Northern Virginia Emergency Medical Services Council

Regional OMD Committee
Wednesday, October 11, 2017
10:00 am

City of Fairfax Fire Station 403
4081 University Drive
Fairfax, Virginia 22030

Those present were:

Dan Avstreih, MD, Fairfax County Fire and Rescue Department, avstreih@gmail.com
Craig Evans, Northern Virginia EMS Council, craig@vaems.org
William Hauda, MD, Fairfax County Police Department, whauda@gmail.com
Brian Hricik, Alexandria Fire Department, brian.hricik@alexandria.gov
Michelle Ludeman, Northern Virginia EMS Council, michelle@vaems.org
Joseph Marfori, MD, Alexandria Fire Department, josephmarfori@gmail.com
Anne Marsh, Arlington County Fire Department, amarsh1@arlingtonva.us
John Morgan, MD, Loudoun County Fire & Rescue, john.morgan@loudoun.gov
Jose Salazar, Loudoun County Fire & Rescue, jose.salazar@loudoun.gov
Reed Smith, MD, Arlington County Fire Department, rsmith@arlingtonva.us
Laura Vandegrift, Northern Virginia EMS Council, laura@vaems.org

The annual Operational Medical Director's meeting was started at 10:09 am by Craig Evans.

DISCUSSION:

Large Vessel Occlusion (LVO) stroke practices
Dr. Morgan asked of all LVO's are going to interventional or pseudo-interventional stroke centers. Anne Marsh stated they have protocols that determine the destination for the patient. If it's an LVO they go to George Washington University Hospital (GW) or Virginia Hospital Center (VHC). Dr. Smith stated they use the LA Motor Scale (LAMS). If the patient has a certain LAMS or a "wake up stroke", they go to a comprehensive stroke center but VHC is working on becoming one now, so it will soon be irrelevant. Arlington received push-back from VHC for sending LVO's elsewhere but Fairfax is not a comprehensive stroke center so they have few choices. Dr. Avstreih stated the national recommendation is to create intermediate facilities, so there are primary and comprehensive but then there will be intervention-capable centers as well. He also said they are keeping abreast on keeping the push toward non-published protocols.

Dr. Avstreih asked if everyone is doing Interventional Radiology (IR) on all of these. Dr. Smith stated they go in and get a CT, back to ED and then they get intervention and go back to CT. If it's a suspected LVO, they get CT and CTA right then and then go back to the ED. VHC doesn't take them all, if they have an identified LVO, they go to GW. VHC is getting there but they don't have providers to do interventions 365 days a year like GW, at VHC is more like 355. Dr. Avstreih said they receive a significant number of transfers from other facilities where they only

have the capability to do these interventions Monday through Friday from 9a-5p and so they are pushing for protocols to resolve that.

Craig Evans advised that Inova is trying to fund a telemedicine program to improve stroke care with Dr. Cochran and the neurology department with a primary goal being to identify the appropriate facility that is closest and maybe that can take into account the fact that someone is there now 9-5. The idea is that you can call in and get a stroke nurse and they can wire in the neurologist to speak with the providers on the scene or en route to the hospital so these decisions can be made. He asked for input on what would make a telemedicine stroke program in EMS better. Dr. Marfori stated that he didn't feel that with the transport times we have in our region that there is a need. This isn't like Texas, where this is in place, where the closest comprehensive stroke center is three hours in the opposite direction. He asked for statistical outcome information showing how using the LAMS or a regular stroke scale versus getting a neurologist on an iPad to do a full 15-20 minute NIHSS exam improves the outcomes. These are the questions that don't help us and muddle the picture for our jurisdictions. Dr. Avstreih said this is donor-driven so we need to carefully monitor this even though it could be an asset in emergency medicine in certain circumstances.

Controlled Substance Kit (CSK) exchange issues
Craig Evans stated that everyone may not be aware that there are some concerns with CSK exchanges regarding security, the CSK disappearing, exchange issues at the pharmacy such as Fentanyl being turned in empty but it wasn't used on the call. The EMS Pharmacy Committee within the Council has a representative and the head pharmacist from each hospital and some representatives from EMS agencies on a subcommittee and they are trying to come up with protocols or a policy on diversion so everyone is on the same page and the fire departments and hospitals are following the same steps when an issue arises. What has been found in the last several issues is that the fire department and pharmacy both have their own policies on how to review and resolve these problems but they don't mesh with each other leading to double notifications of errors, etc. Those meetings will occur in the next few months. One is scheduled for October. He also asked if anyone has medications they want to add or change to the pharmacology lists or to the CSK or any ideas for the future.

Dr. Smith advised they are looking at using intravenous acetaminophen. They don't use it in the ED because the hospital says it's not cost-effective to give a $29.99 IV dose when it's $.05 for the same thing in pill form. In the field, the issue is that the manufacturer states you have to drip it in over 10 minutes but in England, they push it. They are looking into it as part of their pain protocol but have to overcome the drip versus push obstacle. They currently use Toradol and Celebrex. Oral Celebrex does not affect platelets and they actually have neurosurgeons who request that they give Celebrex as opposed to a narcotic for brain bleeds, so they are looking to go away from Toradol because of the downstream effects of bleeding and moving to Celebrex. This is not finalized yet but they are looking into that.

Dr. Avstreih spoke on the CSK issue stating they had some pretty significant issue and some less significant that were just at a poor time. Their head pharmacist Gill Abernathy is personally auditing all of the CSKs that are returned. She has found anything from no ePCR for a patient because they were flown to the burn center, or they are wasting two vials of Fentanyl and only one was given because the paramedic drew up a second dose but never administered it. It's taking her hours because she is not familiar with all of the hows and whys of these situations in the field. Craig Evans stated the pharmacy subcommittee is also trying to come up with an audit procedure as well. Battalion Chief Anne Marsh stated they just re-wrote their policy in Arlington County after the pharmacy meeting to have tighter procedures and exactly specific procedures for waste to render it irretrievable, such as it must be expelled in the sink and not the sharps container, the witness can be your partner or an RN but can't be an ED tech, provide the pharmacy a copy of the ePCR because they have trouble getting into HospitalHub, they have a policy so an engine company can't exchange their CSK with the medic units but that now has the "law of unintended consequences" in that the engine companies won't use their CSK or delay using them because they have to go to the hospital to exchange them and it takes too long. They are also working on a regional policy for investigations. They have not had any incidents in many years but they are working on a policy for it.

Battalion Chief Brian Hricik stated that Alexandria had an incident two weeks prior where they had used one Fentanyl vial that was placed back into the CSK, exchanged the CSK at the pharmacy, received and signed for the new CSK and it was placed in the drug bag in the medic unit and they returned to their station. The pharmacist did not do an immediate reconciliation and called two days later to report that there were three Fentanyl missing from the CSK. He was able to call the crew involved and, and as best they can determine, the "missing" Fentanyl vials fell out of the original CSK when it was opened and they were found lying in the bottom of the drug bag unopened. Unfortunately, the pharmacy didn't follow their own protocols and this never would have had to happen if they had. Chief Hricik has met with everyone in the pharmacy department at Inova Alexandria Hospital to make them aware of the severity of this situation and that by not performing real-time reconciliations, it puts them and the public at risk, as these missing vials could have been on the streets somewhere for several days before them being notified of the discrepancy.

Dr. Avstreih advised that they had a provider who caught a pharmacy error at the pharmacy window recently. When CSK's are exchanged at Inova Fairfax Hospital, they are reviewed by the provider at the window, which is also video recorded. The provider noticed an expired morphine and notified the pharmacist who exchanged it before the provider left the window. Had they left and then noticed the error, the ownership would have been that of the provider for not checking it at the window before leaving.

Blood products on scene

Dr. Morgan advised they had incident in Loudoun County with prolonged extrication of multiple patients who required blood and they had used all of the blood carried on the helicopters on the scene. He contacted Inova Loudoun Hospital and HCA StoneSprings Hospital and requested blood for those patients and was able to get cooperation from both hospitals and had the blood transported to the scene by a Deputy Sheriff and a Loudoun County Battalion Chief. He has discussed this incident with the blood bank manager at Inova Loudoun Hospital and she is on board with devising a plan to supply blood products on scene for incidents that warrant the need.

Dr. Smith asked if the group felt it was beneficial for the OMD's to collaborate and write a whitepaper to NVHA stating that in certain settings, there needs to be a massive transfusion protocol (MTP) in place and have requirements like a physician on scene, have trained Advanced Practice Officers (APO's), MTP is physician-directed or physician ordered and every blood bank agrees to give 10 units of packed red blood cells and 10 units of plasma, showing how and why it's deployable and establish a regional protocol on how we deploy this to the field in situations like an auto accident versus a Las Vegas-style shooting. If the OMD's write this, outlining a massive transfusion protocol to the NVHA, then NVHA has to push that to the blood banks for cooperation. Dr. Avstreih also reminded the group that they need to include that the hospitals don't have to be responsible for storing all the blood as the regional blood bank for Inova Blood Services is in Leesburg, and they are open 24/7, so they are accessible for these types of incidents. Dr.'s Smith and Morgan will write the whitepaper statement using the Loudoun incident and the Las Vegas incident as examples and send it to the rest of the OMD's for input and they'll include oversight, quality assurance, physician/Medical Control orders but with the ability for paramedics in Virginia, under their scope of practice and additional training, to provide the blood under physician direction. Dr. Smith asked if there is interest in the region to do a study on the use of fresh frozen plasma in the field. This is not FDA approved but other areas are looking into it. Richmond Ambulance Authority (RAA) is looking at it and it's used in France. It has a shelf life of approximately 2 years. Dr. Smith will explore this option further and find out what RAA is doing.

Dr. David Skibbie was not able to attend but provided the following information for the meeting: I can pledge Aircare's continuing ability to deliver blood to local scenes as necessary. We have 5 bases with 4 units of O blood at each base, along with a supply of liquid plasma. Even if we're not flying due to weather, we can drive the coolers to a scene or rendezvous with an ambulance. And in case there is any concern: there is no charge to the patient, insurance company, or any other entity for transfusion services delivered by our team.

Regional protocols

Craig Evans advised that as part of the Council contract, we are required to have a regional protocol but right now it has no substance and he'd like to see it have more purpose. Dr. Smith

stated he has concerns about setting a regional protocol for everyone to adhere to. It's like Maryland having state-wide protocols and that system has failed. After discussion amongst the group, it was agreed upon that the recently discussed blood products on scene could become the regional protocol and each department/agency can determine if they wish to adopt it into their own protocols as written or modify it based on their individual OMD's preference. Other considerations are STEMI guidelines, performance measures, and benchmark data as a region. Craig is hoping for this document to be a collaboration from the group of best practices and benchmarks.

Regional EMS training

Craig Evans advised that the state has contract with the Council to help develop EMS training around the region. The chiefs have discussed the need for a regional training facility and the discussion was opened up to the group for their feedback and thoughts on this concept. Dr. Smith advised that currently for Criminal Justice in the region, there is a Regional Criminal Justice Academy. People from every locality go there for basic training and then return to their individual agencies for their specific protocols. We could do something similar for those agencies that do not do everything internally, such as Arlington and Alexandria, but anyone could join in. One requirement is that they must have academic support so he has approached George Washington University (GWU) about this because they have a campus in Loudoun County, right next to the Regional Criminal Justice Academy. They could provide a lead instructor and some administrative staff and each locality would detail an instructor or two to the academy for the classes. Fairfax County uses Virginia Commonwealth University in Richmond right now but Dr. Smith advised it is too costly for Arlington to do the same for the providers. They approached the University of Virginia and they were initially on board but backed out due to a conflict with their local community college program. One of the proposed items with GWU is that after the students, who must be uniformed personnel and not simply undergraduate student, complete the paramedic class, they can continue on to get a degree from GWU for approximately $250 per hour because of their participation with the regional EMS training program, similar to a program they had several years ago called CPEC. Other agencies are interested in this possibility and hearing more about Dr. Smith's progress as it becomes available.

Dr. Smith stated that they do 4 Continuing Medical Education classes per year, PALS and ACLS every other year and this year is ACLS. He stated if any agency needs to have providers attend for credit they are welcome to do so and maybe we can move to an open CE model where we share the opportunities with others. Craig Evans stated that we're going to try to work on that because for the Council's state Continuing Education (CE) contract, they will try to sign all the jurisdictions as subcontractors and get money back to them for the CE's they are already doing, and as a part of that, the Council will consolidate scheduling and this will allow for open CE's and providers having the ability to go anywhere in the region for CE's. This will all be done through the Council's website and will hopefully completed before 1/1/2018.

Dr. Smith stated that Arlington County is trying to get money together to send their APO's to Richmond for advanced skills training on fresh, unfixed cadavers. This will be for advanced procedures such as cricothyrotomies, difficult airways, etc., but if other localities have advanced providers or supervisors that they want to send, he can get them added to the list. The cost is approximately $6000 per cadaver.

Battalion Chief Jose Salazar stated that their simulation lab will open soon and they'll be able to practice on adult, child, and infant. They are going to open that up for sharing in the region also.

Tactical Emergency Casualty Care (TECC) provider certification
Dr. Smith advised that Northern Virginia Hospital Alliance (NVHA) created a series of high-threat medical training for police initially and then expanded to the fire department. Can the OMD's agree that providers will get a NVERS TECC or their regional casualty care training provider card if we are not following NAEMT TECC or TCCC specifically but using a regional training of casualty care? Dr. Marfori said that for physicians they are moving away from cards for every class and certification and we should do the same here. The cards don't mean that you can actually do anything you were taught, they just indicate participation in the class. Dr. Smith said there is some push-back by Fairfax County DFR because they've taken the TCCC class by the state department or TECC through NAEMT and assume that class is better than others but they aren't necessarily better. We need to take the classes and make it what we want it to be for the region, not what NAEMT stole from the classes we taught regionally and added to. Dr. Hauda suggested that instead of a certification card that expires, they could be provided a certificate of participating showing they attended the class and met the requirements of it but it doesn't necessarily expire or have to be recertified. Craig Evans asked if there was a way to come up with a regional course that we can all agree on because the state training contract with the Council that allow for auxiliary training has funds for $60 per student for TECC training. Everyone currently incorporates TECC into their continuing education courses. Dr. Marfori asked if it would it be useful for a whitepaper to show they are providing this training and everyone doesn't have a card but they've been given the training and the go-ahead from their OMD. Dr. Avstreih said there is a real TECC deficit in the EMS and hospital interface. Dr. Smith advised that NVHA funded & created a video with a mock mass bombing, they show the patient coming in and the nurses initiating care, but they also show the equipment, such as a tourniquet and pelvic binder, and what they do so the hospital personnel know what this is all about. The question is how do you get the trauma surgeon or nurse educator to watch the video? Craig suggested showing it at the Trauma & PI Meeting next time. Dr. Smith would like to have it added to that meeting. Dr. Smith agreed to write a whitepaper statement on how we are handling this as a region and collaborate with the other OMD's for input.

State Medical Direction Committee update

The most recent State Medical Direction Committee meeting was canceled because they had no agenda items. Dr. Morgan said they are actively working behind the scenes on a Rapid Sequence Intubation (RSI) policy. Arlington only allows APO's to RSI at this point, Alexandria providers all have the capability to RSI as do City of Fairfax paramedics. Dr. Asher Brand wrote the initial policy and he is very anti-RSI because he believes it's dangerous and there are no true studies on outcomes and it should only be allowed to be done by select providers who have significant numbers of intubations performed before being considered to perform RSI. Dr. Morgan said he may share the policy with the group for review. Battalion Chief Hricik stated that they have been tracking their first pass success rates for approximately 4 years and Dr. Marfori stated he has submitted this information to a pre-hospital medical journal. He stated that when he came in as the assistant OMD he was informed that they were the best in the area and when he asked for statistics and found that they were at 42% first pass so he got better equipment and video scopes and they are now at 90%+ first pass with around 120 intubations per year. It was suggested that the group publish their numbers for the region to show the success. One consideration is outcomes and whether anyone is following up on the patient after they are dropped off at the hospital; do they survive, what long-term complications are there, etc. Dr. Smith does not support Dr. Brand's anti-RSI position. Craig Evans asked if there is any literature that shows the benefits of getting RSI'd earlier for getting into CT or to the OR faster.

Dr. Avstreih asked if anyone is getting a push to write a K9 Narcan protocol. Dr. Hauda stated that they can't perform veterinary medicine so it falls to the K9 handlers to be responsible. There becomes a question about how to handle it because the dogs are technically police officers but Dr. Marfori stated that he had this situation and informed the handler that he wasn't trained, licensed or qualified to give Narcan to the dog and left it in the hands of the handler and their veterinarian. Dr. Avstreih asked if they are allowed to take the drug off of a medic unit and if so, how does it get restocked, who signs for it, etc. It's not just an issue with each department as much as a Board of Pharmacy issue in the end; is it considered a drug diversion? Dr. Hauda stated that for those police officers who do have Narcan, they are authorized to administer it to other officers and the K9s are considered officers, so again it falls back to the handler and their veterinarian for training, routes, and dosing. Alexandria City Police do not currently carry Narcan except for vice officers, however, the other officers know that there is a standing prescription at any pharmacy so many have gone and purchased it on their own and keep it for their own safety. Arlington Police Department has applied for the state grant to get Narcan for their police officers.

Future meetings

Craig Evans asked how often the OMD's would like to hold this meeting. Dr. Smith suggested that annually is not often enough and that unfortunately, there are only five OMD's in the room today so perhaps we could get more attendees but make the meetings only an hour each. His

suggestion is that we hold the meeting twice a year and as part of the OMD endorsement, they are required to attend a minimum of one per year. Dr. Smith also suggested that it be brought up in the Chiefs meeting to suggest that they mandate that their OMD's attend this meeting. Craig stated that he'd bring it up to them. It was agreed upon by the group to hold it the third Wednesday in May and October and there will be multiple reminders sent. It was also suggested that we set up PolyCom for those OMD's who can't attend in person and Craig advised he would set it up for those who cannot attend to call in from outside.

The next two Operational Medical Director's Committee Meeting will take place on Wednesday, May 16, 2018, and Wednesday, October 17, 2018, at 10:00 am and will be located at Fire Station 403, 4081 University Drive, Fairfax, VA 22030. A reminder will be sent prior to that meeting.

The meeting was adjourned at 12:15 pm.

CERTIFICATION OF THE REGIONAL OPERATIONAL MEDICAL DIRECTION COMMITTEE MEETING

Northern Virginia EMS Council
7250 Heritage Village Plaza, Suite 102
Gainesville, Virginia 20155

I, Craig Evans, Executive Director of the Northern Virginia EMS Council certify that the above minutes are a true and correct transcript of the meeting minutes of the Operational Medical Direction Committee held on October 11, 2017. The minutes were officially approved on ____________.

________________________________ ________________________________
Craig A. Evans Date