MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DRUG/DEVICE/PROTOCOL COMMITTEE

April 6, 2011--10:00 A.M.

MEMBERS PRESENT

Jarrod Johnson, DO, Vice Chair, MFR
David Slattery, MD, LVFR
Bryan Bledsoe, DO, MedicWest
Eric Dievendorf, EMT-P, AMR
Nancy Cassell, EMS Professor, CSN
Eric Anderson, MD, MedicWest
K. Alexander Malone, MD, NLVFD
Derek Cox, EMT-P, LVFR
Chief Troy Tuke, CCFD
Aaron Harvey, EMT-P, HFD (Alt.)

MEMBERS ABSENT

Richard Henderson, MD, Chairman
Mary Levy, RN, UMC
Scott Scherr, MD, Sunrise Hospital
Chief Scott Vivier, HFD
Michele McKee, MD, UMC
Gina Schuster, EMT-P, Community Amb

SNHD STAFF PRESENT

Rory Chetelat, EMS Manager
John Hammond, EMS Field Representative
Rae Pettie, EMS Project Coordinator
Mary Ellen Britt, Regional Trauma Coordinator
Judy Tabat, Recording Secretary

PUBLIC ATTENDANCE

Steve Johnson, EMT-P, MWA
Chad Henry, EMT-P, AMR
Larry Johnson, EMT-P, MWA
Richard Main, NCTI
Rick Resnick, Mesquite Fire & Rescue
Tracey Metcalf, RN, TriState CareFlight
Casey Diamond, NCTI
Jo Ellen Hannom, RN, CCFD
Philis Beilfuss
Chief Bruce Evans, NLVFD
Tricia Klein, NCTI
Jay McConnell, EMT-I, MWA
Matt Liguori, EMT-I, AMR

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, April 6, 2011. Vice Chairman Jarrod Johnson, D.O., called the meeting to order at 10:04 a.m. The Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law. Dr. Johnson noted that a quorum was present.

I. CONSENT AGENDA

Vice Chairman Johnson 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, March 2, 2011

Dr. Henderson asked for a motion to approve the minutes of the March 2, 2011 Drug/Device/Protocol Committee meeting. A motion to accept the minutes was made, seconded and passed unanimously.

II. REPORT/DISCUSSION/POSSIBLE ACTION

A. Review of Revisions to Bundle A

Cardiac Arrest (Adult CCC CPR)

Dr. Slattery acknowledged Philis Beilfuss on all her hard work in terms of lining the protocols up to match the American Heart Association (AHA) guidelines. He added that at the last meeting the concept of when and how much the protocols should deviate from AHA guidelines was discussed and he stated in his opinion the one area to deviate from is on continuous chest compressions (CCC). Dr. Slattery stated that he was very disappointed that AHA didn't go with CCC and was adamantly against 30:2 for ALS providers. The initial Adult CCR Cardiac Arrest protocol was modeled after another type of protocol called minimally interrupted cardiac resuscitation championed by Dr. Bobrow's study in Arizona that allowed EMS providers to either do 100% Non Re-Breather (NRB) mask on the patient and do chest compressions in the first 3 to 4 minutes of the cardiac arrest or do CCC plus BVM. Because there are 2 different concepts he feels it makes this protocol confusing so rather than specifics about how many minutes you do chest compressions before ventilations he proposed an operational protocol that reflects the priorities that should happen on scene which will make it more consistent with AHA with the exception of stopping chest compressions to give ventilations in the adult unwitnessed cardiac arrest. He listed his priorities as:

- Chest compressions consistent with AHA at least 100 per minute at least 2" per chest compression.
- Being poised to defibrillate, monitor and pads applied
- IV access and Epinephrine
- Ventilation

Currently the recommendations are CCC with interspersed ventilation asynchronously 6 to 8 times per minute either by Bag Valve Mask (BVM) or by endotracheal intubation and he would propose to stay consistent with that whether the patient's airway is managed or not doesn't matter.

Ms. Beilfuss felt that we are doing an injustice to the patient if we are considering doing BVM without a pause for the ventilation because it will go into the stomach and be ineffective. She added that AHA was very clear in all of the algorithms in the 2010 guidelines that if there is not an advanced airway in place, there should be no positive pressure ventilation and 30:2 is to be done in the standard way of compressions and ventilations.

After considerable discussion, Dr. Johnson stated that most are in agreement that CCC is the way to go but the sticking point seems to be between positive pressure ventilation versus passive pressure ventilation with a Non Rebreather (NRB).

Mr. Chetelat felt that Item #9 and #10 of the protocol need to be addressed. Mr. Cox agreed and felt that there are a lot of numbers being thrown out at you; #5 states a rate of 100 a minutes for 2 minutes, #9 states 30:2, and #17 states 400 compressions.

Dr. Slattery stated that the only item that would be removed is #9 but he will bring his proposal in writing for the next meeting.

Acute Coronary Syndrome (Suspected)

Ms. Beilfuss stated that Morphine has definitely been looked at with some concern and it's likely to be the way it's administered. Previously it was administered 1-2mg titrated to effect and now it is a calculated weight dose. What is being seen in the hospitals and observed in the field is that it is given too fast thus resulting in hypotension and she questioned the possibility of going back to the 1-2mg titrated to effect to the calculated top dose by weight which will also eliminate protocol deviations.

Dr. Slattery felt that the answer is Fentanyl. The problem with Morphine is the histamine release and added that this discussion should be tabled until Dr. Henderson can be present. Aaron Harvey stated that he did discuss this with Dr. Henderson and he is definitively in favor of moving towards Fentanyl. Mr. Cox stated that this would be a significant change and asked if it would be rolled out in this cycle. Dr. Slattery commented that it would be put in just like any new protocol process by submitting an evidenced based proposal including budget and brought to this Committee for review. Mr. Cox then suggested that there be a language change for this protocol rollout when administering Morphine. Dr. Anderson suggested inserting "up to" right before the 0.1 anywhere in the protocols that Morphine Sulfate is mentioned.

A motion was made to change the language when administering Morphine Sulfate to "up to 0.1 mg/kg slow IV to a maximum single dose of 10mg." The motion was seconded and passed unanimously.

B. Discussion of Revisions to Operations Protocols (Bundle B)

Smoke Inhalation

Dr. Slattery informed the Committee that there are still some logistics that need to be worked on with the protocol. Currently the protocol does not allow use in children and Dr. McKee was tasked to bring back a decision from her colleagues regarding recommendations in terms of direction. Dr. McKee could not be here so he suggested deferring the decision until they have pediatric representation. He added that there is not a lot of good evidence in children but felt that if you have a child who is in cardiac arrest there is little harm that is going to be done by giving them the Cyanokit. The Committee agreed.

The current protocol for cyanide poisoning is for indications in the field or for patients that have smoke inhalation plus cardiac arrest, smoke inhalation plus altered mental status or hypotension. He felt that those indications were pretty liberal and since the Cyanokit is $900 to $1000 a dose he suggested that they limit the kits to smoke inhalation plus cardiac arrest or smoke inhalation plus intractable hypotension.
Chief Evans disclosed that he is on the Drug Advisory Committee and stated that the price is a big issue and agreed that the protocol should be tightened up. Dr. Bledsoe agreed and stated that altered level of consciousness is too nebulous and not an indication of smoke inhalation. Dr. Slattery stated that they are working on getting replacements through the grant but eventually the grant will run out. Dr. Bledsoe stated that one thing they are going to have to eventually address is repeat doses. He added if you look at the usage in the United States and some of the data out of Houston, a lot of the smoke inhalation patients are being re-dosed and that is something to consider. Chief Evans stated that there is a reimbursement strategy in place which several states have legislated in their Medicaid guidelines by adding an ICD9 code for reimbursement.

A motion was made to change the language in Item #9 to read "If cardiac arrest or hypotension present, administer Cyanokit 5g IVPB over 15 minutes." The motion was seconded and passed unanimously.

Dr. Slattery added that this is a destination protocol and felt that an alert box be added to state that all patients need to be transferred to the Burn Center (UMC Adult Trauma Center or UMC Pediatric E.D.).

Chronic Public Inebriate

Dr. Slattery questioned the status of WestCare. Mr. Chetelat stated that the funding for WestCare is in the hands of the legislature right now. The thought is if the State decides to pull their funding the hospitals and city's may also pull their funding which will cause a real domino effect in the system.

Pediatric Patient Destination

Mr. Chetelat updated the Committee stating that the Office of Emergency Medical Services & Trauma System (OEMSTS) was required to audit the hospitals designated as pediatric destination facilities for compliance. The letters have been sent out and we are waiting for documentation of compliance back from the 4 hospitals listed in the protocol.

Termination of Resuscitation

Dr. Slattery reported that the National Association of EMS Physicians (NAEMSP) Standards and Practices Committee is currently revising both the traumatic and non traumatic termination of resuscitation guidelines and position papers and felt that the traumatic arrest will need to be adjusted when a change is made. There is a meeting with the American College of Surgeons (ACS) and NAEMSP in a few weeks and this is one of the items on the agenda. He added that our current protocol is unique in that we require them to address potential life threats, airway issues or tension pneumothorax which no other system in the United States is doing and he tried to insert that in the new regulation document and is hoping to see that come through.

Ms. Beilfuss requested consideration to use capnography as another determination to stop resuscitation since just about all the agencies now have capnography. Dr. Bledsoe felt it was an excellent idea and stated that from a risk management standpoint, the argument has been made that asystole is a treatable rhythm and capnography <10 is more suggestive of death than even asystole because of the way the law has been interpreted. Chief Tuke expressed concern due to the fact that he doesn't have capnography in his rurals. Ms. Beilfuss suggested adding the language "if available". Dr. Slattery stated that his only caution was if you have a patient that is not intubated correctly (esohageally), you are going to have a positive reading and questioned whether adding capnography adds anything to that decision point.
Mr. Cox expressed concern over using the phrase "if available" and felt that chances are it won't get done. Dr. Bledsoe suggested making it mandatory. Chief Tuke again referenced his rurals not having capnography. Mr. Chetelat stated that rather than making it mandatory keep it if available and stress it hard in the education component.

A motion was made to change the language in Item #2a1) to read "The patient remains in persistent asystole or agonal rhythm and has capnography (if available) <10 after twenty (20) minutes of appropriate ALS resuscitation, to include:" The motion was seconded and passed unanimously.

Trauma Field Triage

Dr. Bledsoe stated that this protocol is not in compliance with the CDC. He felt the anatomic criteria are supposed to go to the highest level trauma center in the system. He added that he realizes that there is a disagreement with the difference between a Level I and Level II but until that is rectified; it should go to the highest level trauma center in the system. Dr. Malone agreed.

Mr. Chetelat stated the OEMSTS is working closely with the Regional Trauma Advisory Board (RTAB) at this time and has invited ACS to come out to do a complete system review. He recommended that this protocol be tabled at this time until ACS has completed their final report which should take place in July. The Committee agreed.

Legal 2000 Patient Transport Guidelines

Dr. Anderson suggested adding additional language for any Legal 2000 case that results in a return to a hospital due to a medical issue that they are returned to the hospital that conducted the original medical clearance examination. He felt that it doesn't come into play that often, but it would protect the medics and be best for the patient so that recent records, tests, and studies are readily available to help care for the patient.

Mr. Chetelat asked Dr. Anderson to send him his recommendation on the language and it will be reviewed at the next meeting.

C. Discussion of Revisions to Procedure Protocols (Bundle C)

Tabled

D. Discussion of Revision to the Formulary

Tabled

III. INFORMATIONAL ITEMS/DISCUSSION ONLY

None

IV. PUBLIC APPEARANCE/CITIZEN PARTICIPATION

None

V. ADJOURNMENT

As there was no further business, Dr. Johnson called for a motion to adjourn. The motion was made, seconded and passed unanimously to adjourn at 11:13 a.m.