built. Several professional organizations involved with the provision of pre-hospital care and medical direction have described the importance of medical directors in EMS systems and patient care and the unique qualities of the relationship between physician medical directors and EMS providers:

Handbook for EMS Medical Directors, FEMA, March 2012: http://www.usfa.fema.gov/downloads/pdf/publications/handbook_for_ems_medical_directors.pdf

NAEMT Position Statement: Medical Direction of Emergency Medical Services, 2010: http://www.naemt.org/Libraries/Advocacy%20Documents/3-30-10%20Medical%20Direction%20in%20EMS.sflb

Position Statement: Medical Direction for Operational EMS Programs, National Association of EMS Physicians, 2010: http://www.naemsp.org/Documents/POSITION%20MedDirforOperationalEMSPrograms.pdf

Position Paper: Physician Medical Direction in EMS, National Association of EMS Physicians.1998: http://www.naemsp.org/Documents/POSITION%20PhysicianMedDir.pdf

Policy Statement: Physician Medical Direction of EMS Education Programs, -1997: http://www.naemsp.org/Documents/POSITION%20PhysicianMedDir-eduprograms.pdf

The relationship between EMS providers and physician medical directors, referred to as an operational medical director or "OMD" in Virginia, is a unique relationship in healthcare. EMS providers function largely independently in the field, making complex decisions in patient assessment and subsequent decisions about patient care and disposition based on patient care protocols approved by their agency OMD.

Intimate physician involvement in certification training, continuing education, quality assurance and improvement functions, and provider discipline is different in many ways from physician interactions with other health care providers. It establishes a direct line of personal and professional responsibility on the part of the OMD for the patient care provided by EMS providers under his/her guidance and direction. Existing sections of Virginia Administrative Code (VAC) describe the scope of responsibility and authority of OMD's:

Virginia Emergency Medical Services Regulations
12VAC5-31-1040. Operational medical director authorization to practice.

A. EMS personnel as defined in § 54.1-3408 of the Code of Virginia may only provide emergency medical care while acting under the authority of the operational medical director for the EMS agency for which they are affiliated and within the scope of the EMS agency license. Privileges to practice must be on the agency's official stationery or indicated in the agency records which are signed and dated by the OMD.

12VAC5-31-1890. Responsibilities of operational medical directors.

A. Responsibilities of the operational medical director regarding medical control functions include but are not limited to medical directions provided directly to prehospital providers by the OMD or a designee either on-scene or through direct voice communications.
B. Responsibilities of the operational medical director regarding medical direction functions include but are not limited to:
    1. Using protocols, operational policies and procedures, medical audits, reviews of care and determination of outcomes for the purpose of establishing direction of education and limitation of provider patient care functions.
    2. Verifying that qualifications and credentials for the agency's patient care or emergency medical dispatch personnel are maintained on an ongoing basis through training, testing and certification that, at a minimum, meet the requirements of these regulations, other applicable state regulations and including, but not limited to, § 32.1-111.5 of the Code of Virginia.
    3. Functioning as a resource to the agency in planning and scheduling the delivery of training and continuing education programs for agency personnel.
    4. Taking or recommending appropriate remedial or corrective measures for EMS personnel, consistent with state, regional and local EMS policies that may include but are not limited to counseling, retraining, testing, probation, and in-hospital or field internships.
    5. Suspending certified EMS personnel from medical care duties pending review and evaluation. Following final review, the OMD shall notify the provider, the EMS agency and the Office of EMS in writing of the nature and length of any suspension of practice privileges that are the result of disciplinary action.

12VAC5-31-1900. OMD and EMS agency conflict resolution.

A. In the event of an unresolved conflict between the OMD and an EMS agency, the issues involved must be brought before the medical direction committee of the regional EMS council or local EMS resource for review and resolution.
B. When the EMS agency presents a significant risk to public safety or health, the OMD must attempt to resolve the issues in question. If a risk remains unresolved and presents an immediate threat to public safety or health, the OMD shall contact the Office of EMS for assistance.

Regulations Governing the Practice of Medicine, Osteopathy, Podiatry and Chiropractic: Virginia Board of Medicine

18VAC85-20-29. Practitioner responsibility.

A. A practitioner shall not:

1) Knowingly allow subordinates to jeopardize patient safety or provide patient care outside of the subordinate's scope of practice or area of responsibility. Practitioners shall delegate patient care only to subordinates who are properly trained and supervised;

Operational medical directors feel strongly that they must have control over the providers that provide patient care under their supervision given the medical director's direct responsibility for the providers' practice. In the vast majority of cases medical directors base their decisions related to provider practice based both on the quality of care provided to patients entering the EMS system as well as the quality of the entire pre-hospital experience for those patients, including provider/patient interactions and the interactions of the provider with family members and other members of the community, other fire/rescue personnel, law enforcement personnel, and other health care providers including medical office staff and hospital staff . Decisions regarding provider practice including limitations on practice, remedial training, or suspension of practice made by the medical director should be made in concert with and following discussion with the EMS agency's operational leadership and following existing policies and procedures. OMD's should be mindful that many EMS agencies have specific guidelines governing employee discipline that must be followed if a decision is contemplated that may affect the provider's position in the agency. It is understood that in some cases providers may feel that their medical director has rendered an adverse opinion related to their practice that they feel is in error for some reason. All efforts should be made to resolve such disagreements within the EMS agency involved, but there may be cases in which the provider still does not feel that their concerns have been adequately addressed and they desire another level of review and comment.

If the provider's EMS agency has a review and/or grievance procedure that is already in place then that procedure should be followed and the results of that process

used to resolve any continued disagreement between the EMS provider and the OMD. This process could be described in an agency policy or procedure, and could include existing jurisdictional (e.g. county or city) procedures or corporate procedures and may be described in employer/employee contracts or other agreements. Completion of an existing agency appeal or grievance procedure would be considered to constitute final resolution of the disagreement.

In situations in which an EMS agency does not have an existing policy or procedure to address provider concerns, a resource or template is provided to assist EMS agencies in developing a process for resolution of concerns regarding a provider's privileges to practice. A variety of resources could be used in the development of an agency appeal policy including consultation with other EMS agencies, local governments, and legal consultants. In cases where the EMS agency does not have an internal appeal process the agency could follow the process for addressing unresolved conflicts between an agency medical director and EMS agency leadership described in 12VAC5-31-1900. An EMS provider who has received an adverse decision related to their authority to provide emergency medical care could address their concerns to the medical direction committee, medical advisory committee or equivalent of the regional council in which the EMS agency resides. The regional medical director and members of the council medical direction/advisory committee, including peer reviewers, would then review the decision of the medical director as well as the circumstances that led to the decision and provide recommendations to assist in resolution of the disagreement. The review committee is encouraged to make use of peer level review in the review of decisions and formulation of recommendations. A face-to-face meeting may or may not be required for review by the committee. Recommendations by the council review committee could not be held to be binding on the medical director and his/her final decision on the provider's practice status, but would constitute recommendations for constructive resolution of disagreements.

Virginia EMS Advisory Board Recommendations for EMS Provider Appeals

Provider Appeals Template

In Virginia's EMS System, an EMS provider's right to practice is based on endorsement by their Operational Medical Director. For the purposes of this procedure, a "provider" is any individual certified as an EMS provider in Virginia at the level of First Responder or higher. Operational Medical Directors are recognized as having responsibility for the oversight of patient care activities provided by EMS agencies and for remedial training or discipline of the EMS providers that they endorse. (12VAC5-31-1890. Responsibilities of Operational Medical Directors). If in the opinion of the Operational Medical Director (OMD or Medical Director) after review of appropriate information, an action (or failure to act) on the part of a provider has been determined to compromise patient care directly or indirectly, the actions described below shall occur.

1) The provider will be notified in writing of the issues/concerns that merit attention by the Medical Director. Notwithstanding this written notice provision, the provisions of 2 and 3 below, and based on the severity and nature of the act (or failure to act), the Medical Director may immediately suspend a practitioner's right to practice upon receipt of information sufficient in the judgment of the Medical Director to present an immediate threat to patient safety pending further investigation. If the Medical Director invokes an immediate suspension, this shall be followed by written notice to include electronic notice within an appropriate time frame of such immediate suspension.

2) A written, or electronic, explanation by the provider explaining the incident shall be presented to the Medical Director within three (3) working days of receipt of the Medical Director's issues/concerns. If no written explanation of the incident is sent to the Medical Director by that deadline, the Medical Director may base his/her decision upon such information that is available to him/her as of that deadline.

3) The Medical Director, or the provider, may request a meeting to further discuss the issues/ concerns. If this option is exercised, the meeting shall occur within an appropriate time frame of receipt of the request.

4) After reviewing all materials, the Medical Director will issue a disposition of the matter. The Medical Director may exercise one or more of the following options:
   a) No action taken/matter resolved.
   b) Recommendation for remedial training.
   c) Written warning.
   d) Requirement to precept at the endorsed level for a period of time or number of calls/runs.
   e) Temporary suspension of all practice privileges or suspension of specific practice privileges.
   f) Permanent suspension of practice privileges.

   Any disciplinary action(s) taken by the OMD may extend to all agencies in which the provider is endorsed by the OMD. In addition, any disciplinary action(s) taken by the OMD may result in further enforcement action by the Office of EMS.

   After the individual is notified in writing of the Medical Director's decision, he/she may appeal as per the agencies standard operating guidelines (SOG). This appeal must be presented in writing within an appropriate time frame of the decision of the Medical Director to the Medical Director or his/her designee.

5) The committee reviewing the recommendations of the OMD will meet as soon as is practical after the receipt of the written request for appeal. If the practitioner's ability to practice has been suspended for greater than seven.

   (7) days, this meeting will be held with all deliberate speed and effort will be made to convene the meeting within ten (10) days. The committee may consist of the following representatives:

   a) Two (2) Physician members who are not the Medical Director such as the Regional Medical Director, or other physicians on the regional council.
   b) In cases involving ALS providers, two (2) paramedics plus one (1) physician.
   c) In cases involving BLS providers, one (1) ALS provider, one (1) BLS provider and one (1) physician.

6) One member of the review committee shall be designated as the presiding officer for

purposes of hearing an appeal. The presiding officer may elect to hear the witnesses and cross examination is not allowed. The only individual who may address the committee is the provider. The recommendations of the committee shall be presented in writing to the Medical Director.

7) In the event that the committee recommends that the provider be returned to practice under the license of the Medical Director, the Medical Director may continue the suspension. However, it is expected that the recommendations of the committee be considered in the Medical Director's final decision.

Summary of the EMS Advisory Board's Recommendations Pertaining to BLS Patient Care Template

Section of HB1856 Addressing BLS Patient Care Template

III. A standard operating procedure template to be used in the development of local protocols for emergency medical services personnel for basic life support services provided by emergency medical services personnel.

BLS Patient Care Template

Universal Patient Care Guideline

Scene Safety/ Personal Protective Equipment
Primary Survey
Supplemental O2
Obtain and document: Vital signs SAMPLE history Pain assessment OPQRST (medical) DCAP BTLS (trauma)
Appropriate guideline/ consider differential diagnoses If no guideline applies or condition is unknown, consult on-line medical control
Transport per guidelines

Cautions and notes:
Complete vital signs should be taken every 5 min for critical and 15 min for non-critical patients.
Complete vital signs include a minimum of HR, RR, and BP.
Complete vital signs include pulse oximetry.
Do not delay oxygen therapy to obtain pulse oximetry reading.

Abdominal Pain

B	Universal Care Protocol	B

Cautions and notes:
Consideration should be given to other causes of pain that could be interpreted as abdominal in origin such as cardiac pain.
For patients who require pain medication or nausea medication, ALS care should be requested.

Acute Psychological Agitation

B	Universal Care Protocol	B

Cautions and notes:
Careful consideration should be given to acute injuries and/or illnesses that could be responsible for acute changes in behavior, such as hypoglycemia and hypoxia, head injury, or stroke/ICH.
Consultation with law enforcement, mental health professionals, and medical command should guide patient disposition.
ALS care should be requested for patients who require sedation for agitation of a degree that represents a risk of injury to themselves or others.
Physical restraint should be undertaken with caution, and in cooperation and collaboration with law enforcement.

Allergy/Anaphylaxis

B	Universal Care Protocol	B
B	Remove from source of exposure.	B
B	Administer epinephrine using an auto-injector device for severe hives, respiratory distress, and/or shock.	B

Envenomation

B	Universal Care Protocol	B
B	Refer to allergy/anaphylaxis guideline if needed.	B
B	Minimize activity, remove tight clothing or jewelry, immobilize extremity at level of heart.	B
B	For exotic animals contact Poison Control. Do not delay transport.	B

Cautions and Notes:
Signs of envenomation include swelling that begins at the bite mark and spreads proximally within minutes, ecchymosis, hemorrhagic blisters, and severe pain.
Do not use constricting bands or tourniquets, apply cold, incise, or use suction or extractor devices in pit viper envenomations.
Notify the receiving facility if the animal involved is co-transported.
Black widow spider envenomations may present with painful muscle spasms.
Consider contacting Poison Control at 1-800-222-1222.

Hyperthermia

B	Universal Care Protocol	B
B	Move to cooler environment, remove excess clothing, protect from further heat gains.	B
B	For heat exhaustion, PO water if patient can tolerate. Cool with wet towels or fans.	B
B	For heat stroke, use aggressive evaporation (fine mist water spay, ice packs to groin and axillae).	

Cautions and Notes:
Prescription medications and alcohol may predispose patients to hyperthermia.
ALS care should be sought for patients with heat exposure and inability to tolerate oral rehydration, lack of response to oral hydration, or altered mental status.

Hypothermia

B	Universal Care Protocol	B
B	Refer to Special Arrest: Hypothermic Arrest Protocol if needed	B
B	Remove wet/cold garments.	B
B	Protect from further heat loss. Increase ambient temperature.	B
B	Apply heat packs if patient is responsive.	B
B	If moderate to severely hypothermic, wrap head and core with blankets.	B

Cautions and Notes:
If patient is centrally cold to touch, consider severe hypothermia.
Avoid rough handling of the severely hypothermic patient.
Consider hypothermia as a component of acute medical illnesses.
For local cold injury, do not initiate re-warming if there is a risk of re-freezing.

For review – Alaska guidelines

SEVERE HYPOTHERMIA WITH NO LIFE SIGNS:
Rewarming is key to arrest survival in hypothermia. Field techniques are ineffective. The goal is to deliver a viable patient to a facility that can perform effective rewarming (most clinics and hospitals).
Treat as above.
Use **mouth-to-mask** breathing.
An AED may help determine cardiac activity. If any organized (other than VT) electrical rhythm is shown, do not start CPR.
If no pulse (after checking for up to 60 seconds) and no respirations and no contraindications, start CPR. Initiation of chest compressions should only follow careful and adequate ventilation for 3 minutes.
Be careful to not hyperventilate patient-blows off CO2 and causes vasoconstriction.
If CPR can not be continued, it should not be started.
If facility or transport unit is available in less than 3 hours, do not start CPR. If not, and indicated, do CPR for 30 minutes and terminate if no response. If the core temperature is **86° F (30°C) or greater, defibrillation may be used** when indicated.
If core is less than **86° F (30°C),**one set of three stacked shocks may be given if indicated.
If resuscitation has been provided in conjunction with rewarming techniques for more than 60 minutes without the return of spontaneous pulse or respiration contact the base physician for recommendations. If contact with a physician is not possible and delivery of the patient to the receiving facility will be delayed, Emergency Medical Technicians may consider terminating the
resuscitation in accordance with AS 18.08.089.

Near Drowning

B	Remove from water if trained and safe to do so.	B
B	Spinal immobilization if spine injury is suspected or not able to be determined	B
B	Prevent heat loss, refer to “Hypothermia” protocol if indicated.	B

Cautions and Notes:
All near drowning patients should be transported/evaluated.
Almost all near drowning victims will be hypothermic to a greater or lesser extent.
Assess type of incident for the risk of other injuries (surface impacted, object strike, propeller trauma).
Assess water conditions (depth of submersion, length of time).
Monitor airway status closely.

Poisoning/ Overdose

B	Universal Care Protocol	B
B	Identify substance and assure decontamination.	B
B	Flush skin/membranes with water unless contraindicated.	B
B	Naloxone (Narcan) 2 mg IN, titrate to reverse respiratory depression for suspected narcotic overdose.	B

Cautions and notes:
Poison control should be contacted **at 1-800-222-1222**.
ALS care should be sought for patients with abnormal vital signs, significantly altered mental status, and any need for assistance with airway and ventilation.
Aeromedical resources will not transport contaminated patients.

Cardiac Arrest: General Management

B	Universal Care Protocol	B
B	Criteria for Death/ No Resuscitation?	B
B	CPR Interrupt compressions only as per AED prompt or every 2 minutes (5 cycles of CPR)	B
B	AED If witnessed or bystander CPR in progress, apply immediately If unwitnessed, use after 2 minutes of CPR	B
B	Advanced Airway Management Ventilate no more than 10/min (1 breath every 6-8 seconds)	B

Cautions and notes:
Change compressors every 2 minutes.
Allow full chest recoil.
Check femoral/carotid pulse to verify effective CPR.

Chest Pain/ Acute Coronary Syndrome

B	Universal Care Protocol	B
B	Obtain 12 Lead ECG per 12-lead guideline, Transmit 12 Lead ECG per local protocol Consult on-line medical control if acute myocardial infarction or STEMI criteria recognized Transport to closest appropriate facility per local/regional STEMI guidelines	B
B	Aspirin 162 to 324 mg (2-4 baby aspirin) chewed	B
B	Nitroglycerin 0.4 mg every 5 minutes as needed for continued chest pain. No maximum, keep BP >100 mmHg.	B
B	Apply 1 inch 2% Nitropaste (15 mg) topically keeping BP >100 mmHg.	B

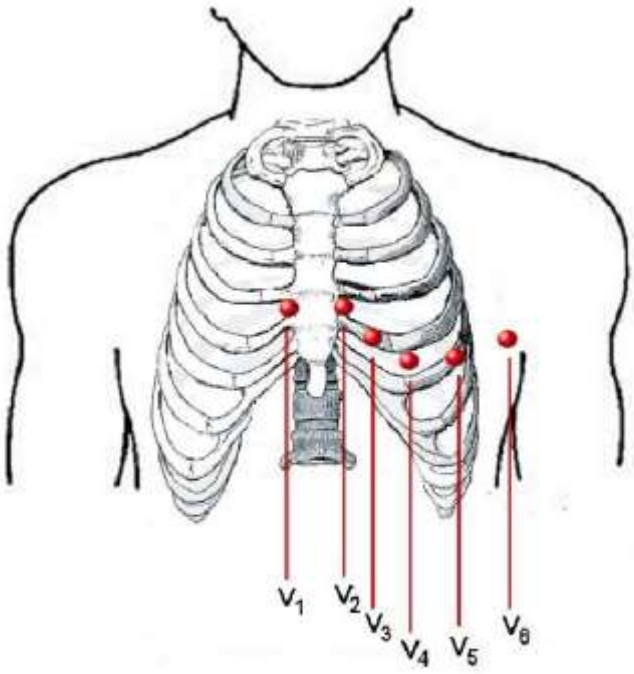
Cautions and Notes:

ALS care should be sought for all patients treated for chest pain or who have had a 12 lead EKG obtained.

If use of Viagra, Levitra, orCialis within the last 72 hours, contact medical command prior to administering nitroglycerine.

Achieving the most rapid transport to a PCI capable hospital may require consideration of the use of air medical resources.

12-lead EKG



First intercostal space is below the clavicle at the sternal border. The first palpable space at the sternal border is considered the second intercostal space.

V1—4th intercostal space at the right sternal border
V2—4th intercostal space at the left sternal border
V3—Directly between V2 and V4
V4—5th intercostal space at midclavicular line
V5—5th intercostal space at anterior axillary line
V6—5th intercostal space at midaxillary line

Altered Level of Consciousness

B	Universal Care Protocol	B
B	Spinal immobilization if indicated.	B
B	For proven or suspected hypoglycemia: Glucose orally if patient can swallow normally and protect airway Glucagon 1 mg IM if oral glucose is not appropriate. For suspected opiate overdose: Naloxone (Narcan) 2 mg IN	B

Cautions and Notes:
Medications are a common cause of altered mental status, including new medications, changes in medication dosages, and discontinued medications (either by design or by accident).
A complete medication list is particularly important in the evaluation of these patients.
Glucometers may be very helpful but results must be interpreted cautiously, particularly if values are borderline.
The goal of naloxone therapy in opiate overdose is to reverse respiratory depression and circulatory collapse, not to restore normal mental status or completely reverse opiate effects. Repeated administration of escalating doses beginning with a conservative dose is desirable.

Seizures

B	Universal Care Protocol	B
B	Protect patient. Do not attempt to restrain.	B
	If patient is hypoglycemic refer to diabetic emergencies guideline.	
B	If patient is pregnant and no history of seizure, refer to OB/GYN Eclamptic Seizure protocol	B

Cautions and notes:
Care during the post-ictal phase should focus on supportive measures.
Status epilepticus is defined as a prolonged seizure without recovery interval, and/or lack of response to first line therapy; it is a true emergency.
Family members, friends, and bystanders can often give a great deal of information about the patient's seizure history as well as the circumstances surrounding current episode.
Care should be given to evaluating each patient for any injuries suffered as a result of a seizure.
Although seizures may not be at all uncommon for patients treated for seizures, new onset seizures require thorough evaluation to exclude a serious cause for the seizure.
Remember that anyone can suffer a seizure when under sufficient metabolic stress, such as hypoglycemia or hypoxia.
Consider overdose or accidental drug ingestion in cases of new onset or unexplained seizures; in children, be sure to consider medications of other family members or household contacts.

Stroke

B	Universal Care Protocol	B
	Focused neurological exam. Cincinnati Prehospital Stroke Scale. Repeat every 15 minutes.	
B	Identify witness to last time pt was seen normal. Transport medical decision maker with pt if possible or obtain contact info for immediate contact by ED physician upon arrival.	B
	If patient's symptoms occurred less than two hours ago, refer to agency/local/regional stroke plan and/or on-line medical control to determine transport destination	
B	If patient is hypoglycemic refer to diabetic emergencies guideline.	B

Table I: Cincinnati Prehospital Stroke Scale

Sign of Stroke	Patient Activity	Interpretation
Facial Droop	Have patient look up at you, smile and show his teeth.	Normal: Symmetry to both sides. Abnormal: One side of the face droops or does not move symmetrically.
Arm Drift	Have patient lift arms up and hold them out with eyes closed for 10 seconds.	Normal: Symmetrical movement in both arms. Abnormal: One arm drifts down or asymmetrical movement of the arms.
Abnormal Speech	Have the patient say, "You can't teach an old dog new tricks."	Normal: The correct words are used and no slurring of words is noted. Abnormal: The words are slurred, the wrong words are used, or the patient is aphasic.

Pearls:
For a stroke patient to be considered for intervention, it is crucial to determine the onset of their symptoms, or"last time seen normal", and for a medical decision maker to be available for provision of informed consent if intervention is considered.
An accurate medication list is also important in the evaluation of the stroke patient, particularly to determine whether or not the patient is taking warfarin (Coumadin) or other anticoagulants (heparin, pradaxa, or others).

CHF/ Pulmonary Edema

B	Universal Care Protocol	B
B	CPAP protocol if available Start at 5-7.5 cm H20	B
B	12 Lead EKG, proceed to Chest Pain protocol if acute coronary syndrome is suspected	B
B	If systolic BP is > 140 mm Hg: 1 inch nitropaste and NTG 0.4 mg SL every 3-5 min, repeat as needed until BP <140 mmHg For systolic BP between 100 mm Hg and 140 mm Hg: Maintain nitropaste and hold further SL NTG For systolic BP < 100 mm Hg Remove nitropaste	**B**

Cautions and Notes:

Allow patient to assume a position of comfort, usually sitting up.
Use of nitropaste may be preferable to SL NTG if hypotension is likely to occur.
Sublingual nitrates and nitropaste may be used at the same time – sub lingual dosing used until topical nitrates have had time to achieve an effect.
Avoid NTG with use of Viagra, Cialis, or Levitra or herbal equivalents within past 72 hours.
The patient's medications may give important clues to the nature of their respiratory distress – "medication constellations" may indicate that the patient is receiving care for a primary problem such as asthma or congestive heart failure.

COPD/Asthma/Bronchospasm

B	Universal Care Protocol Refer to Allergic Reaction Protocol if needed	B
B	Administer albuterol via MDI or nebulizer, may repeat in 5 min Albuterol 2.5 mg and ipratropium 0.5 mg nebulized. May repeat treatments of albuterol as needed	B
B	Consider CPAP Protocol if available Start at 5-7.5 cm H20	B

Cautions and Notes:
All wheezing is not asthma – consider other causes of respiratory distress including congestive heart failure, infection/pneumonia, or inhalation injury in appropriate patients.
The patient's medications may give important clues to the nature of their respiratory distress – "medication constellations" may indicate that the patient is receiving care for a primary problem such as asthma or congestive heart failure.

Pneumonia

B	Universal Care Protocol	B
B	Administer albuterol via MDI or nebulizer, may repeat in 5 min Albuterol 2.5 mg and ipratropium 0.5 mg nebulized. May repeat treatments of albuterol as needed	B
B	Consider CPAP Protocol if available Start at 5 to 7.5 cm H20	B

Cautions and Notes: Patients with pneumonia will generally have had symptoms for hours to days prior to developing severe distress. Other symptoms such as fever and the production of purulent sputum may also be present and suggest pneumonia as the cause of the patient's symptoms.

Patients with pre-existing lung disease may develop symptoms such as prominent wheezing as a result of infection.

Sexual Assault

B	Universal Care Protocol	B
B	Confirm scene safety.	B
B	Do not examine genitalia unless a hemorrhage requires bleeding control.	B
B	Save any clothing and place in paper bag.	B
B	Advise patient not to urinate, defecate, douche, or wash before ED evaluation.	B
B	Transport to facility with sexual assault examiner capabilities.	B

Cautions and Notes:
Obtain only pertinent facts related to the trauma.
Do not question about prior events or information not directly related to care (assailant description, etc).
Ensure law enforcement has been informed.
Transport with provider of same gender if possible.

Vaginal Bleeding

B	Universal Care Protocol	B
B	Collect any tissue or fetal parts. Place in paper bag then into plastic bag for physician examination.	B
B	If hypotensive, refer to hypotensive protocol.	B

Caution and Notes:
Determine last menstrual period.
Always consider pregnancy and complications in women of child bearing age.
3rd trimester bleeding may constitute a medical emergency; contact medical command promptly.

Diabetic Emergencies

B	Universal Care Protocol	B
B	Glucometer protocol per agency medical direction and/or manufacturer recommendations	B
B	For proven or suspected hypoglycemia: Glucose orally if patient can swallow normally and protect airway Glucagon 1 mg IM if no IV access if oral glucose is not appropriate	B

Cautions and Notes:
If a glucometer is not available, or if there is a question about the accuracy of blood sugar measurements, then the patient should be treated if there is any question about hypoglycemia.
Blood sugar levels may fall again after treatment, changes in the patient's condition should prompt re-evaluation and re-treatment if indicated.
Glucometers are least accurate at the extremes of their range, borderline low readings should suggest empiric treatment with glucose.
An accurate medication list is very important in assessing patients with diabetic emergencies, particularly if there have been recent changes in medications or dosages.
Acute illnesses may frequently underlie diabetic emergencies, and providers should be alert for history or circumstances that suggest illness or injury.
Glucometers vary in their requirements for maintenance; agencies should follow the manufacturer's recommendations for maintenance and calibration.

Seizures in Pregnancy/Eclamptic Seizures

B	Universal Care Protocol	B

Cautions and Notes:
Hypertension in the pregnant patient is defined as 140/90 or an increase of 30 mmHg systolic or 20mmHg diastolic from patient's normal BP.
A prior history of seizures in a pregnant patient is very important and can greatly change management.
New onset seizures during pregnancy represent a medical emergency for mother and fetus, contact medical command promptly to ensure that appropriate resources are available.
Pregnant women should be placed in recovery position whenever possible, on their left side, with legs flexed.

Trauma: General Management

B	Universal Care Protocol	B
B	Spinal immobilization if indicated.	B
B	Notify on line medical control of possible trauma alert: Advise mechanism of injury, age and sex of patient, sites of injury, vitals and GCS if available, ETA.	B
B	Split columns within the general table for blunt and penetrating trauma?	B
B		B
B	Maintain patient warmth.	B

Amputation

B	Universal Care Protocol	B
B	For uncontrolled extremity bleeding, refer to hemorrhage control protocol.	B
B	If incomplete amputation, splint entire digit or limb in physiological position.	B
B	Place part in damp gauze, place in plastic bag, wrap in dressing, place on ice/water mix.	B

Burns

B	Universal Care	B
B	Apply dry sterile dressings.	B
B	Spinal immobilization if indicated.	B
B	Irrigate chemical burn with water if water is appropriate to chemical. If powdered chemical, brush off.	B
B	Splint fractures after applying dressing.	B

Cautions and Notes:
Electrical burns may be associated with significant internal and associated traumatic injuries.
In thermal burns associated with inhalation of products of combustion, consider carbon monoxide and cyanide exposure.
Remove jewelry and non-adherent clothing.
Avoid use of wet dressings to avoid the development of hypothermia.

Head Injuries

B	Universal Care Protocol	B
B	Spinal immobilization if indicated.	B
B		B
B	Maintain patient warmth.	B

Cautions and Notes:
GCS should be assessed and documented.
Intracranial pressure may cause hypertension, bradycardia, and altered respiratory rate.

Pediatric: Allergic Reaction

B	Universal Care Protocol, with emphasis on adequate oxygenation	B
B	Remove from source of exposure.	B
B	Administer epinephrine using a pediatric auto-injector device for severe hives, respiratory distress, and/or shock .	B

Cautions and Notes:
All patients who have received epinephrine should be transported for evaluation.

Pediatrics: Hyperthermia

B	Universal Care Protocol	B
B	Move to cooler environment, remove excess clothing, protect from further heat gains.	B
B	For heat exhaustion, oral fluids if patient can tolerate. Cool with wet towels or fans.	B
B	For heat stroke, use aggressive evaporation (fine mist water spay, ice packs to groin and axillae).	B

Cautions and Notes:
The major difference between heat exhaustion and heat stroke is CNS impairment.
Avoid dramatic decreases in temperature which can cause shivering and increase temperature.
Prescription medications and alcohol may predispose patients to hyperthermia.
ALS care should be sought for patients with heat exposure and inability to tolerate oral rehydration,
lack of response to oral hydration, or altered mental status.

Pediatric: Near Drowning

B	Universal Care Protocol	B
B	Remove from water if trained and safe to do so.	B
B	Spinal immobilization if indicated.	B
B	Prevent heat loss, refer to “Hypothermia” protocol if indicated.	B

Cautions and Notes:
All near drowning patients should be transported/evaluated
Almost all near drowning victims will be hypothermic to a greater or lesser extent.
Assess type of incident for the risk of other injuries (surface impacted, object strike, propeller trauma).
Assess water conditions (depth of submersion, length of time).
Monitor airway status closely.

Pediatric: Poisoning/ Overdose

B	Universal Care Protocol	B
B	Identify substance and assure decontamination.	B
B	Flush skin/membranes with appropriate solution if indicated.	B
B	Naloxone 0.1 mg/kg IN for suspected narcotic overdose. Max 2 mg.	B

Cautions and notes:
Poison control should be contacted **at 1-800-222-1222**.
ALS care should be sought for patients with abnormal vital signs, significantly altered mental status, and any need for assistance with airway and ventilation.
Aeromedical resources will not transport contaminated patients.

Pediatrics: General Management of Cardiac Arrest or Pre-Arrest

B	Universal Care Protocol	B
B	Check adequacy of CPR. Perform chest compressions if HR persistently <60 in child/infant or <80 in newborn. 15:2 for multiple rescuer / 30:2 for single rescuer	B
B	AED protocol using pediatric pads if stand alone defibrillator. Use adult pads when using multifunction device in AED mode. Ensure pads do not touch.	B
B	Ensure patient warmth.	B
B	Transport immediately with BLS measures while requesting ALS.	B

Pearls:

If pediatric pads are not available, use of adult pads is acceptable. Ensure they do not touch.

Pediatric: Newborn Resuscitation

B	Universal Care Protocol	B
B	Assess ABC's using base of umbilical cord, brachial or femoral artery, or auscultation of heart sounds.	B
B	Place newborn on back with neck in neutral position.	B
B	Suction mouth prior to nose. Note any meconium presence.	B
B	After delivery, use mild stimulation (dry, warm, suction). If effective respirations are not present after 5-10 seconds of stimulation, BVM at 40-60 breaths/minute.	B
B	If heart rate is <80 bpm with no improvement after BVM for 30 seconds, begin CPR.	B
B	Dry the newborn, wrap in blanket, head cap to maintain warmth. Do not allow newborn to become hypothermic.	B
B	Record APGAR's at 1 and 5 minutes.	B

Pediatric: Altered Level of Consciousness

B	Universal Care Protocol	B

Pediatric: Seizures

B	Universal Care Protocol, with emphasis on adequate oxygenation	B
B	Consider hypoglycemia Glucagon 1 mg IM if oral glucose is not appropriate	B

Pediatric: Respiratory Distress

B	Universal Care Protocol	B
B	Allow child to assume position of comfort.	B
B	Administer albuterol via MDI or nebulizer, may repeat in 5 min Albuterol 2.5 mg and ipratropium 0.5 mg nebulized. May repeat treatments of albuterol as needed	B

Pediatric: General Trauma Management

B	Universal Care Protocol, with emphasis on adequate oxygenation	B
B	Spinal immobilization if indicated.	B
B	Notify MedCom if possible trauma alert (red or yellow category): Advise mechanism of injury, age and sex of patient, sites of injury, vital if available, ETA.	B
B	For evisceration, cover with moist sterile dressing then with plastic. Do not push organs back into abdominal cavity.	B
B	Maintain patient warmth.	B

Pediatric: Amputation

B	Universal Care Protocol	B
B	Spinal Immobilization if appropriate.	B
B	Apply direct pressure to control hemorrhage. Hemorrhage control protocol	B
B	If incomplete amputation, splint entire digit or limb in position found.	B
B	Place part in damp gauze, place in plastic bag, wrap in trauma dressing, place on ice/water mix.	B

Pediatric: Burns

B	Universal Care Protocol, with emphasis on adequate oxygenation	B
B	Apply dry sterile dressings.	B
B	Irrigate chemical burn with water if water is appropriate to chemical. If powdered chemical, brush off.	B

Cautions and Notes:
In electrical burns, consider potential for additional traumatic injury.
In thermal burns, assess for carbon monoxide exposure.
Remove jewelry and nonadherent clothing.

Pediatric Trauma: CNS Injuries

B	Universal Care Protocol, with emphasis on adequate oxygenation	B
B	Spinal immobilization if indicated.	B
B	Maintain patient warmth.	B

Hemorrhage Control

In cases of uncontrolled extremity bleeding:

In cases of uncontrolled bleeding and signs/symptoms of hemorrhagic shock on first patient contact, proceed directly to tourniquet procedure.

Initial attempts at control should focus on direct pressure to the wound.

Compression dressings and hemostatic dressings may be applied in conjunction with direct pressure on the wound.

If direct pressure does not control bleeding, or signs/symptoms of shock develop, move promptly to tourniquet procedure.

In cases of gaping wounds or wounds with significant tissue loss, the wound may be packed with gauze to hemostatic dressing to control bleeding.

Durable Do Not Resuscitate (DNR)

Emergency regulations governing the Durable Do Not Resuscitate (DDNR) program, adopted by the Virginia State Board of Health, became effective January 3, 2000. The emergency regulations amend the EMS Do Not Resuscitate (DNR) regulations and establish a DDNR order that follows the patient throughout the entire health care setting. Once issued by a physician for his patient, the DDNR Order applies wherever that patient may be – home, EMS vehicle, hospital, nursing home, adult care residence or other health care facility.

DDNR Orders can now be written for anyone, regardless of health condition or age. Inclusion of minors is a significant change in the emergency DDNR Order. Durable DNR Orders can be recognized by qualified EMS personnel at all times and in all settings. Valid EMS DNR Orders are considers Durable DNR Orders and do not expire on or after July 2, 1998. Qualified EMS personnel may honor written DNR Orders written for patient in a licensed health care facility.

Other orders regarding treatment have been approved by the Office of EMS, including the applicable portion of Physician Orders for Life Sustaining Treatment (POST or POLST).

The responding EMS provider should:

Perform routine patient assessment and resuscitation or intervention until it is confirmed that the patient has either a Virginia Durable DNR Order or the EMS DNR Order, issued on or after July 2, 1998, a written physicians's order in a skilled care facility, or another accepted DNR order.

Request the original Virginia Durable DNR Form or the EMS DNR Order or POST or look for either form at patient's bedside, on the back of the patient's bedroom door, on the refrigerator or in the patient's wallet. If either of these forms has been defaced, consider the DNR Order to be invalid.

Make a good faith effort to verify identity of the patient through family, friends, and other health care personnel present or photo ID (such as a driver's license).

Be aware that a Virginia Durable DNR Form can be revoked by the following persons: The patient, by destroying the Virginia Durable DNR Form or EMS DNR Form or by verbally withdrawing consent to the order.

The person authorized to consent on the patient's behalf.

A physician who is physically present at the patient's side.

These comforting interventions are encouraged:

Airway (excluding intubation or advanced airway management)
Suction
Supplemental oxygen delivery devices
Pain medications or intravenous fluids
Bleeding control
Patient positioning
Other therapies deemed necessary to provide comfort care or alleviate pain.

Contact patient's physician or On-Line Medical Direction if questions or problems arise.

These Resuscitative measures should be avoided:
Withhold or withdraw if resuscitation has begun prior to confirmation of DNR status:

Cardiopulmonary Resuscitation (CPR)
Endotracheal intubation or other advanced airway management
Artificial ventilation
Defibrillation
Cardiac resuscitation medications
Continuation of related procedures, as prescribed by the patient's physician or medical protocols

Document the call:

Use the standard Pre-Hospital patient Care Report (PPCR) or agency run report to document which identification was used to confirm DNR status: Virginia Durable DNR Order Form, approved alternate form of identification, EMS DNR Order Form or other DNR form.

Indicate the Virginia Durable DNR Order Form number and the patient's attending physician's name. Comfort the family if the patient has expired on arrival and follow agency's procedure for death at home. Complete a PPCR or the agency run report.

Criteria for Death/ Withholding Resuscitation

DNR Patients

Indications:
Pulseless, non-breathing patient who would normally require resuscitation AND
Possess and on scene, properly completed, Virginia DDNR form, physician's order, or other accepted DNR form

Procedure:
Verify that the patient is the person named on the DNR form.
Cease all resuscitation efforts.
Notify law enforcement
Attach original or copy of DNR order to the completed PPCR.

Considerations:
If the patient requires care and is NOT in cardiac arrest, provide care up to the limits of the DNR and transport patient and DNR form.
Prehospital providers cannot honor other legal documents (living wills, etc) without contacting medical command.
DDNR forms may be overridden by patient, guardian of patient, or on-scene physician

Deceased Patients

Indications:
Rigor mortis and/or lividity
Decapitation
Traumatic cardiac arrest upon arrival

Procedure:
Do not resuscitate any patient who meets the above criteria. If resuscitation efforts are in progress, consider consulting medical command for discontinuation of efforts (see Discontinuation Policy) Notify law enforcement.

Emergency Custody Order

Order of substitute decision makers for incompetent patient: (Virginia Code § 54.1-2986)

- Legal guardian for patient (such as Medical Power of Attorney or agent for healthcare decisions in writing)
- Patient's spouse (except where divorce has been filed and is not final)
- Adult child of the patient
- Parent of the patient
- Adult brother or sister of the patient
- Other relative in descending order of blood relationship.

(Girlfriends, neighbors, others with no blood relationship DO NOT qualify as legal substitute decision makers).

Criteria for any ECO: a condition that is an immediate or imminent life threat with:

- a patient who "because of mental illness . . . or any other mental disorder or physical disorder which precludes communication or impairs judgment, is incapable of making an informed decision about providing, withholding or withdrawing a specific medical treatment. . ."

1. Note religious caveat (i.e. Jehovah Witness) that "no person shall authorize treatment . . . that such person knows is contrary to the religious beliefs of the patient unable to make a decision, whether expressed orally or in writing."
2. Virginia Code § 16.1-336. Definitions:
3. "Consent" means the voluntary, express, and informed agreement to treatment in a mental health facility by a minor fourteen years of age or older and by a parent or a legally authorized custodian.
4. "Incapable of making an informed decision" means unable to understand the nature, extent, or probable consequences of a proposed treatment or unable to make a rational evaluation of the risks and benefits of the proposed treatment as compared with the risks and benefits of alternatives to the treatment. Persons with dysphasia or other communication disorders who are mentally competent and able to communicate shall not be considered incapable of giving informed consent.

Psych ECO (Virginia Code § 37.2-808).

Does NOT require a physician assessment to get from magistrate—family or witness to suicidal thoughts / actions / evidence of significant risk of self-harm can call magistrate and request.

“probable cause to believe that any person (i) has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future, (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs, (ii) is in need of hospitalization or treatment, and (iii) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment.”

Emergency Custody Order

Medical ECO (Virginia Code § 37.1-134.21, § 37.2-1103). Emergency custody orders for adult persons who are incapable of making an informed decision as a result of physical injury or illness.

Requires:

Application by a licensed physician verifying that the "adult patient is incapable of making an informed decision as a result of physical injury or illness AND that the medical standard of care indicates that testing, observation, and treatment are necessary to prevent imminent and irreversible harm."

The physician's opinion of incapacity shall only be rendered after:

- either personal evaluation or electronic communication with EMS personnel on scene regarding their evaluation
- an attempt to communicate directly (or electronically) with the adult person to corroborate the EMS assessment of incapacity
- an attempt has been made to obtain consent from the adult person
- the adult person has failed to consent

The magistrate shall ascertain that the adult person:

- has no legally authorized person to give consent AND
- is incapable of making an informed decision regarding necessary treatment AND
- has refused transport AND
- has indicated intention to resist transport AND
- is unlikely to become capable of making an informed decision within the time required.

Should the patient's condition change and the patient become capable of making an informed decision (i.e. hypoglycemia resolved), the physician must be contacted and the patient's wishes respected.

Information needed from you for magistrate to issue medical ECO ("adult person" = patient):

- Name and permanent address of "adult person" if known
- Name of law enforcement agency on scene (+ officer, badge # if possible)
- Name, hospital affiliation, and contact number of licensed physician requesting ECO
- Present location of "adult person"
- Name and address of hospital that "adult person" is to be transported to. (UVA Hospital, 1215 Lee Street, Charlottesville, VA 22908)

You may also be asked what evaluation you plan to undertake. Since you haven't seen the patient yet, but you can't legally do anything that isn't on the order unless the patient consents, you may want to be fairly broad here. Some options may be: physical exam, radiologic studies (potentially including CT scan or MRI), intravenous access, medication therapy, possible mechanical ventilation, hospital admission, laceration repair, fracture management.