

Northern Virginia Emergency Medical Services Council

Regional OMD Committee
Wednesday, October 17, 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
Craig DeAtley, Fairfax County Police Helicopter, flightpadeatley@gmail.com
Craig Evans, Northern Virginia EMS Council, craig@vaems.org
Daniel Gabbay, MD, Ft. Belvoir Community Hospital, dsgabbay@gmail.com
Joseph Marfori, MD, Alexandria Fire Department, josephmarfori@gmail.com
John Morgan, MD, Loudoun County Fire & Rescue, john.morgan@loudoun.gov
Michael Semchyshyn, MD, MWAA, mikesem@hotmail.com
Neha Sullivan, MD, DC Fire & EMS, neha.sullivan@dc.gov
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, scott.weir@fairfaxcounty.gov

The quarterly Operational Medical Director's meeting was started at 10:12 am by Craig Evans.

Approval of Minutes

The minutes from the last quarterly OMD meeting were sent out by email for review. The group unanimously approved the minutes as written.

DISCUSSION:

FACT*R Blood Program – Dr. John Morgan

- Dr. Morgan updated the group and advised that the program is in the final planning stages now. A brief background history of the program is that there was a multi-vehicle, multi-victim auto accident with prolonged extrication in Loudoun County earlier this year that was found to benefit from blood products on the scene. Initially they were able to use what PHI had on their helicopters but subsequently depleted their supply. Once their supplies were depleted, the local blood banks were contacted to supply additional resources which were brought to the scene and administered with physician direction on-scene. A review of the after-action plan revealed that this need for on-scene blood should be explored so there is a clear plan of how to execute this type of response in the future since this particular incident was done by contacting several resources and "asking permission" to take blood out of the hospital's supply for use on-scene for patients that may not even be transported to the hospital providing the blood. Dr. Morgan and Dr. Avstreich from Fairfax Hospital have worked

together on the logistics, resources, guidelines, supplies, etc., to create this regional plan and were able to secure donors to purchase the start-up equipment that will be the property of NVEMSC.

- This is a virtual blood supply in the sense that they are not carrying blood on the medic units but rather have an agreement with Inova Loudoun & Fairfax Hospitals blood banks to prepare 5 units of packed cells, 5 units of RBCs and 1 unit of liquid plasma in special boxes for transport within 15 minutes of this plan being activated during a call with a prolonged extrication time, that being 30 minutes or greater.
 - There will be physician approval required to initiate the packing of blood for transport.
- Loudoun County recently trained their EMS supervisors during an 8-hour in person training session.
- They are hoping to train the rest of the region using a video-based training with a hands-on portion. The Inova video production team will be wrapping that up the video portion soon.
- The OMD's discussed what happens when an agency needs to go outside their jurisdiction for a call and how they receive approval if, for example, Loudoun goes into Frederick County, Maryland. They are in agreement that they will still follow their local protocols as they normally would, however, receiving facilities should be aware
 - This will be brought up at the next COG meeting so everyone is aware but also to determine whether DC and Maryland allow paramedics to give blood, etc.
- The OMD's also discussed a regional cross-cover model amongst themselves via pager/text system so when a paramedic in the field needs approval, they can contact dispatch who reaches the on-call physician and connects them or another option is to create a call list where the field provider contacts their own OMD first and if unable to reach, it goes to one number and sends a blast text to everyone and whoever the first one who calls in is who can give authorization

Drug shortages and alternative medications

Craig advised there was an email sent about Ketamine and concentrations currently being carried. The general response by the group was to not have more than one concentration available in the drug boxes. The pharmacy committee also has requested that the OMDs look at Versed in two different concentrations in the drug bag and while those vials look different, they'd also like there to be a single concentration as to reduce drug errors. Additionally, they would prefer the single concentrations of Ketamine as there is still a national shortage and they're having trouble finding it anyway.

- Currently there are 10/mg, 50 mg/mL, and 100 mg/mL available and most ambulances are carrying 100 mg/mL, however, the providers have reported that using it for pain is a much lower dose than using it for behavioral emergencies which comes out to be 0.1cc and that's very hard to see and measure out accurately in an ambulance
 - Sentara Northern VA Medical Center only uses Ketamine for pain management and they carry the 10 mg/mL for IV and 50 mg/mL for IM
 - Alexandria Fire uses it for pain and behavioral emergencies
- Deputy Chief Andrews asked for the preference of the group as to what they prefer going forward as it relates to medication concentrations
 - Dr. Weir stated that in certain situations, there is no time to pause and do the math for various concentrations to reach the same effect, however, there are others, such as pain management, that you can reasonably take the time to calculate it out based on the concentration you have available.
 - Dr. Reed Smith stated they use it rarely in Arlington County for behavioral emergencies but daily for pain management. There have been some dosing issues because of the multiple vials. Dr. Smith believes that getting rid of two concentrations of Versed and it would be more valuable to have two concentrations of Ketamine
 - Dr. Morgan advised that Loudoun County does not use it IV for pain management in his area but he respects the decisions of the other OMDs and their usage, but it just hasn't been initiated in Loudoun yet. He is in favor of going down to one concentration of Versed, which they do use in Loudoun County, again to reduce medication errors
 - Dr. Marfori advised that Alexandria does not use Ketamine much for pain but he is starting to come around to the idea more and they do use it a lot for behavioral emergencies. Adding multiple doses of multiple medication is just a bad idea in general in his opinion. His units do not carry Versed because he prefers Ativan and that is in their protocols
 - Dr. Weir asked if there were any objections to removing 1mg/1mL Versed
- The physicians discussed waiting until after the Ketamine shortage to then consider transitioning from two concentrations but considering the difficulty in getting it now, it's not the best time.
- Craig advised that with the Versed there is currently 4 vials of 5mg/5mL and 2 vials of 10mg/2mL
 - The group discussed and agreed on bringing down the threshold to 20 mg total, to be carried as 10mg/2mL times 2. All were in agreement

Stroke – LVO

Dr. Weir advised that he was unable to attend the recent stroke meeting and if anyone was aware of any items to be addressed

- Craig advised there are no solid action items to be handled and provided the following update:
 - The AHA has agreed to make the NVEMSC a super user for regional data.
 - The cost is approximately \$3200/year but they will cover it this year
 - There was a discussion during the meeting that they'd like everyone to have a tool to identify LVO, however, it is not being asked that they all use the same one
 - Alexandria Hospital is now Thrombectomy Capable Certified which is the only hospital on the east coast because it's a brand new certification
 - Reston is no longer doing mechanical thrombectomy 24/7, however, they are interested in returning to that capability
 - Statewide stroke meeting is this Friday and Craig is attending.
- The group discussed a way to determine what hospitals are mechanical thrombectomy capable with a letter of commitment so everyone is on the same page
 - Craig will reach out to obtain these so we can include that in our Regional Stroke Plan

Level III Trauma Centers

Dr. Weir asked what Level III trauma centers are in the area. Currently, Loudoun has one and Sentara and Ft. Belvoir are working on becoming Level III certified. Dr. Weir asked how they determine the best appropriate facility and whether it's based on the 2012 CDC field trauma triage guidelines

- Dr. Morgan advised if they meet trauma criteria based on physiologic criteria or anatomic injury patterns to show that the patient could benefit from a trauma center, they go to Level I and Level II preferentially. On the western end of Loudoun they sometimes send to Winchester Medical Center and the east end they sent to Reston or Fairfax, with Reston often being closer by ground depending on their location in the county. Pediatrics preferably go to Fairfax because they have a PICU and are a Level I trauma center. Anything else goes to Level III such as high-risk MOI with good presentation, high-risk categories such as pregnant, anti-coagulants, age, elderly falls, etc., go to Level III.

Ft. Belvoir Community Hospital Update

Dr. Gabbay provided the following update

- Since 2011 they have grown significantly and Ft. Belvoir Community Hospital (FBCH) is listed in the DOD inventory as a community hospital although they are #7 in terms of census in the DOD inventory compared to other facilities.
 - They see approximately 60,000 patients per year in their ED
- There is a push to make FBCH a Medical Center and the Trauma Center designation has to be in place in order to make it a Medical Center. There is an upcoming meeting to push this all forward quickly and Dr. Gabbay will be speaking with OMDs

in adjacent regions as this moves forward as far as what that could mean for their providers' ability to use FBCH in the future

- There are some growing pains and logistics they need to work out, such as admission of civilians and Veterans Administration patients, which they aren't currently able to do and he'll provide an update on that once available
- They do have limited cath lab abilities currently and it's unknown how much that will change with the Medical Center designation

Trauma Triage (SALT vs. START)

Deputy Chief Andrews advised there is a big debate on the use of SALT vs. START Triage. Virginia currently uses START and SALT was started by a physician at Johns Hopkins in 2011-2012 and the CDC made it into the "federal model". There is some debate on which is the better model but CoAEMSP is using SALT for testing of students as opposed to START, creating an education issue for new providers. The current MUCC guideline provides an example of a SALT triage program and now people are thinking that's the better program or the only federally recognized triage model but that is not accurate. Now DC is doing SALT and Maryland is starting to go with SALT. It's been in discussion for the last 6 months at the regional EMS Chief's COG meeting as to some regionalization of triage techniques. This has also been debated in Richmond at the Emergency Management Committee and it's been determined that Virginia will teach both and let the jurisdictions or Regional EMS Councils decide which one they want to use. There has been discussion amongst the regional Chiefs and there is no evidence that has come forth that either is better so, at this time, we'll continue to teach START and use it as our regional model in the regional plan.

Termination of Resuscitation

Dr. Weir advised that most current papers acknowledge 20 minutes of resuscitative efforts before termination should be considered. There is some evidence that longer thresholds and durations of resuscitation have better outcomes and Dr. Weir asked the group to share their resuscitation timeframes and whether it's a time threshold or other reason to terminate

- Loudoun currently has guidelines for 25 minutes
- Fairfax and most other jurisdictions are using 20 minutes
 - Dr. Marfori asked if anyone was including PEA in their Termination of Resuscitation protocols
 - Fairfax and Loudoun currently do
 - Dr. Morgan advised that once the providers hit the 25 minute mark, the EMS Supervisor contacts him to discuss the overall patient picture
 - All calls go directly to him or his designated covering physician and not to the "medical control" phone at the receiving facility because he has found that ED physicians refuse terminations requests and it's putting his providers

at risk working an essentially unviable cardiac arrest patient that they are just going to call in the ED. While he doesn't recommend that model for every agency and locality, it works for him as there has been a relatively small rate of middle of the night calls that it's not yet too disruptive

- Dr. Weir advised their providers call physician on-line medical control for authorization in PEA cases

State Medical Direction Committee Update

Dr. Weir advised that a motion was passed to reconsider the previous motion that originally passed but was retracted regarding IM Ketamine for behavioral emergencies at the EMT-Intermediate level. The state doesn't allow administration of the dissociative dose Ketamine at that provider level. It originally passed on a 4:3 vote that Intermediates could administer Ketamine IM but it was retracted and is for reconsideration. Is there any agency that still has enough EMT-Intermediates that they would like to see this advocated for in our region?

- Dr. Marfori is in agreement with allowing them to do it but they currently only have 2 Intermediates. He stated that he wouldn't want to vote against it and take away from other agencies in the state who rely on an abundance of Intermediates to function at this point despite it not having a large impact on his region and providers
- All physicians in attendance are in agreement with the original decision and there is no encouragement from the group to overturn that decision
 - This will be voted on at the next meeting and Dr. Weir will advise of the outcome

Dr. Weir also advised that there was a discussion from a very rural agency to allow the AEMT level providers to give epinephrine and lidocaine in appropriate cardiac arrest patients where the majority of their ALS providers are AEMTs. He has sent further information on that discussion via email for everyone to read at their leisure as this also does not affect our region but was a very interesting topic and discussion for those that are affected and how they handle it going forward.

There was also discussion at the state meeting about the use of Propofol at the EMT-Intermediate level for a critical care inter-facility transport. The context is around Scope of Practice and typically for Critical Access Facilities that need a patient to be transported to a more appropriate facility and the only available providers are EMT-I's. For example, the patient is already on a Propofol drip and needs to go from point A to point B. The discussion was to not allow EMT-I's to maintain sedation on an already intubated patient on Propofol. At this point, EMT-I's are not allowed to initiate sedation with Propofol. Dr. Weir stated that he shared with the Committee members that he feels if a provider is not allowed to initiate a drug, they should also not be allowed to maintain it, especially if they are not giving them alternative options should the patient drop their blood pressure, etc., so they're being set up to maintain a drug

they can't administer to begin with and have no provision for how to correct it if anything goes wrong. Additionally, if the sending physician knew the patient would have to be inter-facility transported to another facility and there was a likelihood it would be an EMT-I as the highest level provider, why start them on Propofol to begin with? Should we stress the importance of this consideration and the need for the physician to write very specific transport orders on what to do in the event of over-sedation and a drop in blood pressure and how to correct that with the means they have. The discussion was tabled and will be revisited at a future meeting. The discussion is around whether or not an EMT-I is a reasonable crew for an inter-facility critical care transport for a potentially hemodynamically unstable patient that is intubated and on mechanical ventilation.

- Dr. Morgan added that for our region this really isn't an issue, but this is more in Southwest VA where the majority of their ALS providers are EMT-I's.
- Deputy Chief Andrews stated that this has little impact on the 911 services in our area but has a greater impact on the inter-facility transport companies and it's an important discussion and consideration for them.
- The general discussion amongst the physicians in the room was that there is no impact to their operations as there are no inter-facility transports being handled by any of those in attendance today.

EMS Council Update

Craig Evans advised that the Council is currently discussing with the regional Fire Chief's on whether to work on having a Regional EMS Academy. The Fire Chief's meeting in November will be focused on this topic and they will decide as agencies if they are interested in becoming a part of this model. Deputy Chief Andrews added that this will be typically for initial certification and the occasional auxiliary courses like PALS, ACLS, etc. because not all agencies are able to keep up with the training. Craig added that the hope is to keep our providers local for training and to reduce costs. In 2017 there was 60 new paramedics trained through various programs, including VCU, but the cost was over \$1M to do so. The hope is that by keeping it local and with a single program, it will reduce costs and turn out more providers. DC Andrews stated this doesn't negate the present model for continuing education and individual protocol education because those will all still be done by the individual agencies. They did sit down with the Northern Virginia Criminal Justice Academy to better understand how they work, their Bylaws, processes, membership, etc., and that was quite helpful in presenting this to the Fire Chiefs.

Adjournment

The meeting was adjourned at 12:46 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 17, 2018. The minutes were officially approved on

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Craig A. Evans

Date