Northern Virginia Emergency Medical Services Council

Regional OMD Committee
Wednesday, May 16, 2018
10:00 am

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

Those present were:

Byron Andrews, Alexandria Fire Department, Byron.andrewsIII@alexandriava.gov
Dan Avstreih, MD, Fairfax County Fire and Rescue Department, avstreih@gmail.com
John Chesek, Fairfax County Fire and Rescue Department, john.chesek@fairfaxcounty.gov
Craig DeAtley, Fairfax County Police Helicopter, flightpadeatley@gmail.com
Craig Evans, Northern Virginia EMS Council, craig@vaems.org
Brian Hricik, Alexandria Fire Department, brian.hricik@alexandria.gov
Kate Kramer, PA-C, Arlington County Fire Department, kkramer@arlingtonva.us
Michelle Ludeman, Northern Virginia EMS Council, michelle@vaems.org
Anne Marsh, Arlington County Fire Department, amarsh1@arlingtonva.us
John Morgan, MD, Loudoun County Fire & Rescue, john.morgan@loudoun.gov
David Skibbie, MD, PHI Air Medical, dskibbie@phihelico.com
E. Reed Smith, MD, Arlington County Fire Department, rsmith@arlingtonva.us (via phone)
James Vafier, MD, NVCC, vafier@msn.com
Laura Vandegrift, Northern Virginia EMS Council, laura@vaems.org
Scott Weir, MD, Fairfax County Fire and Rescue Department, sweir@fairfaxcounty.gov
Christian Zuver, MD, Prince William County Fire & Rescue, prehospitalcsllc@gmail.com

The quarterly Operational Medical Director's meeting was started at 10:13 am by Craig Evans.

DISCUSSION:

Drug shortages and alternative medications
Craig started a general discussion regarding medication shortages and alternative medications to be considered during shortages. Currently there are 333 being used in the region.

- Dr. Scott Weir advised that there will be no changes in medications for analgesia or seizure but if any changes were to occur, it would be changing Morphine Sulfate due to the decreased usage already. Midazolam is currently the preferred benzodiazepine and Fentanyl is the preferred narcotic
- Dr. John Morgan stated we should consider using Morphine Sulfate as a backup in shortage of other analgesics because it's easily available
- Anne Marsh advised that if they continue to have shortages, their first option would be to remove CSKs from suppression units
- There are no adverse events or feedback from providers in response to shortages currently seen around the region

    - John Chesek advised that they did have two significant labelling discrepancies and there was an issue with who could and couldn't correct them, hospital-wise, but it was later resolved and this is the only known issue at this time
- Dr. Weir stated that non-narcotic, non-opioid analgesics could be considered, but since they are not controlled substances they wouldn't be in the CSK's so each agency could define their own non-narcotic analgesics to be carried on their units and administered by their providers and this doesn't have to be agreed upon regionally
    - Brian Hricik advised they have explored the option of IV Acetaminophen but have gotten significant pushback by the pharmacy due to cost
    - Dr. Weir advised he has also had the same experience while working in the ED
        - It is unknown which hospital pharmacies even carry it because the pharmacists discontinue conversations when asked about it by stating the cost is excessive
- The physicians discussed the use of inhaled isopropyl alcohol via disposable alcohol swabs for nausea and anti-emetic purposes. There are not currently any protocols in place in the region for its use. It is reportedly more fast-acting and effective than Zofran

Craig presented data showing on-scene time to medication given in 5 minutes or less by agency. He will distribute that to the group via email.

PRESENTATION:

FACT*R Blood Program – Dr. Dan Avstreih and Dr. John Morgan

1. Dr. John Morgan and Dr. Dan Avstreih discussed blood transfusions in EMS and how we handle that locally.
    - Background information - There was a prolonged extrication accident scene where several patients required on-scene blood transfusions. Currently PHI carries packed cells and plasma and provided their inventories at the scene of this incident but due to the length of the extrication process, there was a good possibility they would run out of blood resources on the scene and Dr. Morgan made contact with Fairfax Hospital and asked for blood products that could be delivered to the scene. They were able to get the blood from two different hospitals and get it delivered to the scene and saw that there is a valid potential for future needs and discussed how we should proceed as a region to have and provide blood components available for other scenes of a similar nature
        - In the event that PHI is not available or they have run out of blood on a scene, how is our region obtaining blood products? Where do they come

from? Who is responsible for dispensing them and what is the chain of custody?

- The physicians discussed how to proceed and negotiated a project for a "Field Available Component Transfusion Response" (FACT*R) with Inova Blood Donor Services and all entities are in agreement, it is a matter of logistics at this point
    - The blood bank will keep a special box and have a list of quantities to put in the box and a timeframe of 15 minutes to turn the supplies around in.
    - When the blood is needed, the blood bank will be notified and will prepare the box with the pre-determined quantities and supplies and make it ready for pickup
        - Any items not used will be returned to the blood bank to be put back into the normal rotation so nothing is being wasted
        - Currently, Loudoun Hospital does not have fresh/liquid plasma and by participating in this program that will leverage their ability to have it so this is beneficial to them as well
    - An EMS physician would request the blood and take responsibility for it and this would activate the system
        - There will be an east site at Fairfax Hospital and a west site at Loudoun Hospital and the supply would come from the closes site
        - Based on the need, the blood bank would prepare two boxes, the large that is 15x15x15 and the small which is 12x12x12 that contain 5 units of packed red blood cells, 5 units of liquid plasma and 5 units of platelets that will last for up to 12 hours. They have to pack both boxes with the appropriate blood components because they have to be stored at different temperatures
        - The logistical portion from the EMS side is how to pick and transport the blood and how to administer it (tubing, warmers, etc.)
        - Once transported, blood is provided by local agency protocol and there is some collaboration that should happen on who is allowed to give blood and who is trained within each agency. That will be determined by the regional OMD's
- There is an MOU in draft form between Inova Blood Donor Services and NVEMSC
- QinFlow manufactures a blood and IV fluid warmer. The plan is to get two for each site, east and west, in case there is a need to for two at the same time. There will also be a backup battery purchased, mounting brackets and disposable cartridges that will need to be purchased
    - The Council will also need to purchase the tubing for infusion and if they are purchased through BoundTree it's approximately $1000 per case but Inova Blood Donor Services has agreed to purchase it and sell it to us at their cost which is $286 per case

- Inova will provide and pack the boxes at no cost to the Council
- There are two bags that we'll need to contain the supplies and if there are any agencies that have two to donate instead of purchasing, that would be ideal
  - Beth Adams from Fairfax County FRD advised that they are cycling out their bags now and they are red. Craig will explore that option
- The cost for the two QinFlow devices is $13,754, $1,978 for two back-up batteries, $1495.44 for four mounting brackets, $750 for the disposable, single-use cartridges, and $573 for the blood tubing which totals $18,550 as a start-up cost. QinFlow did offer a 15% discount if ordered within 4 weeks. The annual cost will be approximately $573 which is for the disposable tubing but this is also based on usage and expiration dates. The per-use cost is approximately $191

- The cost, at this point, is the only thing preventing this from moving forward. The logistics of where it will be stored, how it will be stored, who makes and replenishes the boxes and supplies is set out.
- Craig advised that the items can be purchased by the Council with the approval of the Board. The cost would be $18,550 for the initial start-up and the replacement/replenishment of the consumables as detailed previously

DISCUSSION:

Regional Benchmarks

Craig Evans asked whether the group would like to establish regional benchmarks for STEMI and stroke. Dr. Weir suggested that we define the metrics because the score that you strive to achieve on that metric may vary from agency to agency but the important part is that everyone is measuring the same things. Craig stated that he'd like the group to come up with at least one metric for each category so he can pull the regional data and share it.

- Significant Trauma – At patient side to transport for severe or multi-system trauma cases
- STEMI – FMC to arrival at the hospital and FMC to 12-lead acquisition within 5 and 10 minutes
- Stroke – Identification of stroke to hospital of notification and then arrival at the hospital
- Airway – Attempts to successful intubation and is unsuccessful if they can successfully ventilate

Craig advised that he presented data for the region at the state VHAC meeting showing first medical contact to 12-lead median time is 11 minutes for all patients (42,421 incidents in 2017). For provider primary impression of chest pain only calls, first medical contact to 12-lead (5835

incidents in 2017) the average was 10 minutes and STEMI only was a 12 minute average (770 incidents in 2017).

Stroke Triage
Craig asked if the group wants to have a regional approach to stroke triage

- Kate Kramer from Arlington advised that she is not in favor of a regional stroke triage plan because they have left it up to each local agency in the past and it has worked well, so there is no need to change it
- Dr. Avstreih stated that he'd argue that the OMD's as a group should discuss the idea so everyone can at least be on the same page and treat strokes as we do STEMI's
- Dr. Morgan stated that he echoes Arlington's thought that we are all very different agencies and there isn't the data to support the need for regionalizing it

Trauma Triage/Mass-casualty Triage System

- START – used for the last 10-12 years, requires LOC, pulse/cap refill, able to answer questions
- SALT – more recently being looked at by the stakeholders, essentially alive, dead or in between and NREMT is considering starting to use that in their testing and many publishers are looking to replace START triage in their books with SALT
- MUCC – the Federal mandate stating you have to have a triage system but essentially pushes you toward SALT. This is a topic of discussion in this COG region. There are pros and cons to both START and SALT but regionally we'll need to get on the same page

Byron Andrews presented the above mass-casualty triage systems and stated that most providers still aren't even proficient with START and in drills, they are fumbling through the index cards trying to figure it out. At a recent meeting in Maryland it as shown that triage by field providers is typically their gut feeling and their observations rather than a formal system. As we move forward as a system and the Washington Metro area, most systems are leaning toward SALT. At the State level, the new curriculum will include SALT and START and will advise the instructors to introduce both but emphasize the system that they do use in their area.

Craig asked if any of the physicians have any strong feelings toward one system or another and is there an interest in a simple triage system regionally for immediate threat/active-shooter type situations. Dr. Reed Smith advised that with TECC it's taught for high-threat situations "You're Red or Dead" and if you can get up and move do so and then they are fully triaged outside of the high-threat environment.

Regional Data Terminology Dictionary
Craig advised that he'd like to produce a document to define terminology across the region so when someone refers to on-scene everyone is referring to an ambulance or ALS resource, etc.

Regional Best Practices Document
Craig stated that just like the terminology document, he'd like to produce a list or document of best practices in the region. Dr. Weir advised he didn't like the term "best practices" because it insinuates that some are not doing the best practice that they could and perhaps the term Successful Strategies would be better. Craig advised that it's not meant to indicate that someone isn't doing the best practice but rather what agencies are doing that works and they can share with the region. The term Successful Strategies was preliminarily agreed upon as the name. The document will be a collaboration of input from all agencies and will be worked on in the future months.

EMS Council Update
The Council is looking at regional data through Mission: Lifeline for CAD and Stroke and the Council will be the hub for that information. The 2018 Northern Virginia Regional EMS Conference is tomorrow, Thursday, May 17, 2018. We are working on the FACT*R Blood Program and that is moving forward.

State Medical Direction Committee Update
Dr. Morgan advised there was a lot of discussion about updating the Rules & Regulations and specifically as it relates to EMS physicians to put something in the Rules & Regulations that it is reasonable for an EMS physician to respond to an EMS scene. This is helpful if they are trying to get something in their job description that indicates that it is within the EMS Rules & Regulations in the event of an adverse event on the scene (hit by car, injury, etc.) there is also no issue with insurance covering it as part of their job duties. Chief Andrews advised this recently came up with Dr. Marfori and his insurance.

The next Operational Medical Director's Committee Meeting will take place on 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 12:27 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 May 16, 2018. The minutes were officially approved on _____.

_____ _____

Craig A. Evans Date