Johnson County EMS Physicians' Committee Minutes

August 29, 2017 6:30PM; 11880 S. Sunset Dr.

Members present: Dr. Barnett, Chair (CMH), Dr. Richardson (SMMC), Dr. Jacobsen (JOCO EMS Medical Director), Dr. Ruthstrom (JOCO EMS Deputy Medical Director), Dr. Bowser (SLS), Dr. Policky (OPRMC), Dr. White (OPR), Dr. Thornton (KUMC), Dr. Yost (SJMC),

Others in attendance: Natalie Hartig (MD office), Melody Morales (MD office), Kevin Joles (OFD), Matt Epperson (Shawnee Fire Department), Eric McClure (Lenexa Fire), Dr. Rohad Khalid (CMH-pediatric neurology), Dr. Marcie Goeden (CMH –pediatric neurology), Jason White, Daren Pfeifer (HCA EMS Liaison), Lindsey Peters (KUMC), Colleen Lechtenberg (KUMC), Karen Olds (SLH), Paul Davis (MED-ACT), Marilyn Rhymer

Members absent: Dr. Allin (KUMC), Dr. Miller (MMC), Dr. Green (KUMC), Dr. Pierson (MMC), Dr. Stamper (MMC), Dr. Fishman (OPRMC),

TOPIC	PRESENTER	DISCUSSION	ACTION	STATUS
Approval of minutes from 06/14/17	Dr. Barnett	Motion made by Dr. Bowser to approve minutes from 06/14/17 meeting, seconded by Dr. Richardson. Motion passed.	Approved	Completed
Standing Items:				
MARCER Diversion Issues	Dr. Jacobsen	• Johnson County EMS System will be advocating for a no diversion status • The Johnson County EMS System Advisory Board is also in support of this position	Information Only	
PulsePoint Implementation	Dr. Jacobsen	• Regional deployment and MARCER initiative • This is a free app that will notify of any medical emergency that is going on in each city • There are AED's mapped within the county and pictures of the AED location • There will be a picture on the map of where there is a cardiac arrest and the person with the app can respond to the cardiac arrest, see where the nearest AED is located, and indicate that they are going to respond to the cardiac arrest • The hope is that this will help increase bystander CPR rates as well as bystander AED use	Information Only	
ECMO and Inter-facility Transfer Issues	Dr. Jacobsen	• We have done ECMO training with HCA • Due to the comprehensive training that would be needed, we have put a hold on implementing this • Dr. Jacobsen asking for committee input on this topic. Due to requirement of the time for notification, it seems as though it is a non-emergent procedure • Discussion around if it is appropriate to take an emergency vehicle out of service		

		to provide a non-emergent procedure • MED-ACT Chief also expressed concern for taking an emergency vehicle out of service to provide a non-emergent procedure with the call volume in the county • Discussion around inter-facility transfers and the issues we have been having with crews being put in tough situations with medications requiring IV pumps and the need to have a nurse accompany the EMS providers. • We will table this topic for now and approach this topic at a later date		
Microhospitals	Dr. Jacobsen	• There will be several new microhospitals that will be coming to Johnson County • We will be setting up a meeting to meet with the medical directors of facilities and St. Lukes and Developers in near future		
New Business:		•		
Preview of Proposed Protocol Changes for 2018	Dr. Jacobsen	• **<u>Stroke Routing PROPOSAL:</u>** <18 years old with signs/symptoms concerning for CVA transport to CMH-Main ≥18 years old with **Cincinnati Stroke Screen Positive** and last known well time **0-3.5 hours** transport to closest stroke center (Comprehensive or Primary). ≥18 years old with **Cincinnati Stroke Screen Positive** and last known well time **3.5-8 hours** and **NEG Large Vessel Occlusion Screen** goes to closest stroke center (comprehensive or primary). ≥18 years old with **Cincinnati Stroke Screen Positive** and last known well time **3.5-8 hours** and **POS Large Vessel Occlusion Screen** transport to Comprehensive Center.		

≥18 years old with **Cincinnati Stroke Screen Positive** and last known well time **>8 hours** goes to closest stroke center (primary or comprehensive).

- Question about if >8 hrs encompasses a wake up unknown
- KUMC expresses concern about the 3.5 hours specifically they feel that 0-3.5 hours +LVO should go to CSC. Another concern is the transfer time after TPA is given
- Dr. Bowser made motion to pass protocol with the addition of "wake-up unknown time", Dr. Richardson seconded, motion passed.

- **<u>LVO Screening Tool PROPOSAL:</u>**

FAST-ED versus VAN

- <u>ASA formulary/ACS protocol (pg. 18)</u>

Administer Aspirin, unless EMS provider can confirm patient already took 324mg of Aspirin within previous 6 hours.

- Changed wording to allow for EMS to not give ASA if they can confidently confirm patient took appropriate dose prior to their arrival

- <u>Anaphylactic Allergic Reaction:</u>

Administer **Epinephrine auto-injector and may repeat every 5 minutes as needed, if additional Epinephrine auto-injectors are available to a total of 3 doses.**

- Removed physician prescribed pt use language

- Appendix F

REHAB AND HAZMAT PRE-ENTRY EXCLUSION CRITERIA:

SpCO: Suspect CO poisoning (to treatment) if SpCO > 5% in non-smokers and > 10% in smokers. However, CO poisoning cannot be ruled out by using non-invasive SpCO monitor.

- Added statement under 5th bullet about CO poisoning cannot be ruled out by using non-invasive SpC02 monitor.

- Cardiac Arrest protocol

Administer naloxone auto-injector or intranasal atomizer and may repeat every 5 minutes as needed, if additional naloxone auto-injectors/atomizers are available

NOTES

- Added bullet to reflect BLS administration of Naloxone auto-injector or intranasal atomizer
- Also changed in poisoning protocol

- Adult Cardiac Arrest Checklist (pg. 150)

☐ **Change compressor every 2 min**
☐ **Metronome on, set to 106/minute**
☐ **Place Q-CPR device, monitor performance**
☐ **LEADER! Also - (1) Timer; (2) Documentation (3) Family liaison, etc.**
☐ **Monitor Visible – Dedicated provider**
- **Assure manual mode / place limb leads**
- **AED Mode PRN**

☐ **Oxygenation/ Ventilation**
- **C**PR = active ventilations; 1 interposed breath after every 10th compression **(DO NOT OVER-VENTILATE)**

☐ Pre-Charge Defibrillator **200J** (< 5 seconds)

- Added 200J to Pre-charge Defibrillator line

- IPAP (pg. 5)

- **Scene Size-Up**: As you approach the scene, assure safety for yourself and the patient. Establish and follow Incident Management Systems.

- **BSI (Body Substance Isolation):** Prior to patient assessment, employ precautions to prevent contact with potentially infectious body fluids or hazardous materials. Wear appropriate protective gear to protect eyes, mucous membranes and skin. Wear other appropriate specialized protective gear when the potential exists for contact with biological and hazardous materials.

Initial Patient Impression:

- Transmit initial patient impression over the radio when the patient has one of the following conditions/circumstances:
  - Critical
  - Trauma Plan Activation
  - Code Blue
  - Type Black
- It is acceptable to upgrade or downgrade incoming units based on initial patient impression. Cancelling an ambulance should not be done based on initial patient impression.

- Made new section titled Initial Patient Impression
- Defined initial patient conditions as: Critical, Trauma Plan Activation, Code Blue, and Type Black

- IPAP (pg. 6)

Multi-Casualty Incident Triage:

- Patients are assigned to one of the triage categories listed below utilizing the

SALT method see *Appendix L- MCI Triage*.

- **Green – Minimal/Non-emergent**. This patient is suffering a minor injury or illness not likely to deteriorate to a life threatening condition
- **Yellow – Delayed/Urgent**. The yellow patient's injury or illness is not likely to deteriorate to a life threatening condition if medical care is not provided immediately; however, there is a risk of deterioration if medical care is not provided in a "timely" fashion.
- **Red – Immediate/Emergent**. The red patient is one whose injury or illness has resulted in life threatening shock or hypoxia or has the potential for the rapid development of life threatening shock or hypoxia if immediate medical care is not provided.
- **Black – Expectant/Death/Non-emergent**. This patient is dead, has suffered an obviously mortal wound, or has sustained an injury or illness requiring resources beyond those available.

- Changed wording from Triage to Mass Casualty Incident Triage
- Defined the categories to be consistent with SALT terminology
- Referenced Appendix L

- IPAP (pg. 12)

Deciding Hospital Destination:

- Note: This section is consistent with the Metro Kansas City Area Ambulance Diversion Guidelines as adopted by MARCER and the Greater Kansas City Health Alliance, see KC Ambulance Diversion Community Plan, (Appendix K).
- Patients are transported to the hospital of their choice in the greater Kansas City metropolitan area in most instances. Johnson County EMS providers reserve the right not to transport to facilities outside the Johnson County area.
- No patient will be transported to a facility that is not listed as an approved receiving facility (as noted in the *Glossary of Terms*).

- Patients may be transported to the following free standing Emergency Departments if they have minor injury or minor illness and provider believes there is a low likelihood that patient will require secondary transport to a hospital. When provider is in doubt, contact free standing medical control for further guidance prior to transport.
  - Overland Park Regional at Olathe
  - Overland Park Regional at Shawnee
  - Shawnee Mission- Lenexa
  - Shawnee Mission- Overland Park
    - Attendants will inform patients that a secondary transport to an inpatient facility may be required if hospitalization is necessary or if more extensive evaluation is required.

- Changed wording to describe process for deciding hospital destination for free standing ED
- Removed triage color associated with those transports

- Obstetrics (pg. 49)

Transport Considerations for Newborn

- When feasible, newborns/neonates should be transported in appropriate restraint device
- Added transport considerations for Newborn
- Suggestion made to change "at home, in home delivery"

Poisoning protocol

- Check for presence of carboxyhemoglobin (COHgB) using SpCO monitoring. However, a negative reading cannot be used to rule out CO poisoning. For patients with suspected or confirmed carbon monoxide exposure, a base hospital physician (preferably at the patient's hospital of choice) should be contacted to address potential diversion to a hospital capable of providing hyperbaric oxygen therapy.
- Added statement within this bullet about a negative reading cannot be used to rule out CO poisoning.

Poisoning Protocol:

Procedures / Interventions	Med Doses	EMT	AEMT	PM
• Administer naloxone auto-injector or intranasal atomizer and may repeat every 5 minutes as needed, if additional naloxone auto-injectors/atomizers are available		•	•	•

- Added bullet to reflect BLS administration of Naloxone auto-injector or intranasal atomizer

- Shock protocol
- Added norepi for adults and epi for peds under treatment options

- Epinephrine Formulary

Dosage/Administration:

- Adult:
- Anaphylactic/allergic reaction:
- BLS- Administer Epinephrine auto-injector and may repeat every 5 minutes as needed, if additional Epinephrine auto-injectors are available to a total of 3 doses.
- **0.3 mg (1:1,000) IM and repeat at the same dose every 5 minutes to a total of three doses as indicated**

Dosage/Administration (continued):

- Pediatric, cont.
- Anaphylactic/allergic reactions:
    - BLS-Administer Epinephrine auto injector and may repeat every 5 minutes as needed, if additional Epinephrine auto-injectors are available to a total of 3 doses.
    - **0.01 mg/kg (1:1,000) IM and repeat every 5 min. to a total of 3 doses (max single dose 0.3 mg)**
- Added BLS administration of Epinephrine auto-injector for adults and pediatrics

- Fentanyl Citrate Formulary

- Adult:
- Acute coronary syndrome, musculoskeletal, abdominal, or soft tissue pain:
- **Up to 100 mcg IV/IO/IM, may repeat in 5 min PRN to a max total dose of 200 mcg**
- **100 mcg Intranasal, repeat at 100 mcg x 1 PRN in 10 minutes to a max total dose of 200mcg**

- Pediatric:
- Musculoskeletal, abdominal, or soft tissue pain:
- **1 mcg/kg IV/IO/IM, max initial dose of 100 mcg may repeat in 5 minutes PRN to a max total dose of 200 mcg**

		• **1.5 mcg/kg Intranasal, max initial dose of 100 mcg may repeat in 10 minutes x1 PRN to a max total dose of 200 mcg** • Changed wording to reflect up to 100 mcg as initial dose and a max total dose of 200 mcg • Also changed wording in intranasal dosing to be consistent with adult wording • Made same changes in Abdominal Pain (pg. 16), ACS (pg. 18), and Pain Management (pg. 51) Protocols • <u>Naloxone Formulary</u> • Adult: • BLS- Administer naloxone auto-injector or intranasal atomizer and may repeat every 5 minutes as needed, if additional naloxone auto-injectors/atomizers are available • Suspected Narcotic Overdose including Cardiac Arrests: • **0.5 – 2 mg IV/IO/IM/Intranasal titrated to reversal of respiratory depression repeated PRN to a max total dose of 4 mg** • Added bullet to reflect BLS administration of Naloxone auto-injector or intranasal atomizer • Field Reference Guide: o Proposal to round doses for pediatric medications ▪ Group in agreement with this change • Dr. Thornton motioned to pass protocols as proposed, Dr. Bowser seconded motion. Motion passed.		
Next meeting Date		• We will propose a meeting date		

Adjournment	Dr. Barnett	Motion made to adjourn. Motion passed.	2025 hrs	