Northern Virginia Emergency Medical Services Council
Meeting Minutes

EMS/Pharmacy Committee
Tuesday, January 16, 2018
10:00 am

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

Attendees: (Alphabetical Order by last name) * indicates by phone

- Gill Abernathy – Pharmacy Manager, Inova Health System
- Tolulope Akinbo – Pharmacy Manager, Inova Mount Vernon Hospital
- Dana H. Anderson* – Pharmacy Manager, Virginia Hospital Center
- Jonithan Brantley – Captain, City of Fairfax Fire Department
- Diane Buckley* –Pharmacy Manager, Sentara Northern Virginia Medical Center
- Cathleen Cowden* – Pharmacy Manager, Inova Loudoun Hospital
- Karen Dunavant* – Pharmacy Manager, HCA StoneSprings Hospital
- Craig Evans – Executive Director, Northern Virginia EMS Council
- Anne Marsh – Battalion Chief, Arlington Fire Department; Secretary/Treasurer, NVEMSC
- Dr. John Morgan – Operational Medical Director, Loudoun County Fire & Rescue
- Tina Pho – Pharmacy Resident, Inova Mount Vernon Hospital
- Dr. Scott Weir – Operational Medical Director, Fairfax County Fire & Rescue Department

Meeting Called to Order – 10:05 am

The EMS/Pharmacy Workgroup topics are auditing of Controlled Substance Kits (CSK), review and revision of the Regional Pharmacy Policy and CSK Exchange Form.

Gill Abernathy advised that there are no new updates from the Virginia Board of Pharmacy. Craig Evans advised that he sent the group a copy of H. R. 304 "Protecting Patient Access to Emergency Medications Act of 2017" for everyone to review. This was put into law on November 17, 2017. This shifts the responsibility from the pharmacies to the EMS agencies for accountability of Schedule II-V drugs. The DEA Regulations have not yet been updated to reflect this. For the Northern Virginia EMS system, it won't change operations and how agencies obtain their medications but will require the agencies to have more responsibility in record-keeping and shift that responsibility away from the pharmacies. Dr. Morgan added that the EMS agencies will likely be required to carry the DEA certificates in the future but the DEA hasn't set forth how that looks. For example, some Medical Directors would be required to get 20 licenses because of how their agencies are set up whereas others would only need one or two. This is still forthcoming from the DEA.

Regional Reporting and Audits

Craig Evans, Northern Virginia EMS Council

1. Craig pulled regional data from ImageTrend and has produced a report that shows each EMS Agency's information as a whole and then drills down to the provider certification number,

medication administered and number of times and overall call volume for that provider over a three month period. This report does not delineate whether a medication was given more than once during a single call, for example a re-dose en route to the hospital.

- There is a data error for all data reported by Prince William County but Craig has discussed with Captain Montminy and he has provided him contact information to reach an IT specialist who can assist in getting that resolved so he can obtain actual numbers for them. Right now it only shows the provider number and all other data is in error.

2. Dr. Weir confirmed that the purpose of the data is just for situational awareness and surveillance to identify trends and use of administration in an early fashion. Gill Abernathy advised that they have a sophisticated algorithm in the hospital setting that records every time a drug is put into a drawer and so they can detect any deviations from there and this is a very elementary version of the same for the use of the EMS agencies and hospital partners. By using this information we are doing our due diligence and it's better than doing nothing at all to identify diversion of drugs.
    - Dr. Weir would like to see agency use patterns or total agency call volumes be added to the spreadsheet. He also requested that a standard deviation be added and programmed into the spreadsheet so as to better identify those with excessive use patterns based on call numbers. Craig advised that he will add that in.
3. Dr. Morgan was concerned about the confidentiality of the information on the report since it does have provider certification numbers and the discoverability of this information should there be any reason for this report to be entered into a legal situation and whether this information could be publicly reported since opioids are a hot topic. Additionally, does this then pinpoint that some agencies treat pain while others don't, some agencies use it more than others in the area, etc., and whether this could be construed as a way or reason to pick out certain providers and further review their usage of certain medications. Dr. Weir advised that while it isn't meant to be used negatively, it is definitely beneficial in being able to pinpoint providers who are administering medications excessively and stopping problems before they get too far. He also suggested a disclosure statement stating it is not intended to draw conclusions around individual provider use or agency use as it does not evaluate the call types and any information contained requires further investigation to determine actual usage, call types, etc.
    - Craig advised this information isn't publicly published or available on a website and will only be distributed to the member agencies and pharmacies as required. The agencies will be able to drill down further into specifics if needed.
    - Karen Dunavant from HCA StoneSprings recommended that a disclaimer be placed on the report to state how this information is used and why. She sent the following wording as a recommendation: "This is a confidential patient safety work product document. It is protected from disclosure pursuant to the provisions of the Patient Safety and Quality Improvement Act (42 CFR Part 3) and other state and federal laws. Unauthorized disclosure or duplication is absolutely prohibited."
    - Dana Anderson from Virginia Hospital Center also sent the following wording as a recommendation: "The contents of this document are strictly confidential. It is not to be photocopied, discussed, or otherwise shared with unauthorized personnel. This document is protected from legal discovery by the Code of Virginia 8.01-581.17"

Regional EMS Pharmacy Policy

The intent is to develop a regional plan with the steps to be taken when a diversion, or suspected diversion, occurs whether in the hospital or the EMS agency so everyone is following the same procedure. A draft of the policy was sent to all attendees for review, revision and discussion.

1. Gill Abernathy requested that the use of the wording "one-for-one" be removed altogether in the document since that indicates that one drug or item is being exchanged for another when this cannot always be the case. For example, if you are returning an entire CSK kit and the new kit is deficient of a drug, it cannot be a one-for-one exchange. It was agreed by the group in attendance that this is appropriate and it will be removed.
2. Section 9 – Update wording to reflect that NVEMSC is running the audit report and will provide it to the agencies and the pharmacist in charge for each hospital.
4. Section 10 – Gill Abernathy requested the wording be changed from "All air is out of the bag before sealing" to "Remove air from bag before sealing"
3. Section 10 – Karen Dunavant stated that her staff will often rubber band the Carpuject's together versus putting them in a separate baggie because the more plastic between the medication and the provider makes it harder to see dates and names. It was recommended that the wording be changed to state "Each medication type is packaged individually within the CSK bag"
4. Section 11 – Anne Marsh suggested that the third item "Ensure integrity, within reasonable effort, of the vials…" be updated to say container since not all medication is in a vial. Craig suggested using drug or medication. Karen Dunavant stated she didn't have a preference in term of drug or medication as long as it's consistent within the policy. It was agreed amongst the group to change vials to drugs and to use the term drugs throughout the policy
5. Section 12 – Jon Brantley asked if there could be emails giving the agencies a heads-up that there is a shortage of certain medications so they are aware of the situation before they get to the window to pick up their kits. Wording will be added to this section stating that emails will be sent by the pharmacies to EMS leadership advising when there is a shortage and when the shortage has resolved. It was suggested that the policy be left somewhat vague but just stating that there will be communication to the EMS agencies about shortages and when they return to stock as much as possible but not placing a burden on anyone to make sure this has to be done
6. Section 13 – Dr. Morgan requested that the wording for CSK checks be changed to not be so stringent because in Loudoun County they have ambulances that may not be in service as an ALS unit for months at a time. By requiring it every shift change or change of personnel, it goes against their internal policy and he would like to see it a little more broad for those reasons. It was agreed to be changed to state "At least monthly or more often depending on department policy"
7. Section 14 – Check Box 2 under agency responsibility was asked by Captain Brantley to be changed so the steps for notifying the pharmacist in charge and the police in a specific order as to not delay in contacting the police. It was recommended by Dr. Weir that "prior to conducting a police investigation if called for by local protocol or policy" be removed because the pharmacists want to know of any tempering or inappropriate use is found, whether being investigated by police or not.
8. Section 14 – Check Box 4 under agency responsibility will have "agency" added after "regulatory"
9. Section 14 – Check Box 5 under agency responsibility will have "Continuously" removed

10. Section 14 – Check Box 1 under Pharmacy responsibility will have “and EMS agency manager” added after operational medical director
11. Section 14 – Check Box 7 under Pharmacy responsibility will have “Continuously” removed
12. Section 15 – Wording changed to remove “and pharmacies” and “to include the contents of the CSK”

Regional Controlled Substance Kit Exchange Form

1. Add wording or watermark behind “Medications Administered To” to state “Or Attach Patient Sticker here”
2. Remove asterisks in “Reason for Dispensing” because excess medication shall NOT be wasted at the pharmacy for any reason, not just breakage or expiration. Also move “use other irretrievable method” to this statement about wasting of medication
3. Karen Dunavant asked whether a pharmacy technician can sign and accept returned CSKs and Gill Abernathy will double check the regulations to ensure that this is correct and advise if not so it can be removed

Drug Shortages

1. Prince William County Fire & Rescue is experiencing shortages with normal saline and Arlington County is having problems with the delivery of Cardizem. They can get the Cardizem but they have to get a 1000cc bag of D5W and run it through a buretrol to get the appropriate concentration. It’s not the drug shortage, it’s the administration system they’re having issues with at Virginia Hospital Center.
2. Captain Montminy from Prince William County asked about the use of epinephrine in 30mL vials and whether anyone has those. Dana Anderson at Virginia Hospital Center presented this topic at our last meeting but stepped out for a moment so Brian Caruth responded that the manufacturer didn’t submit IV administration for FDA approval so it was left off the label because it was not approved. So while it is technically off-label use, there is nothing in the compound that is unsafe, it’s just not labeled for IV use, they just contain different preservatives and additives as those previously labeled for IV use.

Open Discussion

1. Dr. Morgan asked about disposal of paralytics and disposal of other medications. Gill Abernathy advised that under Resource Conservation and Recovery Act (RCRA) there are many medications that can’t be disposed of down sinks or in trashcans, etc., like Nitroglycerine. Cathleen Cowan advised that most likely this doesn’t apply to EMS because of the volume that’s carried in an ambulance, of nitroglycerine for instance, compared to the amount in a hospital. One of the pharmacists will review the medication list against RCRA and report on which medications need to be disposed of in different manners than others to be compliant

Meeting was adjourned at 12:09 pm