EMS COUNCIL INC.

Rappahannock EMS Council
Medical Direction Committee
Thursday, March 12, 2015 at 5:00 pm at the REMS Council Office Location

Members Present	Staff Support	Excused	Guests
Dr. Tania White	Wayne Perry	Dr. Coleen Rickabaugh	
Dr. Doug Johnson		Dr. Jordan Crovatin	
Dr. Charles Beaudette		Dr. Michael Jenks	
		Dr. Steven Taylor	
		Dr. Andrew Reese	

Call to Order

Meeting was called to order at 1703 by Dr. White, the committee chairperson.

Approval of Minutes

There were no previous meeting minutes to approve.

New Business

OEMS Updates:

OEMS and legislative updates for the OMDs no longer require the signature of test waivers for providers. In the past, providers had to complete skills drills and submit documentation to the REMS Council in order to have a test wavier presented to the OMD to recertify without testing. Now once the provider completes the continuing education requirements they can request recertification early or will automatically recertify on the expiration date. Skills drill are no long tied to the recertification process. If there are particular skills you want to see the providers complete, you can work directly with the agency to establish this requirement.

As of July 1, 2015 all minimum didactic hour requirement components for initial certification courses have been eliminated. The clinical and field hours and requirements have not changes. In addition, the state will now allow online classes or a combination of the traditional and online (hybrid).

Guidelines and Training Committee update:

There are a few items related to the regional protocols that needed some discussion to resolve questions that were brought up for clarification. There is a new chairman for the protocol sub-committee and they will be meeting soon to discuss these (and other) topics related to the current protocols.

1) Solumedrol use by intermediates as compared to paramedics. This medication is approved on the formulary for intermediates. However, in the allergic reaction protocol in the medical section, it is categorized as standing orders for the paramedic level. It was recommended to take the entire block (including PO Wysolone) and move it to the intermediate level. This will be presented to the protocol sub-committee for inclusion in the protocol updates.
2) Epinephrine IM versus SQ. There was a discussion about the SQ use of Epinephrine instead of IM during allergic reaction. The general feeling was that there was no need to change the wording since it allowed for either route, at the provider's discretion.

3) C-Collar / Spinal Motion Restriction. Providers are using C Collars and backboards on patients when it is not necessary. There is currently an opt-out protocol for back boarding, but providers are not using it. There are white papers and position papers on the national and state level that indicate the complications related to unnecessary backboarding. In addition, there appears to still be a tremendous over-triage of patients. The group felt that the protocol should be revised to include the wording (3-prong approach) from the white paper.

   Appropriate patients to be <u>immobilized with a backboard</u> may include those with:
   - Blunt trauma and altered level of consciousness;
   - Spinal pain or tenderness;
   - Neurologic complaint (e.g., numbness or motor weakness)
   - Anatomic deformity of the spine;
   - High energy mechanism of injury and:
     - Drug or alcohol intoxication;
     - Inability to communicate; and/or
     - Distracting injury

   Patients for whom immobilization a <u>backboard should NOT be used</u> include those with all of the following:
   - Normal level of consciousness (GCS 15);
   - No spine tenderness or anatomic abnormality;
   - No neurologic findings or complaints;
   - No significant distracting injury;
   - No intoxication

   Spinal precautions can be maintained by <u>application of a rigid cervical collar</u> and securing the patient firmly to the EMS stretcher (**<u>NO BACKBOARD</u>**), and may be most appropriate for:
   - Patients who are found to be ambulatory at the scene;
   - Patients who must be transported for a protracted time, particularly prior to interfacility transfer

   Basically, if there is no pain there should be no backboard and no collar. If there is pain, the patient could receive a c-collar, but no backboard should be used. If the patient is unconscious or otherwise severely injured long backboard and full SMR would be acceptable. Given the evidence of the harm of backboarding, the group felt that it should be specifically stated to NOT use them as opposed to the current language which permits them to not be used. Things such as "standing backboarding" should no longer occur. The protocol will be re-formed using the white paper language and presented to the protocol sub-committee.
4) Therapeutic Hypothermia. There is emerging evidence that hypothermia may not have as strong a benefit as originally thought, or at least the implementation pre-hospital is not without issues. Anecdotally several cases were discussed where patients were cooled below therapeutic levels and arrhythmias were seen due to hypothermia. It is felt that operationally it is difficult to manage hypothermia in the field. In addition, without proper monitoring equipment to ensure core temperature is not compromised it may be worth waiting until arrival in the hospital to begin hypothermia. When reviewing the protocol wording it doesn't REQUIRE hypothermia and the group felt that considering it was still reasonable at this point. It will be a topic to be reviewed at future meetings when additional evidence is available. The group felt that this could be a potential QI indicator to monitor for the region.
5) Lidocaine versus Amiodarone. In the cardiac arrest protocol of the medical section, it currently shows the use of Lidocaine instead of Amiodarone. On page 4, the group wanted to add Amiodarone as an option for antidysrrhythmics. There was also a discussion about the dilution and mixing of Amiodarone. The group decided to leave it as is for now, pending additional information or evidence warranting a change.
6) Impaired field providers. There was an agency who submitted a question about a provider who is currently being prescribed benzodiazepines (Klonopin) for a medical condition. They wanted an interpretation of how this related to the impaired field providers language (Administrative 3.11.1). The group felt that providers using this class of medication would fall into this grouping and it was recommended that they now be waived. There was also a discussion about the language for this section, and the group felt that it was appropriate. No changes were recommended.

   3.11.1 Indications

   Field providers will NOT appear for duty, be on duty, or respond via privately-owned-vehicle (POV) while under the influence of any prescribed, or over-the-counter, medications that could impair their ability to drive or otherwise provide quality patient care. Field providers will ***not*** appear for duty, be on duty, or respond POV while under the influence of intoxicants or illegal substances, to any degree whatsoever, or with an odor of intoxicants on their breath.

Pharmacy Committee update:

Currently, if there is a medication shortage, then the REMS Council is notified. When a facility reports a shortage, the other medical facilities in the region are contacted to determine if they are experiencing the same shortage. Most of the time they are, but sometimes one facility is experiencing the shortage through the specific vender they use.

The current Medication shortages:

Medication Shortage	Approved Alternative Provided	Effective Date
Vasopressin	Epinephrine per Dr. White	2/19/2015
Fentanyl	None	1/1/2013
Lorazepam	None	1/1/2013
Ketamine	None	1/1/2013
Diazepam (Valium)	None. During shortage EMS may use Versed as outlined in the Regional Protocols	1/27/2012

The medications listed below are being distributed but are in alternate packages or doses:

Medication	Current Packaging / Dosage Available for EMS
Narcan (1 - 4mg/10 ml vial)	Effective 5/6/2013: 1- Narcan 0.4 mg/1ml vial will be provided per kit
Etomidate (1- 40mg vial)	Effective 5/6/2013: 2 - 20mg/10ml vials will be provided per kit.
Zofran (4mg vials)	Two 4mg Zofran ODT tablets provided –changed from ODT tablets
Versed 5mg/5ml (pre-filled syringe)	Currently provided in 5mg/5ml vials

Diltiazem has been removed from the list and is being added back to the boxes.

The group wanted to ensure the option of IZ Zofran was available as they discussed reports that we have received that the ODT is less effective if there is active vomiting. If given during nausea (and prior to vomiting) it seems to work well. The group felt it was a good idea to have IV and ODT available since EMT-Basics could potentially administer the ODT in the future. The protocol will be updated to reflect both options and it will be sent to the protocol sub-committee.

The Virginia Board of Pharmacy made a revision to the required signatures for medication exchange. They no longer require a physician's signature, as the state determined exchanges are under the control of pharmacy department. Some pharmacies still want physician signatures, and if they want to require signatures for medication exchanges they may do so. Dr. White advised that a lot of providers are still bringing the white form to the OMDs to sign.

A Division of the DEA made a visit to Lynchburg and reviewed the process used in that area for medication distribution. The DEA's response was that the Virginia EMS system related to standing orders and protocols caused great concern. There have been several meetings on the state and national level, and we don't yet know what will come of it. The concern is related to the Drug Control Act of 1970 – which requires a single prescriber, single patient type relationship.

Heart and Stroke Committee update:

The Stroke committee reviewed the Regional Stroke Plan, and determined that very few changes need to be made to the plan. Areas of change include adding Fauquier Hospital to the plan, as they are now a stroke center; updating the time frame from 4 to 3 hours; adding check sugar, last known well time, and Cincinnati Stroke scale. Anything over 3 hours contact medical control. They all agreed that more education needs to be provided by the departments to ensure that providers are aware of the Stroke Plan and its details.

Wayne made the committee aware of the HeartSafe program in Virginia. The program is designed to promote survival from sudden cardiac arrest, and is focused on strengthening the chain of survival. This is a community program where the quantity and locations of AEDs are establish, CPR training is provided, and citizens interested in the program provide their information to be placed in an alert system. When cardiac arrest occurs, an alert is sent to system participants in the area of the incident so

that they may respond and initiate care. Stafford County now has a HeartSafe program established, and their program is the first of its kind in the Commonwealth. The REMS Council is designated to review all applications for the state of Virginia.

Trauma Committee update:

The Trauma Committee met and reviewed the Trauma Triage Plan. The group worked last year to revise the plan to include the new CDC guidelines from 2012. The REMS council was advised by OEMS that the plans of the regional councils could not exceed the state plan. The state's plan was last revised in 2010, so recent revisions to the REMS have been removed and the council has reverted back to the older version. The only section that remained changed was the ABA Burn section. The Regional Councils are working on completing a trauma survey for OEMS. The state has asked the ACS to perform a review of the state trauma system.

QI Committee update:

QI data from the last quarter was reviewed by the group. Currently agencies (per OEMS guidelines) must review 10% of their call volume quarterly. The QI committee establishes a Medical, Trauma, and System indicator for each quarter. The group was advised that REMS has access to VPHIB through OEMS but the program is not easy for us to obtain the data needed. If the group would like to make recommendation on future indicators provide the council with the information and we will pass it on to the QI committee.

Old Business

No Old Business

Adjournment

Meeting adjourned at 6:15 pm.

Next Meeting

The next meeting is TBA.

Rappahannock EMS Council
Medical Direction Committee
Wednesday, May 13, 2015 at 5:30 pm at the REMS Council Office

Members Present	Staff Support	Excused	Guests
Dr. Tania White	Wayne Perry	Dr. Coleen Rickabaugh	
Dr. Doug Johnson		Dr. Jordan Crovatin	
		Dr. Michael Jenks	
		Dr. Steven Taylor	
		Dr. Andrew Reese	
		Dr. Charles Beaudette	

Call to Order

Meeting was called to order at 1730 by Dr. White, the committee chairperson.

Approval of Minutes

The meeting minutes from March 12 were presented and approved.

New Business

OEMS Updates:

Dr. White provided an update from the last state medical direction committee meeting and reviewed some of the topics that were discussed.

Guidelines and Training Committee update:

There were a few items that have been discussed at the protocol sub-committee, which they are currently working on. Nothing has been completed and is ready to be reviewed/approved by medical direction. The meeting items were discussed as follows:

Administrative Section

- Admin section- 3.2.2 management – discussed who should ultimately decide as to the means of transport for the patient. Recommend adding a comment that the AIC who is responsible for the patient transport has the authority for deciding the mode of transport.
    - The medical direction committee did not have a problem with this change, and will await the final draft.
- Admin Section 3.3 Behavioral Emergencies- Committee would like to see a restraint protocol to include Physical & Chemical restraint –Jake Marshall will research other council protocols and will draft one for our review and proposal.
    - There was a discussion about the use of Haldol and the medical direction committee was NOT in favor of using this medication. There was also a discussion about Geodon and other options. As a substitution, they recommended using Ketamine. While they don't see it being used on a routine basis, they agree that something is necessary when the provider's safety is at risk.
- Admin Section 3.4 Code Gray- change wording from providers should confirm patient is apneic and pulseless to providers SHALL confirm patient is apneic and pulseless. There was also a discussion about patients with LVAD giving false readings and whether that should be added here or in reference section. Going to add information on this topic to the reference section.
    - The medical direction committee did not have a problem with this change, and will await the final draft.

- Admin Section 3.6- Direct Admissions – a discussion if agencies are transporting patients directly to L & D. That is at the discretion of the Provider/Agency. If the provider believes it is better to transport the patient directly to L & D on their cot (i.e. patients membranes have ruptured; patient is unclothed, etc) they can choose to transport. But it is not a requirement to take the patient to the floor.
    - The medical direction committee did not have a problem with this change, and will await the final draft.
- Admin section 3.7.2- item 5. Delete the bolded statement-"The medical practitioner who assumes responsibility for the patient at the hospital shall sign this administration record." Need to bold" Oral orders shall be reduced to writing by the EMS Provider and shall be signed by a medical practitioner"
    - The medical direction committee did not have a problem with this change, and will await the final draft.
- Admin section 3.8.1 #5 delete Resuscitative efforts, once begun, can only be stopped with the guidance of medical control
    - The medical direction committee did not have a problem with this change, and will await the final draft.
- Admin Section 3.15.2 bottom of page 22, Change levels of EMS certification to match current terminology. (ie: EMR-First responder; EMT-EMT-B etc.)
    - The medical direction committee did not have a problem with this change, and will await the final draft.

  Bottom of page 22 –Top of page 23 questions about what qualifies a CCP & AP. This is listed in Reference section page 4.

  There was a brief discussion about the role of CCP & AP and there needs to be additional discussion among the OMD's to ensure consistency with how this is implemented across the region.
- Admin Section 3.16.1 #1 – delete "whether injured or not".
    - The medical direction committee did not have a problem with this change, and will await the final draft.

Medical Section

- Change all levels of EMS certification to match current terminology (FR becomes EMR, EMT-B becomes EMT, etc)
    - The medical direction committee did not have a problem with this change, and will await the final draft.
- Allergic Reaction – move EMT-P # 8 &9 block to EMT-I
    - The medical direction committee did not have a problem with this change, and will await the final draft.
- Altered States of Comfort - #5 should read " If unable to us fentanyl due to patient condition or allergy, administer Morphine Sulfate (Morphine) 2-5 mg q 5 up to maximum of 20 mg until patient is pain reduced or SBP < 90mmHg.
    - Proposal to add Promethazine (Phenergan) 25 mg IV for adults and 12.5 mg for pediatrics as an alternative for nausea.
    - All the bullets need to be renumbered.
        - The medical direction committee had a discussion about the total quantity of Morphine and recommends that the maximum be set at 10mg.
- Cardiac Arrest – Notes #2 Bold " ACLS (add & PALS) treatment algorhythms should be utilized- see reference". Also propose to delete the second and third sentence.
    - On the tachycardia section, propose to add Lidocaine as an alternative to Amiodarone. (On page 4/6 – add Amiodarone as an option for anti-arrhythmic and include Amiodarone dilution information in the medication reference section.
        - The medical direction committee did not have a problem with this change, and will await the final draft.

Trauma Section

Based on feedback from the medical direction committee, there will be a major revision to the backboard protocol.

1) if there is no bony spinal pain, there should not be any immobilization
2) if there is bony spinal pain, the patient should have a c-collar only
3) if the patient is unconscious, they should be placed on a LBB

They want to change the language to prohibit standing backboarding and ensure that the language is less permissive as to allow no backboarding and make it prohibitive to backboard unless it meets the criteria.

The medical direction committee did not have a problem with this change, and will await the final draft.

Clinical Procedures

Under Scope pf Practice- add Intraosseous to the enhanced level.

Therapeutic hypothermia- under notes add # 4 that the agency needs to have equipment to monitor the patient to include a device to cool the IV solutions and a device to monitor core body temperature of the patient.

The medical direction committee did not have a problem with this change, and will await the final draft.

Medication Reference Section

Atropine – update indications to remove PEA and Asystole
Add Infusion rates for each med sheet

The medical direction committee did not have a problem with this change, and will await the final draft.

Miscellaneous

Tranexamic Acid (TXA) – this was recommended to consider as an addition the protocols. Jake Marshall is going to provide a proposed protocol at a future meeting.

This was a discussion at the medical direction committee and they will be reviewing some literature before they make a suggestion regarding the use by EMS.

Pharmacy Committee update:

Currently, if there is a medication shortage, then the REMS Council is notified. When a facility reports a shortage, the other medical facilities in the region are contacted to determine if they are experiencing the same shortage. Most of the time they are, but sometimes one facility is experiencing the shortage through the specific vender they use.

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Zofran (4mg vials)	Two 4mg Zofran ODT tablets provided –changed from ODT tablets
Versed 5mg/5ml (pre-filled syringe)	Currently provided in 5mg/5ml vials

Heart and Stroke Committee update:

The Stroke committee continues to review the Regional Stroke Plan. Nothing has been finalized at this point.

There have been no new applications to the HeartSafe program in Virginia.

Trauma Committee update:

The Trauma Committee for the state has met and reviewed the Trauma Triage Plan, they have updated to the new CDC criteria, so now the regional plan can also be updated. The Regional Councils are working on completing a trauma survey for OEMS. The state has asked the ACS to perform a review of the state trauma system.

QI Committee update:

QI data from the last quarter was reviewed by the group. Currently agencies (per OEMS guidelines) must review 10% of their call volume quarterly. The QI committee establishes a Medical, Trauma, and System indicator for each quarter. The group was advised that REMS has access to VPHIB through OEMS but the program is not easy for us to obtain the data needed. If the group would like to make recommendation on future indicators provide the council with the information and we will pass it on to the QI committee.

Old Business

No Old Business

Adjournment

Meeting adjourned at 6:15 pm.

Next Meeting

The next meeting is July 20, 2015.