



MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DIVISION OF COMMUNITY HEALTH

DRUG/DEVICE/PROTOCOL (DDP) COMMITTEE

June 5, 2019 – 9:00 A.M.

MEMBERS PRESENT

Mike Barnum, MD, AMR, Chairman
Karen Dalmaso-Hughey, AMR
Shane Splinter, HFD (Alt)
Fernando Juarez, RN, NLVFD
Derek Cox, LVFR
Jim McAllister, LVMS
Chief Shawn Tobler, MFR

Chief Troy Tuke, CCFD
Chief Jim Kindel, MFR
Steve Johnson, MWA
Chelsea Monge, CA
Devon Eisma, RN, OM
Samuel Scheller, GEMS
Matthew Horbal, MD, MCFPD

MEMBERS ABSENT

Corbin King, Mercy Air

SNHD STAFF PRESENT

John Hammond, EMSTS Manager
Gerry Julian, EMSTS Field Representative
Rae Pettie, Recording Secretary

Laura Palmer, EMSTS Supervisor
Scott Wagner, EMSTS Field Representative

PUBLIC ATTENDANCE

Michael Holtz, MD
Larry Johnson
Dan Shinn
Dorita Sondereker, RN
Paul Stepaniuk
Daniel Llamas

David Carraway
Jeff Davidson, MD
Brett Olbur
Jessica Leduc, DO
Phaniraj Iyengar, MD

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The Drug/Device/Protocol Committee (DDP) convened in the Red Rock Conference Room at the Southern Nevada Health District on Wednesday, June 5, 2019. Chairman Mike Barnum called the meeting to order at 9:04 a.m. and stated the Affidavit of Posting was posted in accordance with the Nevada Open Meeting Law. Dr. Barnum noted that a quorum was present.

I. PUBLIC COMMENT

Public comment is a period devoted to comments by the general public on items listed on the Agenda. All comments are limited to five (5) minutes. Chairman Mike Barnum asked if anyone wished to address the Board pertaining to items listed on the Agenda. Seeing no one he closed the Public Comment portion of the meeting.

II. CONSENT AGENDA

Chairman Barnum stated the Consent Agenda consisted of matters to be considered by the DDP that can be enacted by one motion. Any item may be discussed separately per Committee member request. Any exceptions to the Consent Agenda must be stated prior to approval.

Approve Minutes for the Drug/Device/Protocol Committee Meeting: April 3, 2019

Chairman Barnum asked for a motion to approve the April 3, 2019 minutes of the DDP meeting. *A motion was made by Dr. Davidson, seconded by Chief Troy Tuke and carried unanimously to approve the minutes as written.*

III. REPORT/DISCUSSION/POSSIBLE ACTION

A. Review/Discuss Stroke Protocol and Possible Stroke Facility Designation Criteria

Dr. Phaniraj Iyengar acknowledged he has been a stroke neurologist for over twenty years. He has worked for Sunrise Hospital and Medical Center (Sunrise) for the past five years. Dr. Iyengar noted that Sunrise was recently certified as a Comprehensive Stroke Center (CSC) by the Joint Commission (JC). They met all the JC requirements, including providing research and neurocritical care services. There are only 150 facilities in the country with this designation because the certification is difficult to attain. He is hopeful that other facilities will also be stimulated to become a CSC to provide the best care possible for stroke patients in the valley.

Dr. Iyengar stated the CSC program entails providing the highest level of care for stroke patients, both ischemic and hemorrhagic. He noted that time is of the essence mainly for ischemic strokes patients that undergo thrombectomy. Sunrise is the only facility that has 24/7 comprehensive stroke care with intervention readily available, which includes a dedicated stroke service. Dr. Iyengar proposed a change to the stroke protocol to provide an added layer of care for patients to be appropriately evaluated, treated, and obtain the necessary post-procedure care at the right place and right time so they can have the best outcome possible. He noted our EMS providers utilize the Rapid Arterial occlusion Evaluation (RACE) Scale as an indicator for large vessel occlusion (LVO). For patients with RACE Scale scores of ≥ 5 , an LVO should be considered as the cause and a plan put in place to get them definitive care at a CSC as quickly as possible because not all patients end up getting the right amount of care following a thrombectomy. The proposed protocol entails adding a 15-minute criterion for this subset of patients. If a patient is within 15 minutes of Sunrise, or any other CSC, the patient should be transported to the CSC to get the patient to the right place in the right time frame. If you have a situation where you have both a CSC and a thrombectomy stroke center close by, the patient should generally go to the CSC because of the comprehensive care that is provided. However, if the patient is closer to the thrombectomy stroke center it would be appropriate to take them there. He noted that Los Angeles and other big cities have protocols that direct patients to a CSC. If the patient is not considered to have a LVO based on the RACE Scale they can go to a certified primary stroke center as well.

Dr. Davidson stated he works at Valley Hospital and they are in the course of completing the process to become a comprehensive stroke program. He noted the EMS crews have expressed that they don't worry much about patients who are identified within 8-12 hours. He noted that this issue that needs to be discussed in a sub-committee. Also, the EMS providers will need to receive education on how to identify which patients to take to a CSC versus an Interventional Radiology (IR) capable facility. There is a limited pool of IR radiologists in the community who are employed at 4-5 different facilities. Patients can always be transferred from an IR facility to a CSC facility. He noted that within the next year there will possibly be two certified CSCs, which is positive for the patients. Dr. Davidson identified two issues he feels requires further discussion in a sub-committee: 1) The time frame for which the EMS providers identify patients with a RACE Score of ≥ 5 probably needs to be simplified; and 2) The decision process for EMS providers once they identify a patient needs to go to a CSC versus an IR, and bypass another facility.

Dr. Iyengar stated that current evidence states any stroke symptom that presents up to 24 hours of onset should be taken to a CSC. Those patients will need a CT, CTP, neurologist, and an interventionist to read the scans. Sunrise's 24/7 availability for those services 365 days a year is paramount. There are facilities that will do thrombectomies but don't always have an available doctor because there is a very significant shortage of those professionals. With regards to educating EMS providers on understanding the RACE Scale, Sunrise has recently completed a video that is widely available. Dr. Iyengar remarked it will be very difficult for EMS providers to

determine whether a thrombectomy capable facility would be appropriate. It would be asking too much of them at that point in their 15-20 minutes of patient interaction.

Dr. Davidson stated there are probably more Code Whites than Code STEMIs on any given day. Many of the patients with altered mental status get clustered into the Code White and are not teased out until they reach the ED. The question “What is the AMS of the patient versus a true Code White?” is another education issue that should be addressed in a sub-committee as well as the benefits of going to a CSC versus a primary stroke center. Dr. Iyengar noted that Sunrise collects approximately 38 different pieces of data that can be provided to help make that decision because in the end they want to look at patient outcomes. He suggested they obtain data from all the facilities to better understand and help them arrive at a decision about stroke management.

Chief Tuke reported that the ED/EMS Leadership Committee agreed to deliver six metrics related to stroke patients. There are members from various facilities that attend the meeting. They will utilize the data to apply it for training EMS providers prior to making it operational. Chief Tuke stated that it won't be an easy task to apply it in the field, but it will be pushed out as a guideline. They need to be careful about how they apply the guideline in the field and to trust the providers to make the appropriate decision depending on the situation where they are farther out than 15 minutes, and if they transport elsewhere, they won't be chastised. The data will help the Committee decide on what the training will include. Dr. Iyengar asked if any of the six metrics include thrombectomy criteria such as door to needle and door to IR. Chief Tuke invited Dr. Iyengar to attend the meetings if he has suggestions that pertain to data collection.

A question arose as to which sub-committee would be appropriate for future discussions. Chief Tuke suggested they bring the issue back to the DDP because the constituency is the same. They could extend the meeting to allow enough time for discussion. Dr. Barnum remarked that the decisions they make could hugely impact certain facilities. There is the potential for a primary stroke center to receive no stroke patients if there is a CSC in the same sector. Mr. Hammond explained it is the practice of the OEMSTS to allow discretion with regards to provider impression, except for trauma destination, which is driven by state law. The protocol will be written to include the word “should transport” instead of “must transport” as there are conditions that will arise that will be confounding and place EMS providers in a precarious position.

Dr. Davidson expressed that there is a huge price tag attached to becoming a CSC which has hindered it in this community and throughout the country. IR capable facilities provide all the services as required by AHA and the American Stroke Association. Becoming a CSC is great for both the community and the patients, but it's a very limiting step in many hospitals' decision to say, “We're IR capable. If we can provide all the services, why do we need to become a CSC?” Dr. Barnum identified issues related to: 1) The data collection that will impact volume with regards to where EMS providers are moving the patients in the system; and 2) Presenting data that shows patient outcomes as it relates to a CSC versus an IR or primary stroke center. Dr. Davidson noted that there will be better outcomes at a CSC for those patients that meet the comprehensive criteria. A patient that doesn't meet thrombectomy criteria might do just as well at a primary stroke center, which is why they exist. Dr. Iyengar suggested they include the stroke coordinators from all the facilities to present the data, then look at the criteria so they have an idea as to what is happening to that patient at that facility. After that, they can make the decision about what EMS providers need to do. If a patient arrives at a facility and they are not able to do an adequate job, it's very difficult to make the case. And unless that facilities improves, things aren't going to get any better. He stated it's important to take the patients to the facilities that have the best outcomes and best services provided in the shortest time available. If they look at the state of stroke care today it would give them a better idea as to how the system is currently working, and they could then take it to the next level by addressing it in the protocol.

Dr. Barnum remarked that the idea of demonstrating that CSCs have better outcomes than other institutions presumably would show that they are. Otherwise there's a problem with the certification process. He noted that the numbers are going to show that there is an enhancement to patient outcome. The question becomes if they look at an actual protocol proposal, what kind of volumes are they going to see in terms of the changes of where patients are going now versus where they would go, and what kind of burden is that going to create on areas such as transport times. The hospital partners are eventually going to want to talk about those shifts, which is an important aspect. Dr. Barnum asked if the next step would be to request a protocol proposal. Mr. Hammond stated the stroke protocol entails using the RACE Scale and going to the appropriate facility. The only change would be to specify going to a CSC if it's within 15 minutes of transit time. Dr. Leduc stated that if you have a

patient with a RACE Score of 5 or higher and you're closer to a thrombectomy site you could go there as opposed to a 15-minute transport to a CSC. Dr. Davidson asked about the time frame in terms of symptom onset. If they identify a patient with an onset of six hours or less who has a RACE Score of 5 and they've eliminated any mimics they would have to bypass a primary stroke center to get to a CSC. Dr. Leduc responded yes, if it's taking a LVO patient to a center that is not capable of interventional management. Mr. Cox asked what the 15-minute transport time is based on. Dr. Iyengar explained it is a national standard. Essentially, each city arrived at a time that is appropriate for that city based on traffic patterns, the nearest availability of a CSC, and the closest thrombectomy stroke center; it's nothing written in stone. He feels 15 minutes is appropriate for the Las Vegas valley. Dr. Davidson stated that even in the worst of traffic, the destination criteria is primarily based on the level of care the patient might need. He expressed that other than trauma, OB and burn patients, the protocol should read "should" instead of "must" when related to patient destination.

Chief Tuke suggested they come back with a draft protocol for further discussion. Dr. Barnum asked the DDP if there was any objection. Seeing no one, he agreed they should place it on the next agenda. Daniel Llamas noted the six metrics related to stroke patients aren't necessarily inclusive of the outcome from a thrombectomy perspective. They could use that as a baseline. He asked what exact criteria or data sets they want to see to make an evaluation on need assessment from a quality perspective. They need to allow for EMS to have a standardization of consistent care. They may have a facility that says they have thrombectomy capability, but without having 24/7 coverage there isn't a guarantee they'll have coverage at the time the patient arrives. They should allow criteria or accreditations in terms of what facilities have to offer consistently, such as they do for STEMI. He related that EMS providers currently use the RACE Scale to bypass a facility because they may not have thrombectomy capability. Mr. Hammond responded that that isn't a problem because they are permitted to do so. Mr. Llamas asked how our EMS system verifies a certain facility is capable 24/7. Chief Tuke replied that we don't yet. The ED/EMS Leadership Committee is currently gathering the data to be able to answer that question. The data has not been collected in a systematic and consistent way to make any determination about a protocol change with regards to bypassing a facility.

Dr. Iyengar agreed to write up a proposal that includes criterion on how patients are currently being managed, including outcomes. Dr. Barnum asked that the proposal include information on educating the EMS crews.

B. Review/Discuss Protocol Development for Sepsis

Chief Tuke stated there has been discussion in the ED/EMS Leadership Committee about the need for a sepsis protocol. Dr. Davidson stated there is a national push towards identifying sepsis. For EMS to identify sepsis in advance of patient arrival would be outstanding. Chief Tuke offered to draft a protocol for the next meeting.

C. Review/Discuss QuickTrach® Device

Chief Tuke noted the use of the jet insufflator is antiquated for critical airways. The QuickTrach® was demonstrated at the UNLV simulation lab and everyone in attendance liked the device. It allows quick and safe access for ventilation in the presence of acute respiratory distress with upper airway obstruction. The biggest issue is the cost to get it placed on all the EMS units. He stated the device is approximately \$110. He is hopeful they can purchase the device as a system to reduce the initial cost. They will also need to consider whether to use it for pediatric patients. Dr. Davidson stated that would potentially double the cost, but there are alternative definitive surgical airways for pediatrics. Mr. Johnson stated the manufacturer said the shelf life is five years, but he wasn't sure about the how it would be affected by the Las Vegas heat. Chief Tuke questioned whether they could use the device past the expiration date so long as the package is sealed and intact. Mr. Hammond stated the OEMSTS is stricter with expired sterile injectables and medications than with needles and suction catheters. Mr. Eisma stated the jet insufflators cost almost \$300 apiece. Mr. Scheller noted that if the tubing is kept in good condition you can use the device indefinitely.

Chief Tuke offered to bring a written proposal that includes price information. He asked for each agency to let him know how many units will need to be stocked. Mr. Hammond stated the protocol roll out is scheduled twice a year, January and July, so they have time to develop a protocol and do a cost analysis. If they roll the protocol out in January, there will be 90 days for everyone to receive training. Dr. Davidson noted that they need to be specific about age and weight.

D. Discussion of Nominations for PharmD Ex-Officio Member

Dr. Barnum stated there was a suggestion to ask a Doctor of Pharmacy to join the DDP as an ex-officio member to advise them on some of the medication issues. He referred the committee to nomination forms for Dr. Shannon Ruiz and Dr. Diane Rhee who both graciously agreed to free their schedules when necessary. He stated that both nominees are heavily involved in education for pharmacists and it will be great to have some of their students attend the meetings. A secret ballot vote was taken. The result was ten votes for Dr. Ruiz and seven votes for Dr. Rhee.

IV. INFORMATIONAL ITEMS/ DISCUSSION ONLY

None.

V. PUBLIC COMMENT

Public comment is a period devoted to comments by the general public, if any, and discussions of those comments, about matters relevant to the Committee's jurisdiction will be held. No action may be taken upon a matter raised under this item of this Agenda until the matter itself has been specifically included on an agenda as an item upon which action may be taken pursuant to NRS 241.020. All comments are limited to five (5) minutes. Dr. Barnum asked if anyone wished to address the Board. Seeing no one he closed the Public Comment portion of the meeting.

ADJOURNMENT

There being no further business to come before the Committee, Chairman Barnum called for a motion to adjourn. A motion was made to adjourn the meeting at 9:58 am.