

July 2014



**Special points of interest:**

- **Vermont Healthcare & EMS Preparedness Conference is October 14-19th at Killington Grand Resort**
- **All of the ambulances in Vermont will be inspected this summer & fall**
- **SALT compliant triage tags are on their way to all services in Vermont**
- **Stephanie Busch starts July 14th in the EMS-C position!!!**

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# Vermont EMS News

## Statewide SIREN Date—Jenna Protzko

Congratulations Vermont EMS, 100% of our licensed ground ambulance services are successfully reporting into SIREN!! With more electronic pre-hospital patient care information than we've ever had before, we have been able to use this data for statewide continuous quality assurance/quality improvement, protocol review, research on pre-hospital responses to farm related injuries and also for highway safety projects and research. Thank you for

your efforts in continuing to provide the most accurate and reliable information as we continue to expand these research efforts. Below are some examples of how we use pre-hospital records for analysis and review, related to statewide CQI:

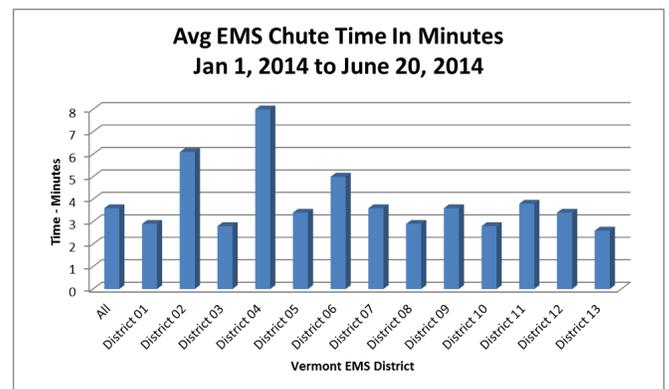
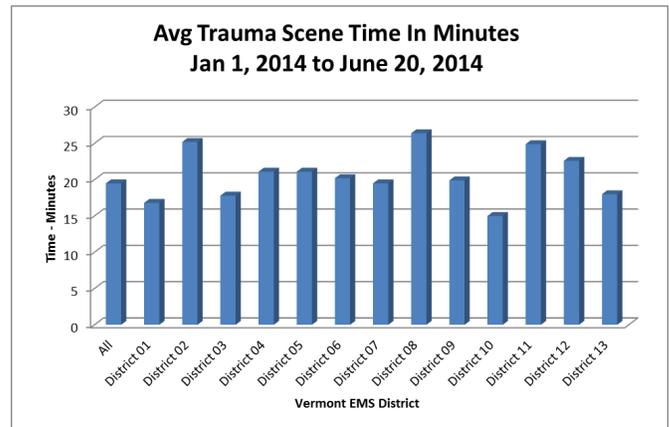
For all electronic Patient Care Report (ePCR) Service Administrators - Please feel free to explore the pre-built CQI reports in SIREN's Report Writer to analyze

information specific to your agency. Contact Jenna Protzko with any questions.

**Documentation goals for this quarter:** STEMI Alert, 12 lead ECG, and Stroke Alert documentation accuracy.

Memos will soon be released to ePCR Service Administrators regarding documentation guidance. Please see your Service Administrator for details.

Statewide Incidents by Type of Service Requested Jan 1, 2014 to June 20, 2014	
Type of Service Requested	Count of Responses
Total Calls	36,219
911 Response (Scene)	27,774
Flagdown/Walk-in Emergent	58
Flagdown/Walk-in Non-emergent	19
Intercept	528
Interfacility Transfer (Scheduled)	3,436
Interfacility Transfer (Unscheduled)	1,787
Medical Transport	1,473
Mutual Aid	825
Standby/Special Event	238
Not Available	81





*"We make a living  
by what we get, but  
we make a life by  
what we give" -  
Winston Churchill*



## Call of the Wolf—Dr. Wolfson

### Avoiding Pitfalls in Advanced Spinal Assessment

The Advanced Spinal Assessment protocol is designed to decrease injury and discomfort to patients caused by unnecessary spinal immobilization while ensuring that no spinal injuries are missed. ALL patients that have a mechanism of injury that could cause a spinal injury, including **"high risk"** OR **"questionable"** injury mechanisms, should have a spinal assessment. All steps of the spinal assessment algorithm must be documented in the ePCR. Several questions have come up regarding how to properly apply the algorithm. Reviewing the following cases will help avoid pitfalls in Advanced Spinal Assessment.

**Case #1 "Questionable Injury":** A 42 year old male crashes his car into a tree at 50 mph. He is ambulatory on scene with no complaints. No spinal assessment was performed as the patient did not have a high risk mechanism. Comments: This patient absolutely needed a spinal assessment. Crashing a car into a stationary object at 50 mph represents a significant potential mechanism of injury. The protocol describes "High Risk" mechanisms which include motor vehicle crash > 60

mph, rollover, ejection, falls > 3 feet/5 stairs, axial load to head or neck, significant injury or mechanism above the clavicle, injuries involving motorized recreational vehicles and bicycle or pedestrians struck/collision. Note that the protocol **ALSO** includes any "questionable" injury mechanisms. This is where one would apply critical thinking and judgment. A car crash at 50 mph, a fall from standing in an elderly person, or any injury no matter how minor, when someone is complaining of pain to the neck, they deserve a full spinal assessment. In this case, it turns out the patient did not have any spinal injuries. If the Advanced Spinal Assessment had been performed it likely would have been all negative and spinal immobilization would have been unnecessary per protocol.

**Case #2 "Distracting Injury":** A 64 year old female lays down her motorcycle at a low rate of speed approximately 5 mph. She is complaining of left sided pain of the ribs, shoulder, abdomen and hip. She is unable to move her hip without severe pain or take a deep breath due to pain of the abdomen and chest. The patient is placed on a long board. The patient reports absolutely no neck

pain and is able to rotate her neck freely so a cervical spine collar is not applied. Comments: This patient appropriately received an Advanced Spinal Assessment. However, distracting injuries were not recognized and therefore the patient was not placed into a cervical immobilization collar as indicated. Difficulty breathing, significant abdominal pain, long bone fractures (including the hip) or other significant trauma represent distracting injuries that make it impossible to reliably clear the c-spine. Keep it simple. By definition, the multiple trauma victim has distracting injuries and should be transported with full long board and cervical spine immobilization. Know the indications for spinal immobilization in patients that have high risk or other questionable spinal injury mechanism: unstable vital signs or abnormal peripheral perfusion, age < 9 or anxious and uncooperative or difficulty standing, altered mental status or evidence of intoxication, distracting injuries, abnormal neurological function, spinal pain or tenderness to palpation, or pain when patient tries to flex, extend or rotate the neck. This patient ultimately was not found to have a spinal injury, but did have multiple rib fractures, a pelvis fracture, a ruptured spleen and a lacerated kidney.

### 6.0 Advanced Spinal Assessment

**EMT/ADVANCED EMT/PARAMEDIC STANDING ORDERS**

**PURPOSE:** The intent of this protocol is to decrease injury and discomfort to patients caused by unnecessary spinal immobilization while ensuring that no spinal injuries are missed. It will assist in the identification of patients who require spinal immobilization. Determination that immobilization devices should be used should be made by the highest level EMS provider. All steps of spinal assessment algorithm below must be documented in the ePCR.

**All patients that have a mechanism of injury that could cause a spinal injury, including high risk or questionable injury mechanisms, should have a spinal assessment.**

**Spinal Assessment: Spinal Immobilization is required when ANY of the following conditions apply:**

- Unstable vital signs or abnormal peripheral perfusion.
- Unreliable patient:
  - Age less than 9 years.
  - Anxious and uncooperative.
  - Communication barriers (e.g., deafness, hard of hearing, language, understanding).
  - Altered mental status (not alert and oriented x3).
  - Evidence of alcohol or drug intoxication.
  - Distracted by circumstances or injuries to self or others (i.e., any other injury capable of producing significant pain in this patient).
- Any abnormal neurological function in extremities:
  - Numbness or tingling (paresthesias).
  - Motor strength not full and symmetrical.
  - Sensation not intact and symmetrical.
- Midline tenderness on palpation:
  - Explain to the patient the actions that you are going to take. Ask the patient to immediately report any pain, and to answer questions with a "yes" or "no" rather than shaking the head.
  - With the patient's spine supported to limit movement, begin palpation at the base of the skull at the midline of the spine.
  - Palpate the vertebrae individually from the base of the skull to the bottom of the sacrum.
  - On palpation of each vertebral body, look for evidence of pain and ask the patient if they are experiencing pain. If evidence of pain along the spinal column is encountered, the patient should be immobilized.
- Pain with movement of neck (cervical flexion, extension and rotation):
  - If the capable patient is found to be pain free, ask the patient to turn their head first to one side (so that the chin is pointing toward the shoulder on the same side as the head is rotating) then, if pain free, to the other. If there is evidence of pain the patient should be immobilized.
  - With the head rotated back to its normal position, ask the patient to flex and extend their neck. If there is evidence of pain, the patient should be immobilized. Do **NOT** assist patient in attempts to rotate neck.

**High risk mechanisms include:**

- Motor vehicle crash >60 mph, rollover, ejection. Simple low-speed, rear-end MVC can usually be excluded. (Simple low-speed collision does not include being pushed into oncoming traffic, being hit by a bus or large truck, rollover, or being hit by a high-speed vehicle).
- Falls >3 feet/5 stairs. Patients >65 years or with a high-risk history such as osteoporosis should be given extra consideration, including falls from standing.
- Axial load to head/neck (e.g., diving accident, heavy object falling onto head, contact sports).
- Significant injury or mechanism of injury above the clavicle.
- Injuries involving motorized recreational vehicles.
- Bicycle or pedestrian struck/collision.

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### Advanced Spinal Assessment 6.0

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## Vermont Celebrates EMS Week—Jess Freire

Thank you to all the providers, families, and friends that joined us on the lawn of the statehouse to celebrate EMS week! Jim Baraw organized the event along with help from District 6. Providers from throughout the state were present including: Rescue Inc., Regional Ambulance, Northfield, Newport, CALEX Ambulance, East Montpelier, Thetford, Richmond Rescue, Lincoln Volunteer Fire Company, Bristol Rescue, Upper Valley, Saint Michael's College.

District 6 presented the Virginia Kaufmann award to Peter Munsell.

Dr. Harry Chen presented the 2014 Vermont EMS Awards to the following:

**Basic Life Support Provider of the Year: Mariah Whitcomb of the First Aid Squad of Thetford and Fire**—Mariah was nominated by Robin Pettingell and Dr. Thomas Trimarco for her 20 years of service with Thetford. She has been actively involved at both the service and district level as a provider, educator, and serves as Deputy Chief for Thetford. She just recently completed her AEMT certification and has recently delivered two babies in the field! Her commitment, professionalism, compassion, and excellent clinical care are just a few of the reasons that Mariah is the Vermont EMS BLS Provider of the Year.

**Advanced Life Support Provider of the Year: Leslie Lindquist of Saint Michael's College Fire and Rescue**—Leslie was nominated by Mary Hall and the student officers of Saint Michael's College Fire

and Rescue. Leslie is an alumna of Saint Michael's and returned as the Assistant Chief in 2013. Paramedicine has been a goal of Saint Michael's Fire and Rescue and Leslie was instrumental in seeing this come to fruition in April 2014. Leslie's passion for emergency medical services and dedication to Saint Michael's College Fire and Rescue and the surrounding response area are just a few of the reasons that Leslie is the Vermont EMS ALS Provider of the Year.

**EMS Educator of the Year: William Mapes of Regional Ambulance Service**—William was nominated by Beth Winter and Kathy Mahar-Stephenson. William is the Training Coordinator for Regional Ambulance Service and the Interim District 10 Training Coordinator. He has an unparalleled depth of knowledge, but is able to deliver education in a way that is accessible to all levels of providers. He is a humble and gracious man and is eager to help others shine in the world of EMS. Whether it is helping to better a skill or master a subject, William is always encouraging and eager to help and that is why he is the Vermont EMS Educator of the Year.

**First Response Service of the Year: Lincoln Volunteer Fire Company**—Lincoln Volunteer Fire Company was nominated by Eleanor Scully, the Vice President of Bristol Rescue Squad. The members of Lincoln have an outstanding relationship with Bristol Rescue, their transporting ambulance

service, by providing initial on-scene stabilization and members to drive the ambulance if needed. Recently, they had five members complete an Emergency Medical Responder class adding to their numbers of licensed EMS providers. The citizens of the Town of Lincoln are grateful that they have such a well-trained first response agency and that they are truly neighbors helping neighbors. Congratulations to Lincoln Volunteer Fire Company as Vermont First Response Service of the Year.

**Ambulance Service of the Year: Richmond Rescue**—Richmond Rescue was nominated by Bill Menning, Joe Gannon, Latimer Hoke, Town Manager Geoffrey Urbanik, Richmond Elementary School Nurse Julie Crenshaw and Principal Michael Berry. Richmond Rescue is composed of approximately 50 volunteers and three paid staff. They have begun a media outreach program to raise public awareness of the role of EMS within the Richmond community. In addition, they assist with the Basic Aid training for fourth grade students, car seat fittings, providing free helmets, and have purchased and installed Automated External Defibrillators at the Richmond Town Office, Library, and Elementary School. Congratulations to Richmond Rescue as Vermont Ambulance Service of the Year.

Congratulations to all the winners and nominees. On behalf of the Vermont Department of Health and the citizens of Vermont, we thank you all for your outstanding service and dedication to providing the best pre-hospital emergency care possible.



*"No act of kindness, no matter how small, is ever wasted" - Aesop*



## Documentation with Guest Writer Kate Soons!

Is Kate really going to talk about documentation? Yup, I am. Why? Because it is important that we, as a profession, effectively communicate in writing our assessment and the interventions we provided. Your patient care report (PCR) is all that remains after the call. Sure, I can conjure up an image of Joe, AEMT getting that 14 gauge IV upside down in the mangled car with a MagLight between his teeth. Very cool stuff (until Joe drools on the patient inadvertently). However, you all know the saying, "If it wasn't documented, then it wasn't done."

Who reads our run forms? Who cares? Plenty of people do - now more than ever. The electronic health record (EHR) is here to stay. With greater access to patient information, care plans are improved, streamlined, and sometimes more appropriate. There are three groups who are very interested in what you have to say in your form.

1. The Emergency Department staff read our forms. We have heard from ED providers all over Vermont since the EMS electronic incident reporting system, SIREN, went live. Their requests are straightforward:

- Why was EMS summoned
- What did you find when you arrived?
- What interventions did EMS provide?
- What was the patient's response to those interventions?

When the EMS provider writes a clear narrative that answers these questions succinctly, the providers who continue care have a much better understanding of what happened on the EMS incident. We truly are the, "eyes and the ears of the ER."

2. Your Head of Service cares about what you write. The notion of continuous quality improvement (CQI) has been

a part of healthcare for decades. CQI is now filtering down to EMS with a focus on doing the right thing for the patient. Did we follow our new protocols? Is there important documentation that was omitted from the narrative? Hopefully, all services have some form of documentation review that ensures protocol adherence and identifies potential training topics.

3. The Billing Agent definitely cares. Paying the bills has become just as much a part of our EMS culture as pizza on training nights. Complete documentation allows an EMS agency to bill for services provided. When key information is omitted, your billing agent chirps at your supervisor. When your supervisor is grumpy, there is no pizza at training night.

What is a good EMS provider to do? Find a format that works for you and stick to it. Writing a narrative is similar to performing a rapid physical assessment - if you write your narrative the same way every time you are much less likely to make an omission. Here are a few tips and tricks that might help.

SIREN gets easier each time you use it. Consider a "head-to-toe" approach. At the top of the screen, click OPTIONS, and then 'Expand All Panels'. Now, you can work each panel, top to bottom - and each tab, left to right. It's really that easy.

We are so very lucky to have Jenna Protzko, Dylan Hudson, and the ImageTrend team continually working to improve SIREN. With the implementation of VTEMS statewide clinical protocols, the "ACTIVE PROTOCOLS" tab has been updated to align with the anticipated treatment. Before completing the assessment and interventions tabs, consider clicking

through those items on your selected active protocol. You probably won't forget to document an intervention!

And then there is the narrative. Often times, this is the portion of the form that gives folks the most difficulty. I break it down into manageable sections, and just fill in the information:

- CHIEF COMPLAINT
- HISTORY
- ASSESSMENT
- RESPONSE to INTERVENTIONS
- TRANSPORT/ COMMUNICATION

### Chief Complaint

The CHIEF COMPLAINT section should introduce the incident with a short, concise sentence:

- "CHIEF COMPLAINT: Chest pain"
- "CHIEF COMPLAINT: Right ankle pain"

### History

The HISTORY section should group subjective information, including the History of the Present Illness/Injury (HPI). Subjective information includes symptoms and details that have to be communicated verbally (S - subjective, S - said). The history section answers two key questions:

- Why was the ambulance summoned?
- What events led to call for EMS?

Begin with a short, "set the scene" sentence:

- "Found alert 76 y/o male sitting in recliner c/o chest pain."
- "Found unresponsive 23 y/o male sitting in driver seat of vehicle involved in MVC."
- "Found alert 42 y/o female standing in living room of her apartment screaming, in care of law enforcement."

The body of this paragraph is typically our conversation with the patient and/or bystanders; and includes the responses to O-P-Q-R-S-T (and I still like U!). It



"Start where you are.

Use what you have.

Do what you can." -

Arthur Ashe



## Documentation with Guest Writer Kate Soons Continued!

can also include a description of the accident scene or details about mechanism of injury.

### Assessment

The ASSESSMENT section should group objective information including the Focused Physical Exam and Detailed Physical Exam. The information included in the assessment section is observed (O—objective, O—observe). A good physical exam

is organized head to toe, and includes abnormal findings, as well as confirmation of normal assessment for pertinent (objective) negatives.

- Begin with detailed description of mental status:
- ◇ “AOx3, in acute respiratory distress, speaking in 1-2 word sentences”
- ◇ “AOx3, NAD (no acute distress) and conversational”
- ◇ “Responds to loud verbal stimulation by opening eyes but not speaking”
- ◇ “Responds to painful stimuli by withdrawing”
- Verify initial assessment:
- ◇ “Airway patent. Normal work of breathing. Skin pink/warm/dry.”
- Continue by body region (examples below):
- ◇ Head/Neck/Spine
- \* “No pain with palpation to head, neck, or spine.”
- \* “Pain with palpation to lumbar region of spine.”
- ◇ Chest
- \* “Equal chest expansion or chest rise.”
- \* “Breath sounds clear and equal.”
- \* “Diminished breath sounds right upper fields. Equal chest rise.”
- ◇ Abdomen
- \* “Soft, non-tender. No guarding.”
- \* “Tenderness with palpation to

RUQ & RLQ.”

- ◇ Extremities
- \* “Moves all extremities.”
- \* “Extremities warm & with pulses present.”
- ◇ Skin
- \* “Pink, warm, and dry”
- ◇ SpO<sub>2</sub>: Document lowest recorded SpO<sub>2</sub> level assessed.
- ◇ FSBG: Document finger stick blood glucose (FSBG) level(s).
- ◇ Enter all vital signs in Patient Vitals section of SIREN.
- Enter all abnormal physical assessment findings into Assessment Findings anatomical map in SIREN.

### Response to Interventions

The “Response to Interventions” section should list all EMS “treatment” performed, and the patient response to the interventions. Make sure that interventions are entered into SIREN under Procedures/Treatments or Medications, too.

- “15 lpm O<sub>2</sub> via NRB administered with improvement in SpO<sub>2</sub> from 86% to 92%. The patient stated no improvement of dyspnea with oxygen.”
- “Albuterol 2.5 mg via neb administered. The patient stated much improvement of dyspnea; and re-assessment of breath sounds revealed less wheezes.”
- “Full spinal immobilization with equal neuromotor function in all extremities before and after immobilization.”

### Transport

The TRANSPORT section should describe how the patient was transported and any assessment change en route.

- “The patient was transported semi fowlers on stretcher with less dyspnea en route.”
- “The patient was transported

supine on stretcher with continued BVM ventilation en route.”

### Communication

The COMMUNICATION section should document contact with Online Medical Direction – anytime an EMS provider speaks to an ED Attending. The name of the ED Attending should be included. Other examples of documentation for this section include:

- “ED advised of possible trauma alert from scene.”
- “ED advised of Stroke Alert from scene.”
- “12-lead EKG transmitted to ED prior to departing scene. Automatic interpretation of, “ACUTE MI” communicated to via radio update en route.”
- “Cancelled call. Discussed with Dr. Wolfson/ ED.”

Critical calls in which there is limited history available are some times better documented in a timeline format. Assessment and interventions can be grouped according to events that occurred “on scene” and “en route”.

- “On scene, patient unresponsive to all forms of stimulation with blood in nose and mouth.”
- “En route, patient ventilated BVM. SpO<sub>2</sub> improved and the patient became more combative.”

### Please “sign” narrative:

Written by John Doe, AEMT  
#12345 on 1/27/12 at 1018

Good documentation takes practice. We are fortunate to have the SIREN Sandbox to practice our documentation skills. Continue to have other crew members proof read PCRs and narratives for clarity. Choose a format, like CHART, to use consistently. Documenting the same format every time will ultimately help you write more complete forms.



“The heart of human excellence often begins to beat when you discover a pursuit that absorbs you, frees you, challenges you, or gives you a sense of meaning, joy, or passion.” - Terry Orlick



## Child Safety Seat Voucher Program—Tanya Wells

The Vermont Child Passenger Safety program recently updated the standards for the Child Safety Seat distribution program. Low-income Vermont children can now receive a **FREE** car seat!

Vouchers are being handed out at the 12 Vermont Department of Health district offices. Guidelines for child safety seat distribution include:

- Only one seat per child.
- Seats are free for eligible children.
- Seats must be obtained at a recognized Vermont fitting station (found here [www.beseatsmart.org](http://www.beseatsmart.org)).
- The seat will not be given away without being correctly installed by a certified child passenger safety technician.
- The card cannot be transferred to someone else.

Program questions can be directed to our State Child Passenger Safety Hotline: 1-888-868-7328



*“There is incredible value in being of service to others.” - Elizabeth Berg*



## Volunteer Recruitment & Retention Campaign—Mallory Staskus

Did you know that 64 of Vermont's 175 EMS agencies are staffed entirely by volunteers? Another 77 agencies utilize EMS volunteers in their agency on a regular basis. Combined, that is 80% of Vermont's EMS agencies who, in some way, rely on volunteer members.

It has been a continuous observation across the country that volunteerism is on the decline and Vermont EMS agencies are feeling it in reduced memberships and strained coverage schedules. The Health Department's Office of Public Health Preparedness and Emergency Medical Services (OPHP/EMS) is working with a Richmond, VT based advertising

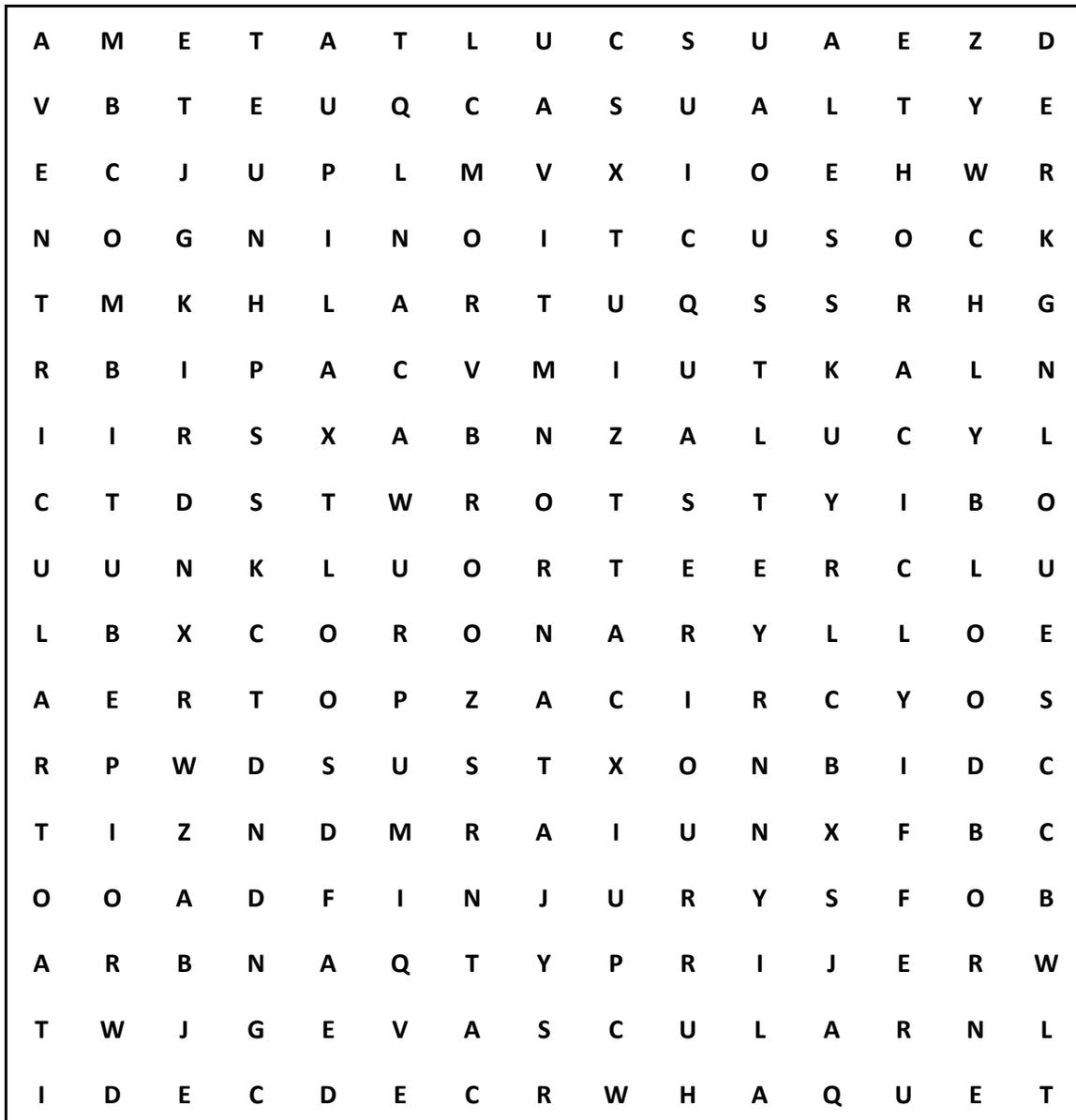
agency to produce a recruitment campaign for Emergency Medical Services and the Medical Reserve Corps health volunteers.

The goal of the recruitment and retention campaign is to increase awareness of the work Vermont providers do everyday, and engage new volunteers to join their local emergency medical services or disaster preparation and response organization. With the recruitment campaign set to launch this fall, we hope to increase membership in EMS agencies and MRC units across the state. The cam-

paign will include television and radio pieces, as well as, a new website to answer questions, spark interest, and direct potential volunteers to their town's squad through an interactive web map.

Along with this recruitment effort, the office is working on a recruitment and retention toolkit to support squads in onboarding new members and maintain active memberships. This will be a collaborative effort between services who have expressed interest, best practice research from across the country, and OPHP/EMS. Keep your eyes open for the campaign this fall!



**EMS Word Search—Ray Walker**

CORONARY

TOURNIQUET

TRIAGE

THORACIC

VASCULAR

BLOODBORNE

COMBITUBE

VENTRICULAR

INJURY

SUCTIONING

CONSENT

CASUALTY

AUSCULTATE

TRANSPORT

## Updates on Naloxone—Mike Leyden

As you are by now aware, the topic of opiate/opioid use, illicit abuse and the related health implications has become a major issue in our state. In his state of the state address earlier this year, Vermont Governor Peter Shumlin declared that we are facing a crisis of opiate drug addiction. In 2013, Vermont reported twice the number of heroin overdoses resulting in death as the previous year. Additionally, the Vermont legislature had recently authorized the distribution of naloxone through several methods: directly to citizens, including drug consumers, friends, or family members. Enhanced liability protections were added for those who call 911 during an overdose incident and use naloxone in an emergency. Medical practitioners can now prescribe naloxone directly to patients and a pilot project was created to distribute Overdose Rescue Kits through regional syringe exchange sites and opiate addiction treatment hubs. Two sites distributed most of the kits in the first six months of the program with additional sites coming gradually online to cover much of the state. The key concept here is that much like Epi Pens and AEDs, naloxone must be available for use in the right place at the right time.

The Office of Public Health Preparedness, Emergency Medical Services, and Injury Prevention in the Vermont Department of Health began implementation of this harm reduction strategy in December of 2013 by partnering with several community-based organizations to reach populations at heightened risk for a fatal overdose. The Overdose Rescue Kits contain two prefilled syringes of naloxone (2mg in 2mL) and two nasal atomizers along with visual and written instructions for use. In the first six months since the kits were made available through the pilot sites, almost 400 kits were distributed and about 10% have been reportedly used to reverse an overdose. Of the individuals receiving kits, 8% were non-drug-users, 44% were active users, and 44% were users in treatment or recovery. Overall, 66% had witnessed an overdose in their lifetime, and 34% had experienced an overdose in their lifetime. Data on use of the kits is gathered on a voluntary basis by encouraging clients to seek a “refill” of the kit contents after use, at which time an interview/debrief is conducted. Based on those interviews, of the 38 kits used in an overdose situation:

- 34 of the incidents reportedly involved heroin (the remainder were not reported)
- 25 kits were reportedly used on a friend, 3 were used on a stranger, 1 was used on a partner, 2 were used on family, and 6 were used on the client themselves (by others present), and 1 was not reported
- 17 incidents were reportedly managed using 1 dose, 11 cases used 2 doses and 1 case used 3 doses. For 8 of the incidents, the number of doses used was not known and 1 was not reported
- In 5 incidents, the patient reportedly took over 5 minutes to respond to the dosage of naloxone administered.
- Only 14 of the incidents reportedly resulted in a call to 911 (which is a task required by law if kits are deployed by citizen rescuers. Improving this notification of the emergency response system will be one of the areas for future improvement.)
- Among the 14 cases where 911 was called, 12 reported a positive experience, and one reported a negative experience with emergency services personnel (and one did not report)

By comparison, using SIREN data we determined that during the same six-month period, EMS providers in Vermont used naloxone to treat suspected opiate/opioid overdoses about 20 times per month (EMTs, AEMTs and Paramedics). Presumably, all of those instances were the result of 911 calls which generated a traditional EMS response.

In response to the increased availability and need for naloxone, the 2014 statewide EMS protocols were revised to allow EMTs to administer naloxone through nasal atomizer. To further increase the likelihood of successful overdose management, this protocol was updated in June of 2014 to include Emergency Medical Responders (EMR). Didactic training is available centrally through LearnEMS/CentreLearn to assure consistency and psychomotor training (skills practice and evaluation) is performed at the local level.

The very rural nature of Vermont dictates that sometimes law enforcement officers are first on the scene of suspected opiate overdoses. In order to increase the speed with which naloxone can be administered, Vermont State Police recently became the first statewide police agency to equip all patrol officers with naloxone. Using train-the-trainer programs developed and delivered by the EMS Office, VSP was equipped in April of 2013. Several other local and county law enforcement agencies are now implementing this program.

Lastly, new legislation in this year’s session provided for direct dispensing of naloxone by pharmacists to clients. We hope that these efforts combined with addiction prevention and treatment strategies will decrease the mortality and morbidity of opiate/opioid and heroin-related incidents in Vermont.

## VT EMS Calendar of Upcoming Events:

- Certified Child Passenger Safety Technician Course (see page 3 for more details):
  - August 19-22, 2014—Barre City Auditorium
  - October 8-11, 2014—Newport Ambulance
- District Chairperson & District Training Coordinators Call: Third Wednesday every other month (July 16th, September 17th, November 19th) at 4:30pm—email Jess for information
- EMS Advisory Committee:
- Instructor Coordinator & Training Officer Call: First Monday every other month (August 4th, October 1st, December 1st) at 4pm—email Jess for information
- Leadership Call: 1st Thursday of every month at 11am, 877-668-4493 (Access Code: 734 141 663)

*All initial, transition, and refresher courses approved by the state are located here: [www.vermontems.org](http://www.vermontems.org) under the “Class Schedule” tab*

## Vermont Healthcare & EMS Preparedness Conference

- This year the Vermont Healthcare & EMS Preparedness Conference will take place October 14-19th at Killington Grand Resort! The conference will follow the same format as last year with Tuesday and Wednesday having pre-conference classes, Thursday having a Healthcare Preparedness focus, Friday will be Trauma Day co-sponsored with the University of Vermont Medical Center and typical course offerings on Saturday and Sunday. Registration and lodging information can be found at: [www.vtemsconference.com](http://www.vtemsconference.com)
- If you are interested in speaking at the conference, the call for speakers will be open until July 18th. You can find the call for speakers application here: [www.vtemsconference.com/index.php/speakers](http://www.vtemsconference.com/index.php/speakers)



## How to Contact EMS:

**By phone:** 802-863-7310 or 1-800-244-0911 (in VT only):

Ray Walker: EMS Program Administrator—can assist with personnel, service, and vehicle licensures, regulatory issues or investigations—**option 1 or (802) 863-7274**

Jessica Freire: State Training Coordinator—can assist with initial and continuing education, CentreLearn, and the Vermont EMS Conference—**option 2 or (802) 863-7255**

Jenna Protzko: EMS Data Manager—can assist with information on the SIREN run reporting system—**option 3 or (802) 951-0160**

Brett LaRose: Child Passenger Safety Program Administrator and Injury Prevention—**option 4 or (802) 865-7734**

Tanya Wells: Child Passenger Safety Program Coordinator—**option 6 or (802) 951-4089**

Mike Leyden: Deputy Director, EMS—**option 7 or (802) 865-7735**

Additional assistance, which will bring you to our administrative team: Kerry Winger, Donna Jacob & Brenda Robert—**option 8**

Chris Bell: Director of the Office of Public Health Preparedness & EMS—**option 8**

Dr. Dan Wolfson: Medical Advisor—**option 8**

**Webpage:** [www.vermontems.org](http://www.vermontems.org)

**Email:** [vtems@state.vt.us](mailto:vtems@state.vt.us)

**Mail:** 108 Cherry Street, PO Box 70, Suite 201—Burlington, VT 05402

State of Vermont Department of Health  
Office of Public Health Preparedness & EMS  
108 Cherry Street  
PO Box 70  
Suite 201  
Burlington, VT 05402-0070