**MEDICAL DIRECTION COMMITTEE**
**1041 Technology Park Dr, Glen Allen, Virginia**
**Conference Rooms A and B**
**January 7, 2016**
**10:30 AM**

| Members Present: | Members Absent: | Staff: | Others: |
|---|---|---|---|
| Marilyn McLeod, M. D. - Chair | Theresa Guins, M.D. | Gary Brown | Adam Alford |
| E. Reed Smith, M.D. | Forrest Calland, M.D. | Scott Winston | Ron Passmore |
| George Lindbeck, M.D. | Chief Eddie Ferguson | Warren Short | Randy Breton |
| Stewart Martin, M.D. | | Michael Berg | Paul Roszko, MD |
| Scott Weir, M.D. | | Debbie Akers | |
| Tania White, M.D. | | Greg Neiman | |
| Cheryl Lawson, M.D. | | Adam Harrell | |
| Charles Lane, M.D. | | Robin Pearce | |
| Christopher Turnbull, M.D. | | | |
| Allen Yee, M.D. | | | |
| Paul Philips, D.O. | | | |
| Asher Brand, M.D. | | | |



| Topic/Subject | Discussion | Recommendations, Action/Follow-up; Responsible Person |
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| **1. Welcome** | The meeting was called to order by Dr. McLeod at 10:35 AM | |
| | | |
| **2. Introductions** | No Introductions, Attendance as per sign-in roster | |
| **3. Approval of Agenda** | | **Approved by consensus** |
| **4. Approval of Minutes** | Approval of minutes from the October 8, 2015 meeting with correction | **Motion by Dr. Martin with corrections, 2nd by Dr. Weir, motion carried** |
| | | |
| **6. Drug Enforcement Administration (DEA) & Board of Pharmacy (BOP) Compliance Issues** | Michael Berg reported there are a couple of active investigations with the DEA. On the Federal level, Dr. Lindbeck reported that a bill has been drafted to attempt to acknowledge EMS and how the pre-hospital environment functions such as protocols and standing orders for drug administration. | |
| **7. Old Business** | | |

| Topic/Subject | | Discussion | Recommendations, Action/Follow-up; Responsible Person |
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| | | | |
| **7. New Business** | | | |
| **A** | TCC Report | Dr. Lane reported that a proposal was presented for a state field preceptor program. A workgroup is being established to review and make recommendations. If you have interest, questions or insight please direct to Dr. Lane.<br>Workgroup concerning the future of Intermediate testing and certification. Dr. Lane expressed opinion concerning the future of the EMT-I programs. | |
| **B** | State Trauma Triage Plan – Dr. Charles Lane | Reported that his region was admonished for having the updated 2011 CDCC FTT plan. Interested in why the state trauma triage plan has not been updated as well. Robin Pearce reported that the regions can have a more stringent requirement but not a less stringent requirement. The trauma triage plan is currently under review but the regional plan must currently continue to follow the state requirements. Robin Pearce also reported that any information shared with an agency or OMD for PI purposes is not discoverable. Gary Brown stated that OEMS is not pursuing any legislative activities to amend and reenact § 32.1-111.4 of the Code of Virginia by adding "trauma center designation" to this section in the 2016 session of the Virginia General Assembly.<br>Dr. McLeod mentioned that the executive committee would be meeting at 1 pm today to address how to start moving forward with the recommendations from the ACS report. | |
| **C** | Regional Trauma Triage Plan – Dr. Charles Lane | Dr. Lane questioned why there is an inter-hospital trauma transfer requirement in the Regional Trauma Triage plans. Committee members stated that have no authority to hold hospitals responsible for these transfer requirements. Per Robin Pearce there is a requirement in the code of Virginia that a trauma transfer plan be in place. Offered clarification on how the regions should address patients who met trauma designation was not transported to a designated trauma center. Dr. McLeod stated there is no answer to the question currently and there is a lot of work to be done to reach answers to how the requirements will be met and who will hold responsibility. Currently the accountability for decisions doesn't exist and ACS has stated this accountability needs to be established. Questions and clarifications on the trauma plan were conducted. | |
| **D** | Image Trend ROSC – Dr. Charles Lane | Dr. Lane stated that ROSC is not an option on the Image Trend reporting system. Request to Gary Brown to review this item and why not an option on the data reporting. | **Add to review of the trauma division that is taking place.** |
| **E** | Image Trend – Service Calls – Dr. Charles Lane | Dr. Lane questioned the addition of a service call option on the Image Trend reporting system. Would be more effective if there was a field to subcategorize field service calls such as lifting assistance, out of oxygen, etc. Gary Brown reported that Paul Sharpe has tendered his resignation effective 01/08/15. OEMS is conducting meetings with OIM and working with Image Trend. These items will be added to items that need to be addressed. | **Add to review of the trauma division that is taking place.** |
| **F** | Scope of Practice Education – Manual wound packing – Dr. Charles Lane | Dr. Lane questioned where are we going with manual wound packing for the future in education and level of care. Dr. Reed Smith stated it is an EMS myth that packing a wound is against the scope of practice of an EMS provider. He stated it needs to be addressed and appropriate training be conducted. It is not outside the scope of practice in Virginia for the manual packing of wounds. Discussion by committee about new procedures and | **Dr. Lindbeck to review and stated that a quarterly review of the SOP can be conducted.** |

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| | | practices being introduced in the ED's and new products being released that could affect prehospital care and how these issues will be addressed and handled by MDC. | |
| **G** | Prehospital Stroke Treatment – Dr. Charles Lane | Dr. Lane stated that the treatment of stroke patients needs to be addressed and more education and guidance provided to prehospital patients on the most recent treatment modalities and evaluation needs for the stroke victim. Discussion by committee concerning this issue. | |
| **G** | IABP Comments – Dr. Marilyn McLeod | Dr. McLeod requested that Randy Breton offer clarification of his concerns about issues surrounding IABP and the lack of understanding by the Medical Direction Committee of the needs of the critical care transport agencies. He clarified his belief that there is a lack of support to the critical care inter-facility transport agencies and the demands of their agencies to move the patients from one facility to another with required appropriate staffing. He had made a request that a physician with inter-facility transport oversight be added to the committee. It is the feeling of the committee that there is representation on the committee already that meets this expectation. Dr. Lindbeck made recommendation that if you feel there are items that the committee is behind on addressing please bring them to the attention of the committee for consideration which can be done quarterly. | |
| | | | |
| **8. Research Notes** | | | |
| **A** | | N/A | |
| | | | |
| **9. State OMD – George Lindbeck, MD** | | | |
| **A** | Executive Summary – Spine – Injury Athlete and NAEMSP Response to NATA Executive Summary | Distributed the report from NATA 'Attachment A' and 'Attachment B' concerning use of the spine board on spine-injury athletes. Discussed the report and offered information. | **See Attachment 'A and B'** |
| **C** | Scope of Practice – 'Lay' level technologies | Discussed with committee how to address lay level devices that are being encountered in the pre-hospital environment (i.e., LVADs, home ventilators) and how these will be addressed in the SOP. It has been the approach that if the individual at home is taking care of these devices it is not outside of the scope of practice for EMS to transport but should include the family member familiar with the device. Stated that the current SOP addresses positives but made need to address items that are not appropriate and should be addressed as a negative. | **Dr. Lindbeck to draft language for consideration at next MDC meeting.** |
| **Office of EMS Reports** | | | |
| **A** | BLS Training Specialist – Greg Neiman | 1. EC Institute<br>a. The next Institute is in the Richmond Area beginning January 30.<br>b. Fifteen (15) eligible candidates – 14 have confirmed<br>c. Next EC psychomotor exam will be held in May – tentatively scheduled in Richmond<br>d. Next institute is set to coincide with the VAVRS Rescue College in Blacksburg June 11-15, 2016 | |

| | Topic/Subject | Discussion | Recommendations, Action/Follow-up; Responsible Person |
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| | | 2. Updates<br>a. The DED Division will stay on the road for 2016.<br>b. Have added a couple of Friday's to the schedule.<br>i. Held one update on Friday in June in the Western Council that was well attended<br>ii. Have had a few requests over the years to add Friday Updates instead of all Saturdays.<br>iii. Added one in January on 29th from 1-5 pm at Henrico Fire in Richmond and one in September in Fairfax.<br>c. See the latest schedule on our Webpage: http://www.vdh.virginia.gov/OEMS/Training/EMS_InstructorSchedule.htm<br>3. Instructor Recertification<br>a. Only a handful of EMT Instructors left in the system | . |
| | | | |
| **B** | ALS Training Specialist – Debbie Akers | 1. NR Stats '**Attachment C'**<br>a. Report distributed with statistics as 01/05/16<br>b. Previously concerns were expressed about the number of students never attempting the exam.In 2015 (Jan-Nov) 523 candidates never took the exam<br>c. Seeing better success rates on the retests for those failing the initial attempt<br>d. Students report they do not feel their instructor has adequately prepared them for the NR Cognitive examination<br>i. Instructors still offering only rote memorization tests instead of critical thinking exams.<br>2. Working on new CE Model<br>a. More information forthcoming<br>b. In April, all Enhanced will be AEMT's will become "C" Level<br>c. If a provider meets eligibility as of July 1 it will remain until they certify despite the changes in CE<br>3. Are addressing the issue with Medical Professional not being allowed to obtain NR certification based on their current policy regarding graduation from an accredited paramedic program<br>a. Have over 15 people waiting for an outcome | **See Attachment 'C'** |
| | | | |
| **C** | Accreditation – Debbie Akers | 1. Accreditation '**Attachment D'**<br>a. No substantial changes<br>b. ECPI has finalized their plans to offer EMS Education Newport News, VA Beach and Richmond<br>i. Contracted with Nick Klimenko and William Hall<br>ii. LSSR to CoA<br>c. As previously reported Roanoke Regional Intermediate Program was placed on probation. Have finished their last announced course Looking to revamp, may be contracting with Jefferson College in the future | **See Attachment 'D'** |

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| **D** | EMSTF – Adam Harrell | 1. EMSTF **'Attachment E'**<br>a. Report distributed.<br>b. FY17 Looking at some substantial changes to the program and may not be in place in FY17 and may be applied for FY18<br>c. Beginning July 1, will no longer fund Auxiliary Programs<br>d. 16th Percentile will begin<br>i. Latest calculation has been completed and should be posted to the web this week.<br>2. Website<br>a. We have Updated the DED Section<br>b. Please Provide feedback | **See Attachment 'E'** |
| **E** | Division of Educational Development – Warren Short | 1. Testing – Warren Short<br>a. Testing Continues<br>b. Reviewing Scenarios<br>2. Symposium<br>a. Only 400 or so proposals submitted<br>b. Usually have 700 or so<br>c. Please encourage people to submit proposals for 2016<br>d. Deadline moved to January 31, 2016<br>3. Testing order for EMT's<br>a. Brought up at TCC about testing order<br>b. Currently requires psychomotor testing to be completed prior to taking the cognitive examination<br>c. Is being reviewed by the office – hope to have a plan in place that removes the test order by July 1st. | |
| **F** | Regulation and Compliance – Michael Berg | 1. Regulations<br>a. Fast Track packet completed in July. Has been submitted to the Attorney General's office for signature that allows the addition of POST/POLST as a definition<br>b. Had a Fast Track Packet to add the word 'affiliation' back into section 910. Governor's Office has chosen not to support this change. Discussed at Executive Meeting. Have a couple of options. Conviction of certain crimes may prevent certification but will not prevent them from affiliating with agencies currently. | |

| Topic/Subject | | Discussion | Recommendations, Action/Follow-up; Responsible Person |
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| | | for money as well as CE. Waiting on letters from upstairs for 2 folks right now and have an ongoing case for a jurisdiction. | |
| **G** | Other Office Staff | **Karen Owens**<br>1. SALT Triage<br>a. Based on MUCC approach. There is no gray tape available anywhere. Will be looking at use of the Triage Tag immediately rather than the use of tape.<br>b. Will take about a year, late November around symposium to do the roll-out of the new information.<br>c. Will be working with the regional councils to assist in their triage plans.<br>d. Will require modifications to Module 1 and Module 2 for the instructors<br>e. Dr. Yee brought up the 30 day requirement for the report from the Regional Councils to submit a report of MCI. Karen Owens agreed to review the timeline requirement.<br>2. Sleep Deprivation Study<br>a. Health and Safety Committee is working on the sleep deprivation study, work on/work off timelines, etc. Still very preliminary work at this time.<br>b. Dr. Lindbeck mentioned the DOT is starting a committee to address this issue as well.<br>**Scott Winston**<br>1. Beginning Triannual Review EMS Plan<br>a. Template will be provided to each standing committee to obtain recommendations for what needs to be added or deleted to the plan<br>b. Will go to the EMS Advisory Board and then to Health Department<br>c. Will take about 18 months so mid-2017 before process is complete<br>2. Designation Process of EMS Councils<br>a. Required to be designated by BOH every 3 years<br>b. Received application from existing councils<br>3. Selecting site reviewers for visits Feb, Mar and Apr<br>4. Recommendations to Board of Health for designation that would be effective July 1, 2016<br>**Gary Brown**<br>1. Symposium<br>a. Reinforced need for symposium submissions and the support of this committee to send in proposals<br>2. Legislation<br>a. GA convenes next week<br>b. Long Session<br>c. Tracking upcoming EMS Related Legislation<br>i. REPLICA reintroduced | |

| Topic/Subject | Discussion | Recommendations, Action/Follow-up; Responsible Person |
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| | 1. Has broad support across the Commonwealth<br>2. Information, Talking points FAQ and Model Resolution is posted on our Website<br>d. Every Friday will send out a Legislative Report and post to our website<br>i. If a Bill affecting EMS is overlooked, please let us know<br>**Amanda Davis**<br>1. eGift and FARC<br>a. Addressed issues during last grant cycle and difficulties encountered by OMD's. Wanted to know if assistance needed to be offered for further assistance to the OMD's | |
| | | |
| **PUBLIC COMMENT** | | |
| **For The Good Of The Order** | 1. Dr. Yee wanted to know about access to ePCR by the hospitals. Additionally, the 12 hour timeline for the handoff of a patient report to the hospitals. | **Add to review of the trauma division that is taking place.** |
| **Future Meeting Dates for 2016** | January 7, 2016, April 7, 2016, July 7, 2016, October 6, 2016 | |
| **Adjournment** | 12:52 pm | |

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

Gary R. Brown
Director

P. Scott Winston
Assistant Director

COMMONWEALTH of VIRGINIA
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**Medical Direction Committee**
**Thursday, January 7, 2016 – 10:30 AM**
**OEMS Office – 1041 Technology Park Dr, Glen Allen, VA 23059**

**Meeting Agenda**

**I. Welcome**
**II. Introductions**
**III. Approval of Agenda**
**IV. Approval of Minutes from October 8, 2015**
**V. Drug Enforcement Administration (DEA) & Board of Pharmacy (BOP) Compliance Issues**
**VI. Old Business**
**VII. New Business**
a. Training & Certification Committee Report – Dr. Charles Lane
b. State Trauma Triage Plan – Use of 2011 CDC FTT plan – Dr. Charles Lane
c. Regional Trauma Triage Plan – Criteria for Interhospital Trauma Transfer – Dr. Charles Lane
d. Image Trend – ROSC – Dr. Charles Lane
e. Image Trent – Service Calls – Dr. Charles Lane
f. Scope of Practice Education – Manual wound packing – Dr. Charles Lane
g. IABP Comments – Dr. Marilyn McLeod
**VIII. Research Requests**
**IX. State OMD Issues – George Lindbeck, M.D.**
a. Executive Summary – Spine – Injury Athlete
b. NAEMSP Response to NATA Executive Summary
c. Scope of Practice – 'Lay' Level technologies
**X. Office of EMS Reports**
a. BLS Training Specialist - Greg Neiman, OEMS
b. ALS & Accreditation Training Specialist – Debbie Akers, OEMS
c. Funding – Adam Harrell, OEMS
d. Division of Educational Development (DED) - Warren Short, OEMS
e. Regulation & Compliance – Michael Berg, OEMS
f. Other Office Staff
**XI. Public Comment**
**XII. Dates for 2016 Quarterly Meetings**
~~a. January 7, 2016~~
b. April 7, 2016
c. July 7, 2016
d. October 6, 2016
**XIII. Adjourn**

# Attachment A

## NATA Executive Summary – Spine Injured Athletes

# APPROPRIATE CARE OF THE SPINE INJURED ATHLETE
## Updated from 1998 document

*Update (as of 8/5/15): NATA has received input from our membership and other organizations regarding the recent release of the Executive Summary from the Task Force on the Appropriate Prehospital Management of the Spine-Injured Athlete. The Task Force believes that the positions taken foster a "best practices" approach for our patients now and in the future. While we support the many locations that have already begun training initiatives for equipment removal, the Task Force does appreciate that the implementation of the positions nationally will take time and dedication. We believe that the input merits altering the wording to allow for greater flexibility.*

*To that end, the Task Force core writing group has proposed revising Recommendation #4 from reading "…equipment should be removed prior to transport" to "when appropriate, protective equipment may be removed prior to transport." The Task Force recognizes the variations in state emergency medical system protocols nationally, the availability of qualified EMS systems and hospital emergency departments locally, the differences in personnel and resources at various venues and levels of competition, and the uniqueness inherent in each situation and with each patient. These, along with medical-legal liability issues, lead us to conclude that it is prudent to state that health care providers make the decision regarding equipment removal on site based on the individual circumstances of the case.*

*Once the "Appropriate Prehospital Management of the Spine-Injured Athlete" statement is completed, reviewed, and approved by the professional organizations represented at the task force meeting, educational materials will be developed by NATA and other groups to assist those health care providers whose education and professional training may not include various components of the recommendations outlined in the consensus statement.*

*A list of frequently asked questions is currently in development. You may contact Katie Scott, MS, ATC, LAT, at katies@nata.org with any additional questions.*

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### Executive Summary

**Background:** In 1998 the National Athletic Trainers' Association served as the host organization for an inter-association task force to develop guidelines for the care of the spine injured athlete. This 2015 document is an executive summary update of that 1998 document providing revised recommendations and key insights for the management of the cervical spine injured athlete. Recently, members of the original task force and additional spine trauma researchers discussed many changes in the current literature regarding pre-hospital treatment protocols for the cervical spine injured athlete-patient. These changes were the impetus for the development of the second inter-association task force.

**Key Points:**

- Traumatic spinal cord injury (SCI) is a devastating condition that merits concerted focus due to its high rates of morbidity and mortality.
- Approximately 12,500 new cases of SCI are reported in the United States each year. Nine percent of these cases are due to participation in sports and recreational activities.
- The athlete-patient with a suspected SCI presents challenges for medical providers that are not common with the general population. The best example for this comes with athletes in equipment-intensive sports such as football, ice hockey and lacrosse where the equipment worn for protective purposes creates a treatment barrier for basic or advanced life support skills requiring access to the airway and chest.
- The sports medicine team must work together as an efficient unit in order to accomplish its goals. In an emergency situation, the team concept becomes even more critical, because miscommunication may lead to errors with potentially catastrophic repercussions.

**Recommendation 1: It is essential that each athletic program have an Emergency Action Plan (EAP) developed in conjunction with local EMS.**

- Preparation is *essential* and should include education and training, maintenance of emergency equipment and supplies, appropriate use of personnel and formation and implementation of an EAP.
- Ideally, an athletic trainer should be on site during all sporting events. If medical personnel are not present, sports administrators should develop procedures for implementing the EAP and ensuring that all coaches are trained as first responders to ensure appropriate care prior to the arrival of trained medical personnel.

**Recommendation 2: It is essential that sports medicine teams conduct a "Time Out" *before* athletic events to ensure EAPs are reviewed and to plan the options with the personnel and equipment available for that event.**

**Recommendation 3: Proper assessment and management of the spine injured athlete-patient will result in activation of the EAP in accordance with the level or severity of the injury.**

**Recommendation 4: Protective athletic equipment should be removed *prior* to transport to an emergency facility for an athlete-patient with suspected cervical spine instability.**

**Recommendation 5: Equipment removal should be performed by at least three rescuers trained and experienced with equipment removal at the earliest possible time. If fewer than three people are present, the equipment should be removed at the earliest possible time after enough trained individuals arrive on the scene.**

***Rationale for Equipment Removal***

- Recent changes in some emergency medical services (EMS) protocols have impacted management of spine injuries in the field and during preparation for and transportation to hospital emergency departments. In the past, it was recommended that protective equipment (e.g., helmets and shoulder pads in football, hockey and lacrosse) be left in place for transport and removed upon arrival in the hospital Emergency Department.
- It is essential and now recommended that, when appropriate, in an emergency situation with equipment-intensive sports (e.g., helmets and shoulder pads in football, hockey and lacrosse), the protective equipment be removed prior to transport to the hospital. Rescuers should be able to recognize when is it NOT appropriate to remove equipment on field of play and have a plan to best manage the patient. The rationale for consideration of equipment removal on the field is rooted in, but not limited to, the following concepts:
    - ***Advances in equipment technology***
    - ***Equipment removal should be performed by those with the highest level of training.*** In most cases, athletic trainers have been exposed to more equipment removal training than many other members of the medical team. As a result, individuals on the field may have a greater knowledge of equipment removal procedures than the hospital emergency department staff.
    - ***Expedited access to the athlete-patient for enhanced provider care***
    - ***Chest access is prioritized***

**Recommendation 6: Athletic protective equipment varies by sport and activity; and styles of equipment differ within a sport or activity. Therefore, it is essential that the sports medical team be familiar with the types of protective equipment specific to the sport and associated techniques for removal of the equipment.**

- A wide variety of facemasks, helmets and shoulder pads exist in the various sports. Members of the medical team should be skilled in facemask, helmet and shoulder pad removal. In an emergency situation, it is important to have access to the airway and chest. As the chest is not accessible when wearing shoulder pads, it is recommended that the medical team remove the shoulder pads on the field of play.

**Recommendation 7: A rigid cervical stabilization device should be applied to spine injured athlete-patients prior to transport.**

- A rigid cervical collar should be applied at the earliest and most appropriate time possible during pre-hospital procedures. With practice, cervical collars can be placed and removed with manual in-line stabilization and potentially minimal risk.
- The medical team needs to continue manual in-line stabilization even after the rigid cervical collar is applied. Several research studies have demonstrated that rigid cervical collars are not effective in controlling cervical spine motion in all planes of movement. Manual in-line stabilization must be maintained until the athlete-patient has been stabilized on a full body immobilization device and a head immobilization device has been applied.

**Recommendation 8: Spine injured athlete-patients should be transported using a rigid immobilization device.**

- The transport of the spine injured athlete-patient requires special considerations which may include, but are not limited to the mechanism of injury, size of the athlete-patient, equipment worn by the athlete-patient, and the number and skill level of the sports medical team members.
- Throughout the years different terminology has been used by pre-hospital medical care teams to describe procedures used to prevent iatrogenic spinal cord injuries. Initially spinal traction was used and was followed by spinal immobilization. Sports medical care teams must now recognize the concepts of ***spinal motion restriction*** (SMR) as compared to spinal immobilization. SMR implies that true spinal immobilization cannot be obtained even with the patient securely strapped to a spine board. Like spinal immobilization, the premise of SMR is to prevent further harm to a spinal cord or column injury.
- Criteria for the use of SMR guidelines and immobilization devices should include:
    - Blunt trauma with altered level of consciousness
    - Spinal pain or tenderness
    - Neurologic complaint (e.g., numbness or motor weakness)
    - Anatomic deformity of the spine
    - High-energy mechanism of injury and any of the following:
        - Drug or alcohol intoxication
        - Inability to communicate
        - Distracting injury
- Recent publications have expressed concern related to the use of the long spine board due to potential harmful effects to the patient if the patient remains on the long spine board for an extended period of time. However, in the case of a potentially spine injured athlete it is recommended that a long spine board or other immobilization device be used for transport.
- The ED medical team is encouraged to assess the athlete-patient on arrival to the ED. Following the assessment, the athlete-patient should be transferred off the spine board to the appropriate hospital bed for further care to decrease chances of pressure sore development and other potential detrimental side effects related to a prolonged length of time on the board.

**Recommendation 9: Techniques employed to move the spine injured athlete-patient from the field to the transportation vehicle should minimize spinal motion.**

- The spine injured athlete-patient should be transferred to the long spine board or vacuum mattress using a technique that limits spinal motion.
    - In the case of a supine positioned athlete, the medical team should use the 8-person lift (previously described as the six-plus lift) to move the athlete-patient to the long spine board.
    - The scoop stretcher may be employed to lift the supine athlete-patient from the field.

- In the case of a prone positioned athlete, the medical team should position the spine board and use a log roll push technique to place the athlete-patient on to the long spine board.

**Recommendation 10: It is essential that a transportation plan be developed prior to the start of any athletic practice or competition.**

**Recommendation 11: Spine injured athlete-patients should be transported to a hospital that can deliver immediate, definitive care for these types of injuries.**

- The choice of the *most appropriate hospital* should be determined and written in the EAP.
- If definitive care is not readily available, spine injured athlete-patients should be transported to the nearest hospital for stabilization and possible air medical evacuation to the nearest trauma center. Attempts should be made to avoid this extra delay in definitive care as the patient in this scenario might have improved outcomes with expeditious definitive management.
- Emergency medical teams should keep in mind that every time the spine injured athlete-patient is moved, the chance for additional neurological compromise increases. For this reason, transfer of the athlete-patient in the pre-hospital setting and within the ED should be kept to a minimum and appropriate transfer devices should be used.
- ED staff must avail themselves of training modules in the event an athlete arrives with equipment in place.

**Recommendation 12: It is essential that prevention of spine injuries in athletics be a priority and requires collaboration between the medical team, coaching staff and athletes.**

**Recommendation 13: The medical team must have a strong working knowledge of current research, as well as national and local regulations to ensure up-to-date care is provided to the spine injured athlete-patient.**

**Recommendation 14: It is essential that future research continue to investigate the efficacy of devices used to provide spinal motion restriction.**

*The National Athletic Trainers' Association (NATA) and the Inter-Association Task Force for Appropriate Care of the Spine Injured Athlete advise individuals, schools, athletic training facilities, and institutions to carefully and independently consider each of the recommendations. The information contained in the statement is neither exhaustive nor exclusive to all circumstances or individuals. Variables such as institutional human resource guidelines, state or federal statutes, rules or regulations, as well as regional environmental conditions, may impact the relevance and implementation of these recommendations. The NATA and the Inter-Association Task Force advise their members and others to carefully and independently consider each of the recommendations (including the applicability of same to any particular circumstance or individual). The foregoing statement should not be relied upon as an independent basis for care but rather as a resource available to NATA members or others. Moreover, no opinion is expressed herein regarding the quality of care that adheres to or differs from any of NATA's other statements. The NATA and the Inter-Association Task Force reserve the right to rescind or modify their statements at any time.*

**Participating Organizations***

American Academy of Family Physicians
American Academy of Neurology
American Academy of Orthopaedic Surgeons – Committee on the Spine
American Academy of Pediatrics – Committee on Sports Medicine and Fitness
American College of Emergency Physicians
American College of Sports Medicine
American College of Surgeons – Committee on Trauma
American Medical Society for Sports Medicine
American Orthopaedic Society for Sports Medicine
Canadian Athletic Therapists' Association
College Athletic Trainers' Society
National Association of EMS Physicians
National Association of EMTs
National Association of Intercollegiate Athletics
National Association of State EMS Officials
National Athletic Trainers' Association
National Collegiate Athletic Association

National Federation of State High School Associations
North American Spine Society
Professional Football Athletic Trainers Society
United States Olympic Committee

***Participation doesn't imply endorsement of the Executive Summary. Participating organizations will be asked to endorse the final consensus statement once it is developed.**

# Attachment B

## NAEMSP Response to NATA Executive Summary

**NAEMSP Response to NATA Executive Summary on the Appropriate Care of the Spine Injured Athlete**

The National Association of EMS Physicians (NAEMSP) supports efforts to collaborate and improve the care provided to athletes with the potential for spinal injuries. The approach to the care of patients with potential of spine injuries has changed as the medical evidence improves. Many studies have questioned practices of "spinal immobilization" and many EMS agencies around the world have begun advancing their practices to reflect this evolving evidence of best practice in this area

**Recommendation 1: Each athletic program develop an EAP in conjunction with EMS**

NAEMSP supports this recommendation. It is essential that athletic programs plan and train with local EMS to provide care to potentially injured athletes. With established collaborations, the transition of patient care will be improved.

**Recommendation 2: Time outs**

NAEMSP supports this recommendation

**Recommendation 3: Proper assessment of the patient**

NAEMSP supports this recommendation

**Recommendation 4: Protective equipment should be removed prior to transport**

NAEMSP supports this recommendation.

**Recommendation 5: Removal of Equipment by at least three trained providers**

NAEMSP supports this recommendation. With appropriate preplanning and training between athletic programs and EMS, the collaborative team is better prepared to remove equipment while minimizing spinal motion.

**Recommendation 6: Sports medical teams need to be familiar with the protective equipment**

NAEMSP supports this recommendation. With the various removal techniques, EMS providers should be familiar with the removal procedures for equipment used by athletes in their localities.

**Recommendation 7: Rigid cervical stabilization devices.**

NAEMSP supports the intent of recommendation. As noted in the recommendation, there are several studies which have demonstrated that the rigid cervical collars are ineffective in controlling spinal motion. Additionally, there are other studies with have demonstrated an increase in intracranial pressures. Rigid cervical Collars may also induce distraction of existing injuries and cause potential difficulty in assessing and controlling the airway

**Recommendation 8: Transport using a rigid immobilization device**

NAEMSP cannot fully support this recommendation. As noted in the 4th bullet of the recommendation, recent publications have expressed concern related to the use of the long spine board due to potential harmful effects if the patient remains on the board for an extended period of time. Long spine boards are appropriate as a patient transfer device (i.e. aid in transfer from ground to stretcher). Its lack of utility as a patient transport tool has resulted in its removal from use by many EMS systems.

NAEMSP supports collaborative approaches at a community level between EMS Medical Leadership and local sports trainers and sports physicians regarding the safest means of field treatment and transport of the potentially spinal injured athlete. This should be based upon local EMS standards and founded in the evolving evidence of best practice in this area.

NAEMSP does support comments regarding rapid ED assessment and removal of backboard within the 5th bullet. However, this may be an unnecessary commentary on a standard practice of emergency physicians and nurses.

**Recommendation 10: Transportation plan be developed prior to practice or competition**

NAEMSP supports the recommendation.

**Recommendation 11: Spine injured athlete-patients should be transported to a hospital that can deliver immediate, definitive care for these types of injuries**

NAEMSP supports recommendations to preplan destination decisions. Transport of the injured athlete to an appropriate facility for initial evaluation/stabilization and/or definitive care should be based on accepted local trauma destination determination guidelines/practice patterns If a definitive care hospital is not readily available, the transport to the “closest appropriate” hospital may be better wording than the “nearest” hospital. After stabilization at the closest appropriate hospital, the injured athlete should be transferred to the “most appropriate trauma center or other hospital with services which can provide definitive care” for the injured athlete.

**Recommendation 12: Prevention of spine injuries**

NAEMSP supports the recommendation.

**Recommendation 13: Medical team should have strong knowledge of current research**

NAEMSP supports the recommendation.

**Recommendation 14: Future research on the efficacy of devices**

NAEMSP supports the recommendation.

# Attachment C

## National Registry BLS Statistics

# EMT Statistics
# As of 1/05/2016

**Virginia:**

| | |
|---|---|
| **Report Date:** | 1/5/2016 3:27:31 PM |
| **Report Type:** | State Report (VA) |
| **Registration Level:** | EMT-Basic / EMT |
| **Course Completion Date:** | 3rd Quarter 2012 to 1st Quarter 2016 |
| **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 |
|---|---|---|---|---|---|---|
| 8515 | 65% (5555 / 8515) | 76% (6435 / 8515) | 76% (6491 / 8515) | 0% (5 / 8515) | 13% (1131 / 8515) | 10% (890 / 8515) |

**National Registry Statistics:**

| | |
|---|---|
| **Report Date:** | 1/5/2016 3:29:36 PM |
| **Report Type:** | National Report |
| **Registration Level:** | EMT-Basic / EMT |
| **Course Completion Date:** | 3rd Quarter 2012 to 1st Quarter 2016 |
| **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 |
|---|---|---|---|---|---|---|
| 229647 | 69% (157446 / 229647) | 79% (182219 / 229647) | 80% (183606 / 229647) | 0% (200 / 229647) | 11% (26157 / 229647) | 9% (19806 / 229647) |

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

# Attachment D

## Accreditation Report

# Accredited Training Site Directory

As of January 5, 2016

Virginia
OFFICE OF EMERGENCY MEDICAL SERVICES
Virginia Department of Health

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## *Accredited Paramedic Training Programs in the Commonwealth*

| Site Name | Site Number | BLS Accredited | # of Alternate Sites | Accreditation Status | Expiration Date |
|---|---|---|---|---|---|
| ***American National University***[1] | 77512 | Yes | -- | National – Suspended | CoAEMSP |
| ***Central Virginia Community College*** | 68006 | Yes | -- | National – Continuing | CoAEMSP |
| ***Germanna-Rappahannock EMS Council***[2] | 63007 | No | -- | Suspended LOR | |
| ***Historic Triangle EMS Institute***[3] | 83009 | No | 1 | Voluntary Retired | CoAEMSP |
| ***J. Sargeant Reynolds Community College*** | 08709 | No | 5 | National – Continuing | CoAEMSP |
| ***Jefferson College of Health Sciences*** | 77007 | Yes | --- | National – Continuing | CoAEMSP |
| ***John Tyler Community College*** | 04115 | No | -- | 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 | |
| ***Piedmont Virginia Community College*** | 54006 | Yes | -- | National – Continuing | CoAEMSP |
| ***Prince William County Dept of Fire and Rescue*** | 15312 | Yes | -- | CoAEMSP – LOR | |
| ***Rappahannock Community College*** | 11903 | Yes | -- | CoAEMSP – LOR | |
| ***Southside Virginia Community College*** | 18507 | No | 1 | National – initial | CoAEMSP |
| ***Southwest Virginia Community College*** | 11709 | Yes | 4 | National – Continuing | CoAEMSP |
| ***Stafford County & Associates in Emergency Care*** | 15319 | No | 1 | National – Continuing | CoAEMSP |
| ***Tidewater Community College*** | 81016 | Yes | 4 | 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.

- [1]American National University has suspended their CoAEMSP accreditation for a period of up to 2 years.
- [2]Germanna-Rappahannock EMS Council has suspended their Letter of Review.
- [3]Historic Triangle EMS Institute voluntarily retired their Paramedic accreditation effective April, 2015. Current cohort of students will complete and test for their National Registry certification.
- Prince William County has completed their first cohort class and their initial accreditation site visit is scheduled for November, 2015.
- Rappahannock Community College has completed their first cohort class and will be working on the submission of their self study.
- Central Shenandoah EMS Council is in the process of accreditation at the paramedic level in Virginia which is described on the OEMS web page at: http://www.vdh.virginia.gov/OEMS/Training/Paramedic.htm
- John Tyler Community College has been granted their Letter of Review from CoAEMSP.

## ***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 | 3* | State – Full | May 31, 2016 |
| ***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, 2017 |
| ***Henrico County Fire Training*** | 08718 | No | -- | State – Full | August 31, 2020 |
| ***James City County Fire Rescue*** | 83002 | No | -- | State – Full | February 28, 2019 |
| ***Nicholas Klimenko and Associates*** | 83008 | Yes | 2 | State – Full | July 31, 2016 |
| ***Norfolk Fire Department*** | 71008 | No | -- | State – Full | July 31, 2016 |
| ***Paul D. Camp Community College*** | 62003 | No | -- | State – Conditional | May 31, 2016 |
| ***Roanoke Regional Fire-EMS Training Center*** | 77505 | No | -- | State – Probation | July 31, 2016 |
| ***Southwest Virginia EMS Council[1]*** | 52003 | No | -- | State – Conditional | December 31, 2015 |
| ***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.

- [1]One year visit will be scheduled in the next month to review paperwork and evaluations from initial course.

## ***Accredited AEMT Training Programs in the Commonwealth***

| *Site Name* | *Site Number* | *# of Alternate Sites* | *Accreditation Status* | *Expiration Date* |
|---|---|---|---|---|
| ***Frederick County Fire & Rescue*** | 06906 | -- | State – Conditional | **July 31, 2016** |

## *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 – Conditional | July 31, 2016 |
| **Chesterfield Fire & EMS** | 04103 | -- | State – Conditional | July 31, 2016 |

# Attachment E

## EMSTF Report

# Emergency Medical Services Training Funds Summary

As of January 5, 2016

Virginia
OFFICE OF EMERGENCY MEDICAL SERVICES
Virginia Department of Health

Virginia
OFFICE OF EMERGENCY MEDICAL SERVICES
Virginia Department of Health

# ***EMS Training Funds Summary of Expenditures***

| Fiscal Year 2014 | *Obligated $* | *Disbursed $* |
|---|---|---|
| | | |
| 19 Emergency Ops | $1,120.00 | $360.00 |
| 40 BLS Initial Course Funding | $785,196.00 | $380,237.25 |
| 43 BLS CE Course Funding | $94,010.00 | $39,182.50 |
| 44 ALS CE Course Funding | $224,950.00 | $80,115.00 |
| 45 BLS Auxiliary Program | $130,000.00 | $61,300.00 |
| 46 ALS Auxiliary Program | $304,000.00 | $177,985.00 |
| 49 ALS Initial Course Funding | $1,188,504.00 | $615,334.15 |
| **Total** | **$2,727,780.00** | **$1,354,513.90** |

| Fiscal Year 2015 | *Obligated $* | *Disbursed $* |
|---|---|---|
| | | |
| 19 Emergency Ops | $2,480.00 | $540.00 |
| 40 BLS Initial Course Funding | $737,320.50 | $354,375.75 |
| 40 BLS Initial Course Funding | $4,284.00 | $0.00 |
| 43 BLS CE Course Funding | $58,460.00 | $32,663.80 |
| 44 ALS CE Course Funding | $146,335.00 | $66,263.75 |
| 45 BLS Auxiliary Program | $88,705.00 | $17,960.00 |
| 46 ALS Auxiliary Program | $548,376.00 | $141,720.00 |
| 49 ALS Initial Course Funding | $1,009,204.00 | $591,193.05 |
| **Total** | **$2,595,164.50** | **$1,204,716.35** |

| Fiscal Year 2016 | *Obligated $* | *Disbursed $* |
|---|---|---|
| | | |
| 19 Emergency Ops | $0.00 | $0.00 |
| 40 BLS Initial Course Funding | $0.00 | $46,544.28 |
| 40 EMT Initial Course | $503,064.00 | $124,749.37 |
| 43 BLS CE Course Funding | $0.00 | $5,320.00 |
| 43 Category 1 CE Course | $104,422.50 | $16,563.75 |
| 44 ALS CE Course Funding | $0.00 | $8,251.25 |
| 45 Auxiliary Course | $322,720.00 | $34,000.00 |
| 45 BLS Auxiliary Program | $0.00 | $4,280.00 |
| 46 ALS Auxiliary Program | $0.00 | $39,360.00 |
| 49 ALS Initial Course | $954,720.00 | $255,692.53 |
| 49 ALS Initial Course Funding | $0.00 | $92,486.90 |
| **Total** | **$1,884,926.50** | **$627,248.08** |