MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DIVISION OF COMMUNITY HEALTH

DRUG/DEVICE/PROTOCOL COMMITTEE

December 03, 2014 – 09:00 A.M.

MEMBERS PRESENT

Jarrod Johnson, DO, Chairman, MFR
David Slattery, M.D., LVF&R
Troy Tuke, Clark County Fire Department
Frank Simone, NLVFD
Clem Strumillo, Community Ambulance
Chad Fitzhugh, Mercy Air
Derek Cox, LVF&R
Doug Dame, AMR (Alt.)
Mike Barnum, MD, AMR
Tressa Naik, M.D., Henderson Fire Dept.
Eric Anderson, MD, MWA
Chief Chuck Gebhart, Boulder City Fire Dept.
Brandon Hunter, MWA
Chief Scott Vivier, Henderson Fire Dept
Chief Rick Resnick, MFR

MEMBERS ABSENT

K. Alexander Malone, MD, NLVFD
August Corrales, JTM
Eric Dievendorf, AMR

SNHD STAFF PRESENT

Christian Young, MD, EMSTS Medical Director
John Hammond, EMSTS Supervisor
Mary Ellen Britt, EMSTS Manager
Judy Tabat, Recording Secretary

PUBLIC ATTENDANCE

Stephen Johnson, MWA
Jim McAllister, LVMS
Steven Carter, AMR
Dineen McSwain, UMC
Shelton Jourdan, CSN Student
Jason Driggars, AMR
Monica Manig, HFD
Glenn Glaser, MWA
Sarah McCrea, LVFR
Cameron Seisan, LVAPEC

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The Drug/Device/Protocol Committee convened in Conference Room 2 at The Southern Nevada Health District on Wednesday, December 03, 2014. Acting Chairman Christian Young, M.D. noted that Chairman Johnson would be late and called the meeting to order at 09:00 a.m. The Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law. Acting Chairman Young noted that a quorum was present.

I. PUBLIC COMMENT

Public comment is a period devoted to comments by the general public on items listed on the Agenda. All comments are limited to five (5) minutes. Acting Chairman Young asked if anyone wished to address the Committee pertaining to items listed on the Agenda. Seeing no one, he closed the Public Comment portion of the meeting.

II. CONSENT AGENDA

Acting Chairman Young 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, October 01, 2014

Acting Chairman Young asked for a motion to approve the consent agenda which included the minutes of the October 01, 2014 Drug/Device/Protocol Committee meeting. *Motion made by Member Slattery, seconded by Member Anderson and carried unanimously.*

III. REPORT/DISCUSSION/POSSIBLE ACTION

A. Selection of Drug/Device/Protocol Committee Chairman and Vice Chairman

Dr. Johnson stated that Dr. Bledsoe as the current Vice Chairman will automatically be placed in nomination for the position of the Chairman and asked the Committee if there were any other nominations for Chairman.

Dr. Slattery questioned if Dr. Bledsoe wanted to commit to being Chairman. He stated that if he doesn't then he would nominate Dr. Barnum as Chairman or as Vice Chairman if Dr. Bledsoe accepts.

Dr. Johnson stated that the Committee will accept Dr. Barnum as a nominee as a Vice Chairman to be placed into the Chairman position if Dr. Bledsoe declines his nomination and asked if there are other nominations.

Dr. Johnson nominated Dr. Naik and asked if there were any other nominations for Chairman, hearing none, he called for a roll call vote.

Doug Dame (Alt)	Dr. Bledsoe	Brandon Hunter	Dr. Bledsoe
Chief Gebhart	Dr. Barnum	Chad Fitzhugh	Dr. Barnum
Troy Tuke	Dr. Barnum	Dr. Johnson	Dr. Bledsoe
Clem Strumillo	Dr. Naik	Frank Simone	Dr. Naik
Chief Vivier	Dr. Bledsoe	August Corrales	absent
Derek Cox	Dr. Naik		

Dr. Johnson stated that Dr. Bledsoe in his absence will be Chairman going forward. He asked Dr. Barnum and Dr. Naik if they would accept the Vice Chairman nomination. Dr. Barnum and Dr. Naik answered in the affirmative. Dr. Johnson asked if there were any other nominations for vice chair. Hearing none he called for a roll call vote.

Doug Dame (Alt)	Dr. Barnum	Brandon Hunter	Dr. Barnum
Chief Gebhart	Dr. Barnum	Chad Fitzhugh	Dr. Barnum
Troy Tuke	Dr. Barnum	Dr. Johnson	Dr. Barnum
Clem Strumillo	Dr. Naik	Frank Simone	Dr. Naik
Chief Vivier	Dr. Naik	August Corrales	absent
Derek Cox	Dr. Barnum		

Dr. Johnson stated that Dr. Barnum will be Vice Chairman. If Dr. Bledsoe does not accept the position of Chairman, Dr. Barnum will be placed in the Chairman position and Dr. Naik as the Vice Chairman. Dr. Slattery agreed.

Dr. Anderson announced that Dr. Bledsoe accepted the Chairman position.

B. Discussion of Termination of Resuscitation Protocol

Dr. Young stated that in the previous meeting it was discussed that the Termination of Resuscitation Protocol is not being utilized and the crews are unnecessarily transporting patients where resuscitation efforts may have been unsuccessful in the field. He questioned the Committee to see if there was any interest in changing the Termination of Resuscitation Protocol.

Dr. Slattery agreed that this protocol is really underused. He added that the providers communicate there is inconsistency when they call for medical control and felt that they need to do a better job of making sure all of the

Emergency Department (ED) groups are on board with this protocol. He expressed a word of caution for the shockable rhythm patients and stated that he felt some of these patients might survive.

Dr. Johnson noted that in Mesquite he has probably had more requests for termination of resuscitation because of the locale.

Mr. Cox felt that they should be collecting and looking at how many termination of resuscitations are occurring on an annual basis.

Dr. Barnum agreed and added that he hadn't had a call in a year in a half and then had 2 in the last week and both of them were presented excellently on the telemetry by the crews. What Dr. Johnson mentioned about getting calls in rural areas with extended transport times touches on the fact that a lot of these have to do more with logistical constraints than anything else. He suggested adding an educational component to the protocol in an advisory capacity to take into account the extended transport times. He added that they can then use it as an instructional tool to place at the facilities for the physician who takes this type of call so they understand that this is an appropriate request. He felt that the hit or miss nature of who they get on the telemetry radio speaks to the need as a system to find a way to direct medical command of calls preferentially to EMS physicians.

Dr. Young agreed and felt there is a role for education here. He added that when he gets a call for termination of resuscitation, he has a set list of questions and felt that could be an educational opportunity for them to reach out and have those scripts available to put next to the telemetry at the hospital.

Dr. Slattery stated that he just queried the CARES registry for the City of Las Vegas and they've had about 2700 arrests in the registry since 2008 and their termination of resuscitation was 144 so less than 5% of the time.

Mr. Simone stated that if it is a solid protocol then their clinicians should be following it. He felt that it should be more of an educational component and make sure the crews know the protocol and then look at the data.

Ms. Britt stated that most of the hospital systems are represented either on the Board or in Committee and asked if there is a way to get this information back to the ED physicians. If part of the problem is the crews are not receiving the order to stop resuscitation in the field or if the crews have stopped asking because historically they have been refused, then that needs to be addressed.

Dr. Johnson agreed and felt that having some numbers to see how often this is being asked for and what percentage of time it was declined would help so they can review each case. The other step that could be done as a Committee is write up a checklist and attached that with the protocol and bring it to the ED/EMS Regional Leadership Committee and ask them to post it by their telemetry.

Mr. Tuke stated that they need to train the crews and make sure the doctors are on board. What he hears from the crews is when they call in most of the time they get a nurse first and they don't have time to wait for the nurse to get the doctor. When that telemetry box goes off, a doctor needs to answer it based on the way they have set up the protocols. The other issue he hears from the crews is they don't feel comfortable calling the code in front of the family so it is easier for them to load them up and take them. He felt that they need to do some public education so that the crews are not put in that uncomfortable situation when they do make that call.

Dr. Young agreed adding there are more resources in the hospital when working that patient; you have additional nursing staff, chaplain staff, and social worker staff to help with the family. One of the first steps of educating the public is breaking that conception of not running lights & sirens on these cardiac arrest patients and that was just implemented. He stated it will require a lot of education but felt they have to clean up their own house first and not having a physician on the radio is unacceptable.

Chief Gebhart advised the Committee that a Valley Wide CISM (Critical Incident Stress Management Team) is forthcoming so hopefully they have some of those resources.

Mr. Simone stated that he has developed an educational component for their crews that if they are going to be considering termination of resuscitation at the 10 minute mark they are either packaging or they are going to do 10 more minutes and that is when they need to have a frank discussion with the family to prepare them. At that point if they see the emotional component kicking in they will call TIPS (Trauma Intervention Programs).

Dr. Slattery agreed and stated that Mr. Simone's idea of developing an education component around this for the crews would be helpful and suggested the Education Committee develop that component.

Dr. Johnson summarized the discussion stating that each agency will send their termination of resuscitation data to the QI Directors Committee; emphasize education for our crews and the public, and create a checklist and education for the hospitals.

Member Tuke made the motion that the Education Committee develop an educational approach to increase understanding of the Termination of Resuscitation Protocol focusing on field crews, ED physicians and the public. Seconded by Member Cox and carried unanimously.

C. Discussion of Therapeutic Hypothermia Study Proposal

Dr. Young stated that at the previous meeting there was a motion to consider removing prehospital therapeutic hypothermia from our protocols because of the lack of definitive evidence supporting it and that motion did not pass. What came out of that meeting was a charge to start to look at some outcome data. There was a suggestion made to look at certain metrics of the cardiac arrest patient who get return of spontaneous circulation (ROSC). With the brief transport times, it was felt that those metrics were a little more sophisticated than what they would be able to execute going forward. Dr. Young noted that Dr. Anderson and Dr. Bledsoe had looked at this on their own for a study that they will be presenting and turned the meeting over to Dr. Anderson.

Dr. Anderson presented a study to answer the question "Are cardiac arrest outcomes better for patients who receive prehospital induced therapeutic hypothermia in Clark County, Nevada?" Over a 22 month period they did a retrospective review of all medical cardiac arrests using the CARES database for MedicWest and AMR and matched that data to the hospital data. The inclusion criteria were you had to be an adult and you had to get a pulse back after arrest. They excluded trauma cardiac arrests, pediatric cardiac arrests, pregnant women and prisoners. There were 2 arms of this study, you either were cooled or you weren't. There were 117 patients cooled and there were 204 patients that weren't. Out of the 117 ROSC patients that received therapeutic hypothermia, the survival percentage was 35.9. For the 204 ROSC patients that did not receive prehospital cooling, the survival percentage was 47.1. They used Fisher's Exact Test to analyze the data and the P-value was not significant. They concluded that there were no significant differences in outcomes for patients who received prehospital ITH when compare to those who did not received prehospital ITH.

Dr. Slattery questioned the purpose of the study for this meeting. He felt that this study in a retrospective fashion does not answer the question whether therapeutic hypothermia makes a difference in outcomes. The most important piece of information this study shows is the destination discrepancy of the different hospitals which he felt is something that they should look at going forward. He added that this study allows you to give some percentages and say there is no difference between percentages but the sample size isn't large enough.

Dr. Young stated that the goal of this study was to look at therapeutic hypothermia and maybe it was an oversimplified way to look at it but felt there was valuable information that came out of this study. He asked the Committee if it would be worthwhile to continue to do this going forward.

Dr. Slattery felt that if the focus is solely going to be on one piece of that bundle of care then it wasn't worth their time. He added that cardiac arrest is such a complex disease; you can't look at cardiac arrest survival and just pick one piece of that out and just focus on that. There is great value in continuing to look at the bundle of care for sudden cardiac arrest in our system and felt that the place for that is the Quality Assurance Committee.

Dr. Anderson argued that eliminating one unnecessary step allows you to concentrate more on those things that are important. If you don't have to worry about hanging the 2 bags of 4 degree saline, then you can really concentrate on your bagging, and you can get your 12 lead, especially in the limited 14 minutes that you have here in the valley to get them to the hospital. He felt that less is more.

Dr. Young acknowledged that these were great discussion points and felt that the discussions will continue. He added that he will send out Dr. Anderson's presentation to the members. He questioned why there isn't a way where the crews can do a code chill like when they call STEMI's or call code strokes, so you have that cooling blanket waiting on arrival and use their hospital resources to initiate that bundle gets continued.

Dr. Anderson stated that the problem with that is each hospital system is a little different and some of them specifically don't want you putting on the cooling pads in case they are going to the cath lab and some want you to so it is very system dependant.

Ms. Britt stated that in terms of process, this type of a question would go to the QI Directors Committee for outlining how this will be done and how they proceed.

Dr. Young agreed and stated they will put that on the QI Directors agenda for discussion.

IV. INFORMATIONAL ITEMS/ DISCUSSION ONLY

Ms. Britt thanked Dr. Johnson for his service over the last 2 years and stated that he has done a great job of keeping this Committee on track with some pretty important issues.

V. PUBLIC COMMENT

Public comment is a period devoted to comments by the general public, if any, and discussions of those comments, about matters relevant to the Committee's jurisdiction will be held. No action may be taken upon a matter raised under this item of this Agenda until the matter itself has been specifically include on an agenda as an item upon which may be taken pursuant to NRS 241.020. All comments are limited to five (5) minutes. Chairman Johnson asked if anyone wished to address the Committee. Seeing no one, he closed the Public Comment portion of the meeting.

VI. ADJOURNMENT

There being no further business to come before the Committee, Chairman Johnson called for a motion to adjourn; the motion was made, seconded and passed unanimously to adjourn the meeting at 10:07 a.m.