Pharmacy Meeting
Northern Virginia EMS Council
May 2, 2016
Minutes

Those present were:
Gill Abernathy, Inova Health System, gill.abernathy@inova.org
Jonithan Brantley, City of Fairfax Fire Department, jonithan.brantley@fairfaxva.gov
Cathleen Cowden, Inova Loudoun Hospital, Inova Fair Oaks Hospital, cathleen.cowden@inova.org
Mark Guditus, Fairfax County Fire and Rescue, mark.guditus@fairfaxcounty.gov
Brian Hricik, Alexandria Fire Department, brian.hricik@alexandriava.gov
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Michael LaSalle, Prince William County Fire & Rescue, mlasalle@pwcgov.org
Michelle Ludeman, Northern Virginia EMS Council, michelle@vaems.org
Todd Lupton, City of Manassas Fire & Rescue, tlupton@manassasva.gov
Anne Marsh, Arlington County Fire Department, amarsh1@arlingtonva.us
Arpit Mehta, Inova Fairfax Hospital, arpit.mehta@inova.org
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Marcia Pescitani, Northern Virginia EMS Council, marcia@vaems.org
Greg Rauch, City of Fairfax Fire Department, greg.rauch@fairfaxva.gov
Annette Reichenbaugh, Reston Hospital, annette.reichenbaugh@hcahealthcare.com
Dustin Rice, Fairfax County Fire & Rescue, dustin.rice@fairfaxcounty.gov
Jose Salazar, Loudoun County Fire & Rescue, jose.salazar@loudoun.gov

Prior to the actual Pharmacy Meeting, the EMS Operations representatives from the region met to discuss the upcoming meeting and make sure all understood where we were. The group wants to make sure all understand that this is not an attempt at a regional protocol. The issue that led up to the form that will be discussed today was when a transport unit would transport to a hospital that was not the usual destination for them, a hospital that was a specialty facility, or was outside their area. Replacement of drugs used on the call seems to always be an issue as each jurisdiction and hospital does the exchanges differently.

In an effort to standardize the paperwork for this exchange, the Council has devised an "EMS Drug Issue Sheet". It has gone through a few revisions thus far, and hopefully today's meeting with the pharmacists will iron out any other issues. The form contains drugs that are all-inclusive for the region. We have heard back from some of the pharmacies about a few issues that still exist. Some of those drugs that are problematic are epi pens, vasopressin, and nitro spray. Not all pharmacies carry those items. Expense is an issue to add them.

There are some other drugs that are used but only by one agency. There are also some doses or containers that are not listed or are listed that are not at the pharmacies. For example, mag. sulfate. If the pharmacy cannot provide the replacement, it will be up to the agency to find the replacement on their own. They may have to go back to their "home" hospital to get it. The question is, can we all work around these differences?

Note that the CSK drugs are not on this form. The pharmacies do not want those on this same form. The CSK has its own form. The goal of this meeting is to get the Drug Issue Sheet revised in a way so as to work for all agencies in the region.

Greg suggested that the Council try to get together with the pharmacies a couple times a year to make sure all is going well and to address any issues or changes that they see fit. This will help keep the lines of communications open between OMDs, EMS and the hospital pharmacies. Drug shortages may necessitate meetings more frequently, but being able to identify the players from each entity will help mobilize these urgent issues as they are identified.

After the form is released for use in the region, EMS should not go to a pharmacy and ask for a drug that is not on the form. We will also have to have a plan where new drugs are added and we must be able to refresh the forms being used at the pharmacies. We need to remember that EMS is not making the decisions as to which drugs are carried, that is the decision of the OMDs.

The question came up about out of region hospitals, like GW. Anne Marsh said that GW makes up the CSK kits for Arlington when they need to replace those drugs.

There was discussion as to what should be done with the forms after the exchange has been made. Essentially, the pharmacies can do whatever they want to do with the form afterwards. They can be used for billing/reconciliation, shredded, kept, etc. Having these forms available may help agencies and pharmacies identify diversions.

Some agencies will want to make arrangements to have those forms returned to the agency so that billing may be done. Jose also said that some agencies exchange the drugs in the ED, not at the pharmacy. Sentara is also piloting use of the Pyxis Jose said that use of the Pyxis had created some accountability issues with their hospitals.

Kate asked if the OMDs had seen the forms. Greg said they had. He asked if the list includes any drugs that no one uses. The following drugs were identified as those that may need to be removed; Haldol, Vecuronium, Vasopressin, Terbutaline.

The main message to all is that this form contains all the drugs used by EMS in all the NV Region. There may be a couple exceptions, but the intent is to have this list contain the “all inclusive” of all drugs used.

Anne Marsh asked if anyone is able to replace their Cyanokits at the pharmacies at their hospitals. Some of the EMS Ops folks that were present said they can do that exchange, especially if the EMS kits are almost expired. Prince William was one of the hospitals that was mentioned that could exchange the kits for EMS.

The pharmacists arrived and the official meeting began at 10 am. Greg welcomed all and shared that the EMS operations folks would like to try to get together with the region’s hospital pharmacists twice a year to stay in touch and to address any issues or successes they are having with EMS.

Greg explained the objective of the NV Regional EMS Drug Issue Sheet. The intent of this checklist is to be used by EMS at any hospital in the NV Region to restock their drugs. We all cross borders and this could help with drug exchange issues. If the pharmacy can use the sheet for billing, that is great, they may also choose to return it to the agency, file it, shred it, or archive. The sheet represents what EMS can ask for at the region’s hospital pharmacies.

Cathleen Cowden, from Loudoun, said they use a different form. She said that the pharmacists cannot verify whether an agency is asking for a drug that their agency uses or not. It was clarified that if that

happened, there was a record and it would be handled by the agency, and the EMS agency will handle it. She asked if each jurisdiction would have their own form with their own drug lists. Greg explained that the list is an all-inclusive listing of all drugs that are used in the region by all agencies. He also said that the intent was for all agencies and pharmacies to use the same regional form.

Greg also explained that if a particular hospital pharmacy does not carry a specific drug, or a specific dose of a drug that is listed on the list for replacement, then the agency must find a way to get that drug either from their home hospital or from the jurisdiction. It will not be the pharmacy's issue to find the drug. They can only exchange what they have.

Gill also brought up the refrigerated drugs, and the appropriate units are the only ones that should be asking for them. There was also a brief discussion on the short shelf life of some drugs.

The group then took a closer look at the list itself. They identified vasopressin as one of the drugs that is no longer used, so it should be scratched from the form.

Greg related that this list is not meant to dictate protocols in any way, and said that it will be a good tool for the pharmacists to use to suggest any changes that may need to be addressed.

The group discussed TXA and that it was a costly drug. The group was interested in the cost and how EMS was using it in Trauma cases. All agreed that use of this drug may increase in the future. The pharmacists said that they were interested in how EMS doses the drug. They use 1 gram/100ml/10 minutes infused via IV. A secondary dose is 1 gram over a longer period.

Greg mentioned that Cyanokits are another example of an item that may or may not be resupplied by the hospital pharmacists. The region has been fortunate to be supplied with a cache of kits via grant funding.

Gill asked if the omission of vial size on the form was deliberate. Greg said that it was, and that it really didn't matter. Gill thanked the Council's group for this work, putting this all together, and that it was a thankless job.

Gill asked about safety measures, for example, mag. sulfate, and that it must be pushed over time. The group assured the pharmacists that they are all trained on administration - when to administer and how to administer, in their respective protocols, and that each agency's protocols are different.

Again, the Council hopes to be able to meet with the pharmacists every 6 months to look at the list and make any revisions or needed changes. Drugs may change, as well as concentrations, some because of shortages. For example, right now, Loudoun is the only agency that uses Labetolol. Should that remain? Another specific drug was Terbutaline, used by Manassas and Manassas Park. The form may actually help identify drugs that are no longer used, or no longer current, for the OMDs to reevaluate.

Gill asked about the process for adding a new drug. The pharmacies are always looking at new drugs. She asked how EMS goes about adding new drugs. It was explained that the agency OMDs decide based on cost, likelihood of use, results, and whether it is listed on the state Medications and Procedure schedules or not. If all items are OK, then our group can add the new drug to the list.

Greg reiterated that if there is an issue with a hospital pharmacy carrying a drug or not, there is no mandate for the pharmacies to carry that particular drug.

There was a discussion on which agencies are charging for transports, and who is billing the patient insurance companies. There was also a discussion whether the agencies are trying to recover all fees, including co-pays or just accepting what the insurance pays. After the conversation it was clear that most agencies charging policies differ from the others.

Then there was a discussion as to whether the hospital pharmacies charge the EMS agencies for drugs. Most hospital reps said they consider not charging a community services. There is a local option issues. Some bill EMS, some do not. Since this topic is complicated, it will be discussed at another meeting.

It was determined that when properly completed, the EMS Drug Issue Sheet can be used as a legal form for documentation.

There was a discussion about expired or expiring drugs and whether they can be returned or exchanged. Some pharmacies use a special sticker for drugs that are going to expire soon. Some allow exchanges via the 1:1 exchange. The 1:1 exchange was discussed as a great example of regionalization. We may need to look at expired/expiring drugs and consider a regional policy for how to deal with that scenario.

The use of expired drugs for training was also discussed. Greg suggested that EMS Operations look at how each agency handles expired/soon-to-expire/opened drugs. It seems all di this differently now, and perhaps this could be resolved in similar ways in a regional plan. Perhaps this topic can be explored at the next meeting.

Again, the vial size and concentration was discussed. It was determined that the vial size is not really a big factor to separate out on the form; however, the concentration is important to leave intact. A couple of changes were identified that needed to be made to the form as currently stands. The TXA should be 1 gram / 10 ml. Vasopressin will be removed. Nitro spray was discussed. Some use this, so it will be one the form. That item was discussed by all. Novant facilities resupply this to Manassas. There is apparently an infectious risk, so the spray can only be used for one patient. It is expensive. This is an example of how this sheet can identify potential issues and bring the details back to the OMDs. This discussion may assist the Novant / Manassas in a decision to keep or omit Nitro spray use in the future. It was reiterated that if the pharmacy does not have the item when requested, the agency is responsible for getting the item from another pre-determined supply (home hospital or agency).

When asked if there were any other issues that they thought may need addressing in this forum. Pharmacists expressed concern about temperature conditions and drug boxes that have been left in heat/cold. It was noted that most units have climate control abilities, but regionally this could still be improved upon.

Additional items of concern included:

- Narcotics control and how it is working, how it can be improved. The regional CSK has had a positive effect.
- Physician signature on controlled substance is still needed (not for Schedule 6)
- CSK form, sometimes physician's signature is missing. Pharmacist will send the provider back for the signature or contact the EMS Supervisor to intervene. So far, all have been responsive.
- Flyouts with multiple agency response always causes signature issues.

The rest of the form was reviewed and all agree it makes sense. It also meets the Board of Pharmacy requirements. There was additional discussion on audits and how the forms can help. Asking for the medical record number helps the hospitals.

The CSK Form was reviewed and all agreed it can stand by itself. PCRs have historically been hard for the pharmacies to get. The CSK has all the required fields; however, the board of Pharmacy still wants to see the PCR. Providers still need to complete all forms completely and correctly.

There was discussion on the EMS patient identifier number which is different from the Medical Record Number (sticker). The hospital registrar provides the sticker at Fairfax but not all hospitals make that sticker available. If the Medical Record Number is not added to the form before EMS leaves, the date of birth can also be used to get the other patient info. The pharmacists agreed to try to get the EDs to provide the Medical Record Number or sticker so it can be on the EMS Drug Issue Sheet. There are outliers that will always be issues getting the ID info: no ID, trauma, unresponsive, homeless, etc.

In summary, we want to use the new form on July 1. This gives EMS Ops time to make any changes that are needed. Some research needs to be done to make some decisions and that will take time.

Action items regarding the form:

- Vasopressin comes off
- Labetolol will be reviewed in 6 months. Loudoun still uses.
- Nitro spray will remain and will have its own line.
- TXA dose will change to 1 gram / 10 ml

Greg asked all present to go back to their agencies and hospital pharmacists and identify those absent from this group and those who should be here. Any names and contact info should be forwarded to Marcia at marcia@vaems.org.

Our next meeting will be Wednesday January 11, 2017. 1:30 p.m. City of Fairfax Fire Department. 4081 University Drive, Fairfax, VA.

The meeting was adjourned.