

MINUTES

PINELLAS COUNTY EMS MEDICAL CONTROL BOARD

Thursday
May 17, 2012
10:00 a.m.

EMS Headquarters
12490 Ulmerton Road/Largo, FL

MEMBERS PRESENT

Dr. Roberto Bellini
Dr. Stephen Haire
Dr. Henry Kurusz, III
Dr. Paula Pell
Dr. Hiten Upadhyay
Mr. Brian Flynn
Dr. Cecele Murphy
Dr. Joe Namey

STAFF PRESENT

Dr. Laurie Romig
Lynn Jones

MEMBERS ABSENT

Mr. Keith Neeley
Mr. Glen Waters

GUESTS PRESENT

Craig Hare, EMS & Fire Admin
Mark Postma, Sunstar
Vicki Glenn, Sunstar
Glenn Davis, St. Petersburg College
Doug Swartz, Clearwater Fire
Debbie Vass, Sunstar
Karen Macauley, All Children's Hospital
Don Crowell, Pinellas County Legal Secretary

1. CALL TO ORDER

Dr. Haire called the meeting to order at 9:55 a.m. There was a quorum.

2. Approval of meeting minutes from November 17, 2011

Dr. Haire motioned for approval and it was seconded. The motion passed unanimously.

3. Resignation of Mr. Ricky Satcher

Dr. Romig pointed out the copy of Mr. Satcher's letter of resignation in today's agenda packet. She notes the effort and dedication he displayed as a member and chair of the MCB and suggests the board send him a letter of thanks and congratulations on his new endeavor. Dr. Romig is asked to compose the letter and it is agreed the board members will sign it.

4. Protocol Discussion/Approval

- Trauma Transport Protocol (TTP)

Dr. Romig said TTPs were previously emailed to all board members in anticipation of the previously scheduled meeting. The approval of two new provisional trauma centers within west central Florida created a mandatory revision of our previous TTPs per State law. Because of strict time frames for revision, the draft TTPs were submitted to the State, approved and implemented prior to presentation to the Board.

Dr. Romig and Mr. Hare outlined the revision process, including communication with the State to seek clarification of the law and related rules in order to achieve full compliance, the logic used in developing the intent and language, and described preliminary projections of the effects of the changes in the protocol. The language was based on the tenet that State law and rule requires that patients meeting Trauma Alert Criteria must be transported to the closest appropriate Trauma Center, regardless of jurisdictional or county lines. Based upon communication with the Bureau of EMS and recognizing that objective criteria should be the starting point, the term "closest" was defined for TTP purposes in terms of road miles from the center of each grid to the Trauma Centers. County GIS staff provided the data. The protocol development group recognized that a number of external factors could affect transport time over those distances; this was addressed by strengthening language regarding the ability of on-scene personnel to take these factors into account when making destination decisions.

The two new Provisional Level 2 Trauma Centers (Bayonet Point in Pasco County and Blake Medical Center in Manatee County) in west central Florida are likely to impact Pinellas County trauma care differently. Blake Medical Center is not likely to be a common closest Trauma Center destination due to the location of Bayfront Medical Center. However, Bayonet Point will be the closest Trauma Center by driving mileage for much of north Pinellas. The criteria for identifying the closest Trauma Center to each grid also identify St. Joseph's Hospital as the closest Trauma Center for much of central county, resulting in their receiving proportionately more patients than in the past. We believe that there will be little effect on transports to Tampa General, as these are typically for TGH's burn services and/or related to directional traffic on the Howard Frankland and Gandy Bridges. The Board was furnished with a Pinellas County Trauma System Update document, which includes a preliminary analysis of the potential impact of the TTP changes on trauma patient distribution. We recognize that the changes could play a part in the continuing viability of the joint Bayfront-All Childrens Trauma Center designation and plan to pursue further analysis and communication with Bayfront and All Childrens to define specific issues and actions while maintaining compliance with State law and administrative code.

- CCT Pain Management Protocol

This protocol comes from the CCT Medical Operations Manual. At an early stage of the current drug shortages we faced a possibility that we would not be able to obtain Fentanyl or Morphine or Fentanyl for pain control. After analysis of options, Dilaudid was determined to be the most reasonable alternate for these medications and a quantity of the medication was ordered and delivered. Shortly thereafter, it became clear that Morphine continued to be available, even if in smaller quantity than usual. Because investigation showed that we could not return the Dilaudid for credit, Dr. Romig proposed that Dilaudid be added to the Critical Care Transport Team formulary in order to get some value from the purchase. This protocol contains the necessary information for the addition. Following discussion of appropriate dosing, Dr. Romig agreed to modify the dosing information to an initial dose of 0.5 mg with additional increments of the same dosage every two to five minutes as needed. With this change, a motion to approve the protocol was passed unanimously.

- Protocol 3.1 (Add ambulance to response for 32B3: “unknown problem, unknown status”)

At the request of the Medical Dispatch Review Committee, the Board was asked to approve the addition of an ambulance to dispatched units responding to Bravo 3 level 32 card (Unknown Problem) calls out of an abundance of caution. The Board unanimously approved the request.

Mr. Hare updated the Board on the current status of planned changes to remove first responders from Alpha level responses for the 17 (Falls) and 26 (Sick Person) cards. Because of some objections to the concept by some First Responder agencies, and despite previous approval of the Medical Control Board and the EMS Advisory Council, a conservative implementation plan is in process. A community educational package has been designed and the County Commission will workshop the topic and then make a disposition on the plan.

- NuMask Protocol

Dr. Romig explained the NuMask is not an airway device but rather an intra-oral mask with wings fitting between the lips and gums. It is used with a regular bag valve device and allows hands-free bagging. If the bag has to come off for defibrillation, for example, the NuMask keeps the seal. This device was first used with tactical medics who can't carry a lot of heavy equipment. It has been field tested with cardiac patients and allows use of the ResQPOD much earlier than has been practical in the past. This device would be used in cardiac arrest patients and would be optional in other positive pressure ventilation situations. The protocol and device information was presented to the Board for review and approval. The protocol was approved unanimously.

- CAPP Protocol Changes related to NuMask

Dr. Romig explained that this is a change to incorporate the NuMask to the CAPP (Cardiac Arrest Perfusion Protocol). The change was approved unanimously.

- Hypertensive Urgency/Emergency Protocol

Dr. Romig advised that this is an update to reflect current practice in other EMS systems and Emergency Departments regarding the treatment of hypertension (high blood pressure). In general, elevated blood pressure levels that are not associated with end-organ damage (stroke, angina, MI, kidney failure, etc.) are no longer treated acutely. It may be treated indirectly when end-organ symptoms and findings are present but is still not the focus of treatment. Instead, treatment will be guided by the symptom complex that the patient is exhibiting. Patients with blood pressure above a certain threshold but no priority symptoms will be advised to follow up with their primary care physician. The protocol was approved unanimously.

- Behavioral Emergencies Protocol

Dr. Romig said that current protocol requires that a patient with an overdose or suspected overdose who was Baker-Acted was always transported to the closest facility for medical clearance unless otherwise approved by OLMC. This protocol change allows primary transport to a Baker Act facility for all Severity Green patients, including overdoses. Severity Yellow patients will continue to require OLMC approval to bypass the closest Emergency Department to go to a Baker Act facility. This change should benefit both non-Baker Act receiving Emergency Departments as well as our psychiatric patients who are likely to receive psychiatric evaluation and care more quickly. Another change is the elimination of Haldol from the formulary. With the increasing frequency of multidrug intoxications and overdoses and the increasing prominence of drugs that can trigger Excited Delirium, Haldol may have a higher likelihood of causing harm. Haldol is also on the list of drug shortages; where it is available, it is extremely expensive. The updated protocol as approved unanimously.

5. Drug Shortages

Dr. Romig pointed out two spreadsheets that have been developed to show existing drugs and possible replacements if necessary. They represent part of the current effort to address epidemic drug shortages. One spreadsheet includes all known available usable formulations of current formulary drugs and alternates for those drugs. It allows Dr. Romig to examine available drug concentrations, total dosages, and formats (such as vial or Carpuject). Dr. Romig subsequently ranks alternatives chiefly with patient safety in mind.

The second spreadsheet is updated weekly and reflects quantities of drug on hand in the warehouse along with target par levels based on 6 to 8 month historical distribution rates and reorder levels. It also tracks pending orders and deliveries received or pending. This has been very helpful in managing the drug shortage situation. One example of a result of this information is Dr. Romig's prediction that it will not be practical to revert to normal prioritization of Fentanyl for Level 1 pain management until we have received at least a six

month par level based on old usage rates. This will be complicated by the need to also consider expiring meds that require replacement.

Mark Postma of Sunstar reported that he was part of a group that went to Washington D.C. to meet with Health and Human Services about the drug shortage issue. He learned that the FDA does not require drug manufacturers to contact vendors if they are going to stop making a particular drug unless they are the sole provider of that drug. The FDA also does not control manufacturers on what they make. There has also been talk at both state and federal levels of the possibility of extending expiration dates on some drugs; however, Dr. Romig judges this to be an unacceptable risk at this time.

6. System Update

Craig Hare reported that a Mr. Bruce Moeller has been hired to replace Dick Williams, former Public Safety Services Director, who has retired. Mr. Moeller is from Sunrise, Florida and has been a city manager and also has a fire background. He will start in August.

7. Open Forum

8. Next Meeting: July 12, 2012

9. The meeting was adjourned at 11:00 am.