MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DRUG/DEVICE/PROTOCOL COMMITTEE

May 6, 2009--10:30 A.M.

MEMBERS PRESENT

Richard Henderson, MD, Chairman
Allen Marino, MD, MWA
John Higley, EMT-P, MFR
Eric Dievendorf, EMT-P, AMR
Jarrod Johnson, DO, MFR
David Slattery, MD, LVFR
Chief Bruce Evans, NLVFD
Chief Scott Vivier, HFD
Jo Ellen Hannom, RN, CCFD
Sandy Young, RN, LVFR
Christian Young, MD, BCFD

MEMBERS ABSENT

Chief Kevin Nicholson, BCFD
Ron Tucker, EMT-P, MWA
Eric Anderson, MD, Southern Hills Hospital
E.P. Homansky, MD, AMR
Jackie Levy, RN, UMC

SNHD STAFF PRESENT

Joseph J. Heck, DO, Operational Medical Director
Mary Ellen Britt, RN, Regional Trauma Coordinator
Trish Beckwith, Field Representative
Lan Lam, Recording Secretary
Rory Chetelat, EMSTS Manager
John Hammond, Field Representative
Rae Pettie, Project Coordinator
Judy Tabat, Administrative Assistant

PUBLIC ATTENDANCE

Larry Johnson, EMT-P, MWA/AMR
Brian Rogers, EMT-P, HFD
Lewis Morrow, Endocrinologist
Alan Rice, MD, Pediatric Endocrinologist
Julie Tacker, CARES Foundation
Steve Patraw, Boundtree
Rebecca Dennon, UMC
Paul Stepaniuk, EMT-P, HFD
Gretchen A. Lin, CARES Foundation

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, May 6, 2009. Chairman Richard Henderson, M.D., called the meeting to order at 10:32 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. A motion for Committee approval of the following items on the Consent Agenda was made, seconded, and carried unanimously.

Minutes Drug/Device/Protocol Committee Meeting April 1, 2009

Dr. Henderson asked for a motion to approve the minutes of the April 1, 2008 Drug/Device/Protocol Committee meeting. A motion was made, seconded and passed unanimously to approve the minutes as written.

II. REPORT/DISCUSSION/POSSIBLE ACTION

A. Review of Revisions to Module A and Module B of EMS Protocol

Tabled

B. Discussion of Revisions to Module C of EMS Protocol

Ms. Sandy Young noted that the procedures protocols are inconsistent; there is a protocol for defibrillation, but not capnography. The committee debated the need for a procedure protocol for all Health District approved devices and whether the education piece should be eliminated from the treatment protocols. Chief Bruce Evans suggested they add some of the procedures to the annual skills sign off.

Dr. Heck advised the committee to agree to a standardized template; the revisions submitted to date have come in various formats. After much discussion, the Committee agreed to mirror the procedures protocols after the formulary to include indications, contraindications and specific equipment needed.

John Higley stated he would like the annual skills sign off to include high risk, low frequency skills instead of skills performed on a recurring basis. Dr. Heck suggested they defer this discussion to a later date.

The following protocols were reviewed from Module C:

Acute Coronary Syndrome -

1. Added alert box between #9 and #10 stating, “After ABCs, acquiring a 12-lead EKG is the highest priority on-scene.”
2. Changed verbiage in #11 to read, “12-lead EKG and IV access should be obtained prior to administration of Nitroglycerin.”
3. Deleted #14 which made reference to the Fibrinolytic Elibigility Checklist.

Advanced Airway Management - No changes

Cardiac Arrest -

1. Globally replaced “Combitube” with “supraglottic airway device” throughout the protocol manual.
2. Added an alert box under “ILS” which states, “Compressions are the single most important action to be taken, followed by timely defibrillation.”

Cardiac Dysrhythmia: Asystole - No changes

Cardiac Dysrhythmia: Bradycardia - No changes

Cardiac Dysrhythmia: Monomorphic Ventricular Tachycardia - No changes

Cardiac Dysrhythmia: Pulseless Electrical Activity - No changes

Cardiac Dysrhythmia: Supraventricular Tachycardia - No changes

Cardiac Dysrhythmia: Torsades De Pointes - No changes

Cardiac Dysrhythmia: Ventricular Fibrillation or Pulseless Ventricular Tachycardia – There was a concern that hypothermia should be addressed in this protocol. After some discussion, it was agreed that a hypothermia protocol should be written. At this time, no changes were made.

Hyperkalemia - No changes

Shock - No changes

Formulary - Lasix removed

C. Discussion of Inclusion of Injectable Glucocorticoids as Treatment for Adrenal Insufficiency

Gretchen Lin introduced herself as a representative from the Congenital Adrenal Hyperplasia Research Education & Support (CARES) Foundation which is a support organization for families affected by Congenital Adrenal Hyperplasia (CAH). CAH is an illness which causes a lack of production of cortisol. Individuals suffering from CAH require a glucocorticoid shot to counteract the potentially life-threatening symptoms. Ms. Lin urged the Committee to include injectable glucocorticoids in the Clark County EMS formulary for treatment of individuals suffering from adrenal insufficiency for emergency response. She reported 1,500 people in the state of Nevada are suffering from this illness; approximately 75% are identified by medical ID tags. Ms. Lin also reported a study performed in Canada showed 24% of patients that suffer from this illness have died because they did not receive the emergency care needed.

In response to a question concerning the percentage of CAH patients who carry medication with them, Ms. Lin stated that a recent event sponsored by the CARES Foundation showed 30% of parents aren't receiving proper training on how to give injections and 50% are newly diagnosed infants without medications. She cited a recent occurrence in Overton where parents were unable to give the shot to their child. Fortunately, dispatchers were able to offer their assistance by talking the parents through the procedure.

Dr. Henderson inquired about the cost of the medication and its shelf life. Steve Patraw from Boundtree approximated the cost to be $3 per vial, with a 5-year shelf life.

Dr. Slattery stated that a better approach may be to increase awareness of this illness in the emergency department. He asked if there was a benefit to giving hydrocortisone in the field in the urban environment, as opposed to addressing hypoglycemia and hypotension and then letting the ERs give the hydrocortisone.

Dr. Henderson stated that the reason Morphine is given in the field is because it's not just the ten minutes of transport time these patients would be waiting; it's the 10-15 minutes of waiting for a bed, in addition to 15-30 minutes of waiting for the nurses' assessment in the emergency department before the patient is seen by a doctor. These times must be taken into account, not just the transport time.

Ms. Lin gave an example of a family that took their child suffering from CAH to the emergency department. The doctors spent 3 hours looking up the illness. Although it sounds easily recognizable, Ms. Lin believes in a general trauma situation, there would be a delay as the symptoms are not easily recognizable as CAH. Dr. Marino believes this issue is beyond EMS; the problem is kids going home without medication and parents not being taught how to give shots. Dr. Alan Rice stated that parents are being trained, but during a crisis they experience the adrenaline of having an unconscious child. Finding the device and using it becomes difficult.

Chief Evans asked if Solu-Medrol would be an effective form of treatment. Dr. Rice stated Solu-Cortef is the best form of treatment. Solu-Medrol would only treat part of the problem. It won't be effective for patients suffering from primary adrenal insufficiency, where they do not make glucocorticoids and mineralcorticoids because Solu-Medrol will only replace glucocorticoids and not mineralcorticoids. Dr. Rice stated that since Solu-Cortef takes effect in minutes, if given to a child on the way to the hospital, it would stabilize them for a few hours while waiting in the hospital. Patients will die during an adrenal crisis without Solu-Cortef even if they're given saline, dextrose or any other support measures. Dr. Rice believes Solu-Cortef should be given to patients with medic alert bracelets stating they suffer from adrenal insufficiency or to a patient that has been identified by a family member or themselves as being such. He noted that the risk of giving Solu-Cortef to a patient not suffering from adrenal insufficiency is minimal.

Chief Evans made a motion to add Solu-Cortef to the formulary. This motion was seconded and passed. Dr. Marino opposed, stating he would like to get additional input from the pediatric ER physicians.

Dr. Heck clarified that although the Committee agreed upon the addition of Solu-Cortef to the formulary, it will need to be presented to MAB for final approval. He advised that passing a public policy based on one interest group will set a precedent which opens the door for other special interests groups with special treatment needs requests in the future. He cautioned the need to view these types of requests from a logical level.

Dr. Marino was not convinced that pediatric emergency rooms are unable to recognize CAH. John Hammond stated that he researched other systems who have switched from using Solu-Medrol to Solu-Cortef due to price, and its multi-use for asthma patients. Dr. Heck stated that Solu-Cortef is a steroid and steroids are currently not included in the formulary. Dr. Marino stated that steroids take 4 hours to take effect; these patients may as well be given the steroid when they get to the hospital instead of adding it on every transport vehicle. Dr. Slattery concurred that it didn't make sense to add to our current formulary and protocols when we can educate the 14 hospitals in the valley to improve recognition and treatment of these patients.

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 11:57 a.m.