Southern Nevada Health District

MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DIVISION OF COMMUNITY HEALTH

DRUG/DEVICE/PROTOCOL COMMITTEE

May 4, 2016 – 10:00 A.M.

MEMBERS PRESENT

Mike Barnum, MD, Vice Chairman, AMR
Tressa Naik, MD, Henderson Fire Dept
August Corrales, JTM
Jim Kindel, Boulder City Fire Dept.
Troy Tuke, Clark County Fire Dept
Ryan Bezemer, Community Ambulance
Kim Moore, Henderson Fire Dept
Steven Carter, AMR
Brandon Hunter, MWA
Derek Cox, LVFR
Frank Simone, NLVFD

MEMBERS ABSENT

Bryan Bledsoe, DO, Chairman, MWA
Jarrod Johnson, DO, MFR
Devon Eisma, RN, Mercy Air
K. Alexander Malone, MD, NLVFD
David Slattery, MD, LVFR

SNHD STAFF PRESENT

Christian Young, MD, EMSTS Medical Director
Laura Palmer, EMSTS Supervisor
Rae Pettie, Recording Secretary
John Hammond, EMSTS Manager
Gerry Julian, EMS Field Rep

PUBLIC ATTENDANCE

Stephen Johnson, MWA
Jason Driggars, AMR
Peter Fecteau, AMR
Sarah McCrea, LVFR
Jim McAllister, LVMS
Glenn Glaser, MWA
Pericles Cordova, AMR
Steve Krebs, MD, UMC

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The Drug/Device/Protocol Committee (DDP) convened in Red Rock Trail Conference Room at the Southern Nevada Health District on Wednesday, May 4, 2016. Vice Chair Mike Barnum called the meeting to order at 10:06 a.m. The Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law. Vice Chair Barnum noted that a quorum was present.

I. PUBLIC COMMENT

Members of the public are allowed to speak on Action items after the Committee's discussion and prior to their vote. Each speaker will be given five (5) minutes to address the Committee on the pending topic. No person may yield his or her time to another person. In those situations where large groups of people desire to address the Committee on the same matter, the Chair may request that those groups select only one or two

speakers from the group to address the Committee on behalf of the group. Once the action item is closed, no additional public comment will be accepted.

Vice Chair Barnum asked if anyone wished to address the committee. Seeing no one, he closed the Public Comment portion of the meeting.

II. CONSENT AGENDA

Vice Chair Barnum 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, April 6, 2016

Vice Chair Barnum asked for a motion to approve the consent agenda, which included the minutes of the April 6, 2016 Drug/Device/Protocol Committee meeting. *A motion was made by Member Tuke, seconded by Member Naik, and carried unanimously to approve the minutes as written.*

III. REPORT/DISCUSSION/POSSIBLE ACTION

A. Review of the Chronic Public Inebriate (CPI) Protocol

Sarah McCrea stated she has had discussions with various EMS agencies related to the verbiage in the current CPI protocol. The title lends itself to misinterpretation because it implies that only the chronically public inebriated patient qualifies, as opposed to a one-time event. She suggested they rename the protocol "Public Intoxication." Ms. McCrea noted that she invited Robert Vickrey, Program Director for Community Triage Center, to provide clarification on the processes they currently have in place.

Ms. McCrea suggested they strike the word "alcohol" from the first sentence in #1, as it is too inclusive, and replace it with "controlled substance". She noted that "controlled substance" may also be too inclusive. They may need to come up with something that covers a variety of different conditions.

Ms. McCrea suggested they change the word "may" in #1 to "will," "should," or even "must" as it is stated in the Trauma Field Triage Criteria (TFTC) protocol. Mr. Hammond noted the TFTC protocol is supported by state law; our protocols are not. He explained that changing "may" to "must" doesn't take into account caregiver intuition or assessment. Although the patient meets all criteria listed in B. 1-10, if the EMS provider feels the patient should go to the hospital for some underlying medical concern, the protocol shouldn't restrict him from doing so. There may be a bad outcome as a result. After some discussion it was agreed to change "may" to "should". Dr. Young stated he often sees intoxicated patients in the ER that could have been taken to an alternative destination to sober up. It's safe, it decompresses the ER, and it should be utilized more often. In his opinion, the protocol is safe with the current vital sign criteria.

Troy Tuke stated Clark County FD's volume in the strip corridor increases exponentially on Fridays, Saturdays and Sundays. In the past, the crews had difficulty offloading patients to WestCare. Since then, WestCare has changed their intake parameters to align with our protocol so the crews don't encounter the same problems they experienced in the past. Mr. Simone suggested they revise B.10 to read, "Approval of the physician or medical staff upon assessment of the patient prior to transport to an alternative facility." Mr. Tuke noted that CCFD has been working towards training the security staff and their onsite required medical team on the alternative destinations. The training should be completed within the next few months.

Mr. Vickrey stated WestCare has a 100-bed capacity. Laura Palmer inquired as to the ratio of nurses to patients. He replied they have two nurses on duty per shift, per location. Ms. Palmer noted that there could potentially be one nurse monitoring 50 patients at any one time. Dr. Young asked if WestCare has a process in place for staffing and other issues, and how they plan to alert EMS crews when have reached capacity. Mr. Vickrey stated WestCare hopes to utilize EMResource for system

management, along with a network alert. Ms. McCrea stated she has been encouraging the crews that are more regionally located to call ahead to ensure WestCare is able to receive the patient prior to transport.

The Committee agreed to revise #2 to read, "If there is ANY doubt about whether the person is in need of emergency medical care, the person should be transported to a receiving facility." The current language reads that the patient should be transported to the "closest" receiving facility, thereby not giving the patient the choice to choose a hospital.

Ms. McCrea suggested removing "….other than signs and symptoms of MILD withdrawal from alcohol and/or substance abuse" from the Alert Box to clarify that we want to include patients who are currently intoxicated; not patients who are experiencing symptoms of withdrawal; the purpose of the protocol is to transport people who are actively under the influence to an alternative destination, such as WestCare. Patients who have signs and symptoms of withdrawal from alcohol and/or substance abuse should be transported to a hospital. The Committee again agreed that it would be safe to take a patient whose vitals are within the parameters of the protocol to an alternative destination. Dr. Young noted there are some patients who meet all vital sign criteria that are hemodynamically stable and not in acute withdrawal who may have a component of dual diagnosis or underlying psychosis. He asked if that is a concern at WestCare. Mr. Vickrey responded that WestCare is creating the staff and structure to treat acute mental health disorder. Mr. Tuke expressed confidence that the EMS crews will make the right decision about whether to take a patient to a hospital or to an alternative destination. Now that WestCare has changed their intake process, crews will become more comfortable taking patients there, and the numbers will increase.

Steve Johnson commented that the glucose range listed on all other Clark County protocols is 60-250; however, it's listed as 50-250 on the CPI protocol. He suggested they revise it for the purpose of standardization.

A motion was made by Troy Tuke to make the following changes to the CPI protocol:

1) *Change the name of the protocol to "Public Intoxication;"*
2) *Revise #1 to read, "A person who is suspected to be intoxicated and has no other emergent medical need should be transported to an approved alcohol and drug abuse facility rather than a hospital's emergency department IF the patient meets ALL of the following criteria;"*
3) *Change the blood glucose level from 50-250 to 60-250;*
4) *Revise B.10 to read "Approval of the physician or medical staff upon assessment of the patient prior to transport to an alternative facility;"*
5) *Revise the Alert Box to read, "All of the above parameters must be met and the patient must be clinically stable;" and*
6) *Revise #2 to read, "If there is ANY doubt about whether the person is in need of emergency medical care, the person should be transported to a receiving facility."*

The motion was seconded by August Corrales, and carried unanimously.

B. Discussion of Adding the Handtevy Tool as a Broselow Equivalent

Dr. Peter Antevy, founder and Chief Medical Officer of the Handtevy Dosing System Pediatric Customization for EMS tool, gave a PowerPoint presentation to the Committee. The pediatric resuscitation system delivers customized pediatric resuscitation and utilizes a highly interactive training program that results in reduction of medical errors, enhanced quality of pediatric care, and improved sense of teamwork. Dr. Antevy stated it will empower field providers to perform rapidly and efficiently on all pediatric calls. The new application launched in January. It can be used on a Windows device such as a tablet, and can subsequently be streamed right into the ePCR.

The Handtevy Dosing System is now being utilized in 31 different states, which includes 105 different EMS agencies. The first unfunded peer review study comparing the Broselow and Handtevy Dosing

System was published in February. The findings show a significant difference in error rate and discordance with protocols when using the Broselow. The EMS providers who took part in the study remember they were given a 2-minute tutorial on both systems, and they overwhelmingly preferred the Handtevy tool.

Another study looked at age vs. length; they were found to be statistically equivalent, according to the data presented by Dr. Antevy. He noted that hospitals across the country are now moving towards age-based resuscitation.

Dr. Antevy explained the Handtevy Dosing System can be customized to fit any EMS agency's or hospital's protocols to match 100%. He presented the following unpublished data from Polk County, Florida:

1) In 2012-2013 they had 38 pediatric arrests 2012-2013; the survival to discharge was zero.
2) In 2014-2015 they had 52 arrests, of which 17 regained ROSC; 12 children left the hospital neurologically intact.

Dr. Antevy noted that most of the pediatric arrests were drowning victims. After the second year of continued improvement, Polk County decided to publish the data. He commented that Denver has been using the Handtevy tool for about six months. They have shown an increase in Fentanyl use by 116%, and an increase in Versed by 197%. It's difficult to calculate the Fentanyl dosages for pediatrics. If the paramedics know the dose before they get there, they will use the medications.

Dr. Antevy stated it takes less than 24 hours for revisions to the system to be uploaded for use via a portal. The same portal allows you to query the number of runs you had in a certain timeframe, including the medications that were given. A very detailed spreadsheet is generated, which can be exported as well. He stated they have a 100% retention rate, and 100% positive feedback. He would be happy to share the names of their clients should anyone wish to contact them directly to ask about the Handtevy Dosing System.

A motion was made by Troy Tuke to accept the Handtevy Dosing System as a Broselow Equivalent. The motion was seconded by August Corrales, and carried unanimously.

Mr. Hammond stated the recommendation will go back to the Medical Advisory Board for further discussion and endorsement.

IV. INFORMATIONAL ITEMS/ DISCUSSION ONLY

Vice Chair Barnum announced that Eric Dievendorf will be leaving AMR to become the new Clinical Manager for the Western area of New York State. Eric has been a paramedic in our system for 16 years and he will definitely be missed.

Dr. Naik distributed fliers for the EMS Pub Quiz, to be held at Shakespeare's Grill & Pub in Henderson, on May 17th to celebrate EMS Week. She invited everyone to bring their team and rise to the challenge.

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. Vice Chair Barnum 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, Vice Chair Barnum called for a motion to adjourn; *A motion was made by Troy Tuke, seconded by August Corrales, and carried unanimously to adjourn the meeting at 11:10 a.m.*