MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DRUG/DEVICE/PROTOCOL COMMITTEE

October 6, 2010--10:00 A.M.

MEMBERS PRESENT

Richard Henderson, MD, Chairman
Eric Anderson, MD, MedicWest
Chief Troy Tuke, CCFD
Eric Dievendorf, EMT-P, AMR
Steve Johnson, EMT-P, MedicWest (Alt)
Gina Schuster, Community Ambulance
E.P. Homansky, MD, AMR
David Slattery, MD, LVFR
Christian Young, MD, BCFD (Alt)
Rick Resnick, EMT-P, MFR
Brian Rogers, EMT-P, HFD (Alt)
Chief Bruce Evans, NLVFD

MEMBERS ABSENT

Chief Mike Myers, LVFR
Jarrod Johnson, DO, MFR
Chief Scott Vivier, HFD
Kevin Nicholson, BCFD
Mark Calabrese, EMT-P, MWA
Mary Levy, RN, UMC

SNHD STAFF PRESENT

Joseph J. Heck, DO, Operational Medical Director
John Hammond, EMS Field Representative
Judy Tabat, Recording Secretary
Rory Chetelat, EMSTS Manager
Trish Beckwith, EMS Field Representative
Lan Lam, Administrative Assistant

PUBLIC ATTENDANCE

Dale Carrison, MD, UMC
Derek Cox, EMT-P, LVFR
Chris Baker, TriState CareFlight
Larry Johnson, EMT-P, MedicWest
Jo Ellen Hannom, RN, CCFD
Jay Fisher, MD, CHW
Gerry Julian, Mercy Air
Steve Patraw, Boundtree

CALL TO ORDER – NOTICE OF POSTING OF AGENDA

The Drug/Device/Protocol Committee convened in the Clemens Room of the Ravenholt Public Health Center on Wednesday, October 6, 2010. Chairman Richard Henderson, M.D., called the meeting to order at 10:01 a.m. and the Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law. Dr. Henderson noted that a quorum was present.

I. CONSENT AGENDA

Chairman Henderson stated the Consent Agenda consisted of matters to be considered by the Drug/Device/Protocol Committee that can be enacted by one motion. Any item may be discussed separately per Committee member request. Any exceptions to the Consent Agenda must be stated prior to approval.

Minutes Drug/Device/Protocol Committee Meeting June 2, 2010

Dr. Henderson asked for a motion to approve the minutes of the June 2, 2010 Drug/Device/Protocol Committee meeting. A motion to accept the minutes was made, seconded and passed unanimously.

II. REPORT/DISCUSSION/POSSIBLE ACTION

A. Discussion of Induced Hypothermia Protocol

Mr. Chetelat stated that most of the agencies with the exception of Mesquite Fire & Rescue and Boulder City Fire have joined in the Hypothermia pilot and in a manner of moving forward this Committee needs to develop a protocol and send it to the MAB for final approval. Dr. Henderson stated that the protocol submitted for review is Henderson Fire's and questioned if every agency was using the same protocol. Dr. Homansky stated that there are minor differences and asked if the agencies can continue to use their protocol they have now until the official protocol is in place. Dr. Henderson felt that using their protocol shouldn't impact the process. He then asked if any agency has had any experience with shivering in the field. Everybody stated there have been zero cases. Dr. Henderson asked if there was any objection to pulling out the medicines for shivering. Dr. Slattery stated that initially they wanted the first rollout of the protocol to be very conservative since in rural areas and in longer transports you are going to see shivering but added that since there is a post resuscitation care protocol that covers sedation he agreed to take it out and if shivering becomes an issue it can be brought back. Dr. Henderson stated that the other difference was in the fluid bolus and it was agreed to make it 30ml/kg to a max of 2 liters.

Dr. Slattery stated that the most important part of this protocol that needs to be addressed is item #9 with regards to transporting the patients to the closest facility with an established induced hypothermia protocol and equipment. The language as it stands was not sufficient since it only addresses the protocol and equipment and he felt that it also needs to address the comprehensive post resuscitation care. The criteria that Las Vegas Fire & Rescue (LVFR) required before transporting to a cooling center was to see their protocol, a letter of support from the administration and the pathway for cooling as well as review of 2 cases that they've successfully cooled and re-warmed. All the emergency departments and physicians are on board with this but the problem comes with the ICU level of care and that is where this system needs to make sure that this procedure is standardized and being done consistently.

Dr. Heck questioned how to go about determining which hospitals will step up and participate because once that is in place the protocol will be OK as long as we list the currently approved hospitals or destinations. Dr. Homansky stated that you have to make the criteria clear to the hospitals so they know what the playing field is. Dr. Slattery stated he would be happy to do it.

Dr. Slattery stated that he would like item #9 to read "transport to the closest facility with an established induced hypothermia protocol and equipment approved by the Health District". Dr. Heck stated he will put this in protocol format with the recommended changes and then send it out for everybody's approval before the next MAB and hopefully within the interim period a subcommittee will work with the hospitals to come up with the criteria and then figure out which hospitals get listed.

Chief Tuke voiced concern that the Committee is not taking the time to develop the protocol properly before they are asked to bypass hospitals, extend the transport time of a patient in cardiac arrest and go to a hospital that can't even be defined. He asked how he was going to justify a bad outcome. He felt that a pilot has morphed into a semi protocol with everybody doing their own thing with no approved cooling centers.

Dr. Slattery stated that he understood Chief Tuke's concerns and felt that is why item #9 is so important for this protocol. He couldn't speak for the other agencies but stated that LVFR built the destination criteria explicitly into their pilot protocol. LVFR has 3 facilities they transport to; Valley Hospital, UMC and Sunrise Hospital. He added that he reviewed at least 2 cases of successful cooling and re-warming at those facilities, they have a protocol in place and have a letter of support from the administrators. Brian Rogers stated that Henderson Fire uses the same criteria as LVFR and they transport to St. Rose deLima, St. Rose Siena and Sunrise. Dr. Heck asked if AMR using any other facility other then 5 listed. AMR answered in the negative.

Dr. Heck recommended that the first draft of this protocol will list those 5 facilities since they have been vetted through the process and approved for the pilot. In the meantime the criteria needs to be worked out and sent out to those facilities that are interested in joining in and asked if Dr. Slattery had a draft of those criteria. Dr. Slattery stated he did and that he will make it happen this month.

Mr. Chetelat stated that they are working to get another nurse managers meeting the last week of October and would like to present the criteria at that meeting for their input and recommendations and invite them to the MAB.

Dr. Anderson questioned how we would expect the facilities to get the 2 cases that are currently being required. Dr. Slattery stated it is essential to have that requirement because there is a learning curve in the process and the 3 facilities had no problems demonstrating the 2 patients.

Dr. Heck recapped stating that he will fix the protocol based on the changes stated to include:
Medications for shivering will be removed.
IV fluids will be changed to 30ml/kg to a max of 2 liters
#9 will be more forceful in its language and list out the 5 facilities that have met the criteria.

Then it will go to the MAB in November. The criteria to become a cooling facility will be put together and pushed out to the hospitals and be presented at the nurse managers meeting.

A motion was made to use Las Vegas Fire & Rescue's Induced Hypothermia Protocol with the recommended changes. The motion was seconded and passed unanimously.

B. Discussion of Addition of Continuous Positive Airway Pressure (CPAP) Device as an Optional Item to the Official Air Ambulance, Ground Ambulance & Firefighting Agency Inventory

Dr. Anderson stated that MedicWest Ambulance (MWA) and American Medical Response (AMR) were interested in bringing forward CPAP to allow their medics in the field to apply this to select patients, mainly those with CHF, COPD and respiratory distress. The literature shows significant benefit to applying CPAP in the field both in patient improvement that the medics see in real time and even more significantly improvement in patient outcomes directly measured by decreased lengths of stay. He added that he would like the Committee to review the protocol submitted but stated there would be one change and that is the current device that they are looking at actually administers 7.5cm of water, instead of 5cm.

Mr. Rogers stated that Henderson Fire did pilot this product and it's not that CPAP wasn't beneficial but the end number was so small the cost benefit analysis for this product was just not there. Overall our medics along with our EMS supervisors decided to discontinue the study and felt it was not a good device for their department at the time.

Dr. Slattery stated that CPAP has been pilot tested by 3 difference agencies in the last 3 or 4 years and the instructions to them during their pilot was to look at how often it would be used to see if it is financially feasible and each time 3 different agencies came back and decided that it was not financially feasible. Not only would there be a price impact to our agency but also the shared cost with the hospital because when you avoid intubation on a patient that really doesn't impact the EMS agency but has a huge impact for the patient and also the hospital. There has to be an agreement from the EMS agencies leadership and operations standpoint that this is something that is affordable.

Dr. Anderson stated that AMR and MWA are looking at adding it as an optional item to the inventory and not requiring all agencies to use it. Dr. Slattery stated that this system is moving away from disparity of care so if it's coming before this Committee it will be for all agencies.

Dr. Heck stated that CPAP does work but the studies included in the handouts do not address the issues of transport times. In a system where there are relatively short transport times he questioned whether CPAP is something worth the cost benefit ratio when a patient could be manually ventilated until the point they get to an emergency department. He stated that he will leave it to the Committee to make a decision as to whether or not they want to move forward with the device but it's the opinion of the Office of Emergency Medical Services & Trauma System (OEMSTS) that we can't keep making treatment's an optional item.
Dr. Homansky stated that the request on the table is just for an AMR/MWA trial and shouldn't turn down the opportunity to gather more data. Dr. Heck questioned whether there has been any recent data presented on the number of non-arrest intubations that have been done in this system. Dr. Slattery stated

that AMR and MWA have a very robust data collection process and if you could tease out the number of patients with CHF and COPD exacerbations that were intubated in field in a year's period of time those would be the potential patients in terms of making that decision.

Dr. Heck stated that this will be the definitive pilot program sponsored by AMR/MWA, disregarding the previous 3. There needs to be a clear end point that may be a retrospective analysis of how many patients might have been impacted and their outcomes versus 100% usage going forward on patients that would fall into your criteria and what their outcomes were and then a comparison analysis.

Mr. Chetelat stated that this will need to go back to the MAB for approval of a pilot so between now and November if we could get the actual pilot written proposal we will bring it to the MAB.

C. Discussion of Addition of CyanoKit®

Chief Evans stated that the CyanoKit® equipment that was brought here on a grant has been sitting warehoused at the County. Working with Dr. Bledsoe and Dr. Malone they would like to incorporate the CyanoKit® in a system wide study to look at all transports that are smoke inhalations going to UMC and have the Burn Center Care Team at UMC focus more on assessing smoke inhalation. He added that checking with the hospitals, all the cyanide levels have to be sent to the lab and results don't come back for a couple days so he would like to educate the physicians to look for lactate levels that are above 10. One of the indicators now that they are starting to advocate for is the administration of the drug if you have a smoke inhalation patient come in that is hypotensive or altered level of consciousness and they have a lactate level that is above 10. He stated that in the handouts is a sample protocol and would propose that the kits be put in all supervisor vehicles and battalion chief vehicles since it is an expensive drug and instruct that if the kit is administered the destination would be UMC Burn Center.

Brian Rogers stated that this was approved before for just fire personnel and asked if this would be for all patients. Dr. Henderson agreed that this should be for anybody coming out of a fire in an altered state.

Chief Evans disclosed that he is on the advisory board for the company that makes the CyanoKit® and also with the Cyanide Treatment Coalition and the Fire Smoke Coalition.

Dr. Slattery stated that this medication obtained from the grant has been under his license and he has been holding off on deploying it because he didn't feel comfortable about just treating the firefighters. He added that the protocol needs to define what severe hypotension is and gave an example of severe hypotension systolic <70 or hypotension unresponsive to IV fluids.

Dr. Henderson felt that this is a harmless therapy and felt that a systolic <90 would be best because he didn't want to wait until they are so sick that they are down to 70. If it turns out they are using too many then we can come back and look at it. He would rather error on the side of over treating when you've got something so safe.

Chief Evans stated that altered level of consciousness is probably the single most important issue of giving the kit. You can't really overdose somebody and some systems are even contemplating this going down to the EMT-Intermediate level just because its profile is much like Narcan.

Dr. Heck expressed the fact that the Kit will be a mandatory piece of equipment to be deployed on supervisory vehicles but noted that OEMSTS does not inventory supervisory vehicles, only transport so this will be an issue that this Committee will need to work through. He asked if the suggestion was a smoke inhalation protocol or is it taking a piece of this and putting it into the overdose poisoning protocol and including cyanide toxicity as part of that protocol.

Dr. Slattery stated that currently in the burn protocol it is directed to go to the burn center for all smoke inhalation and felt that that was not happening, so maybe a separate smoke inhalation exposure protocol may be the best way.

Dr. Heck referred to the draft protocol and questioned if this Committee was still looking at using the 3 degree's of mild, moderate and severe exposure within this protocol or just concerned about the person that is going to get the CyanoKit®.

Dr. Slattery stated that the protocol should be designed just like our current protocols which are BLS/ILSALS interventions.

Dr. Heck stated he will write up a draft protocol to bring back to this Committee for approval prior to the MAB in November.

Mr. Chetelat questioned what happens when the drugs run out that were purchased through the grant. Dr. Henderson stated that the agencies will have to start stocking it like anything else.

III. INFORMATIONAL ITEMS/DISCUSSION ONLY

None

IV. PUBLIC APPEARANCE/CITIZEN PARTICIPATION

None

V. ADJOURNMENT

As there was no further business, Dr. Henderson called for a motion to adjourn. The motion was made, seconded and passed unanimously to adjourn at 11:25 a.m.