

**Medical Advisory Committee**  
**January 13, 2004**

**Attendance:** Joe Barger- EMS, Ruth Burk- EMS, Eric Freed- REACH, G. Jaksa- Kaiser W.C., Dale Poppert- Kaiser W.C., Chris Gaut- Kaiser Richmond, John Sahagun- AMR, Dave Borghelli- AMR, Lori Altabet- John Muir, Sam Bradley- AMR, Dub Fields- AMR, Andy Swartzell- SRVFPD, Debbie Meier- SRVFPD, J. Rampulla- DSP, P. Freitas- John Muir, Carol Gallagher- Con Fire, Nancy Daniels- Moraga-Orinda Fire.

**12 Lead EKG Program:**

- Goal of the program: Prehospital personnel are able to provide advance notice to receiving facilities for patients with acute EKG changes, and expedite door to wire time for those patients who require invasive intervention.
- Currently Moraga-Orinda Fire has program in place and has completed approximately 100 EKG's in 2003.
- San Ramon Valley Fire will be starting their program soon.
- This will probably be a 2 year process to get implemented (if it is agreed to move forward with this). First there needs to be validation that the community wants this program.
- Sutter Delta and CCRMC have diagnostic cath lab capabilities only, no invasive procedures. SRRMC does have invasive cath lab services, but does not provide surgical intervention. Kaiser WC and Richmond do not have cath labs.
- Dr. Barger would like to develop a task force to begin discussions about a county-wide program. Need to research other Counties that already have existing programs.

**EMS Goals for 2004:**

- To get the QI process "off the ground"
- Currently we have many data sources available to assist in the review process including AMR's database, base forms from John Muir as well as the digital recordings, electronic PCR'S for all of the agencies.
- QI process will include the EMS agencies internal QI, trauma, medical, and base hospital QI.
- Need to develop educational forums between prehospital personnel, base hospital and EMS.
- Evaluate the possibility of 12 lead program
- CCT-P - need to add these treatment guidelines to the policy manual.
- WMD interventions. The Mark1 autoinjector antidote kits have been ordered and will be distributed to the providers as soon as available

**Requests from prehospital providers:**

- A. Swartzell- SRVFD would like adult intra-osseous devices
- J. Sahagun- AMR would like thermometers, Tylenol for pediatric patients, and antiemetics. Also it was requested that policy 9 be re-evaluated, specifically the section that deals with destination of patients who have ingested medications and thus are considered "unstable" and must be transported to the closest facility. Discussion regarding use of nitrous oxide for analgesia in the prehospital setting- D. Poppert states that it was eliminated at KWC as they found it very ineffective and difficult to achieve desired level of sedation. There are very few EMS systems using this. Per Dr.Barger, this will not be added in Contra Costa County.

## **Treatment Guideline changes 2004:**

- Elimination of base contact for all medical items including; Versed, Dopamine, lasix and Morphine for CHF.
- Base Hospital will remain a resource for prehospital personnel and will continue to play an active role in trauma destination decisions.

**Policy 9 change:** Purpose of policy change to assist with destination decisions for burn patients. Several changes in burn center designation over the past year.

- CHO and Alta Bates are no longer designated burn centers
- Adult Burn Center (>14 years old) DSP
- Pediatric Burn Center (14 years and <) UC Davis Medical Center, Sacramento.
- Criteria for referral to burn center based on ABA guidelines
- Comments regarding suggested changes: Dr. Freitas and other participants requested that the policy be more specific regarding e.g. burns to hands, face- what %, 2<sup>nd</sup> or 3<sup>rd</sup> degree. Also there was a request to be more specific regarding items C 4,5 and 6.
- The ages on the draft policy were incorrect and will be corrected to read adult > 14 years old and pediatric 14 years or less.
- EMS staff will review this policy further, revise and redistribute prior to next MAC meeting.

**Policy 19 change:** Purpose of policy change is to facilitate the field pronouncement where appropriate without the need for base contact.

- Probable death now includes Blunt or penetrating traumatic arrest (adults only). Patients must be apneic, pulseless with a one minute documented asystole or wide bizarre rhythm less than 20 per minute. If ALS response, do not initiate CPR. If BLS initial response, cease CPR to assess patient. If all of these criteria met, prehospital personnel should notify the coroner and complete a PCR.
- Under the introduction section of the policy, the language will need to be changed regarding “at no time shall a paramedic discontinue CPR” unless verbal order by physician or DNR order available.
- This policy will need further review and revision by EMS staff.

## **Policies for deletion:**

- **Policy #25** Controlled Substances – this will be incorporated into policy #17 First Responder Paramedic Programs
- **Policy # 29** End-Tidal CO2 Detection Devices – As of December 2003 these are required on all intubated patients. Training video was sent to all agencies/providers regarding use of these devices.
- **Policy #26** Pulse Oximetry

## **Policy distributed for review:**

- **Policy # 10** Declining Emergency Medical Care AND/OR Transport (Previously Patient Refusal) MAC members were asked to review this draft and send comments back to EMS. In addition this policy is still undergoing internal review.

## **Trauma Triage:**

- Approximately 2 undertriages per month. Head injury is the largest category in all age groups, especially the elderly.

- Of the elderly falls that are anticoagulated and have positive intracranial bleeds, there is a 50% mortality.
- Paul has done a literature review of “Head Injuries in Anticoagulated Patients” for EMS, John Muir Trauma Service and John Muir ED Physicians group that he will send to the MAC Committee.
- There are approx. 300 elderly trauma patients per month that are called into the base. Most are elderly falls.
- EMS will continue to track and review elderly head injuries cases

#### **CCT-P:**

- Alameda County and Contra Costa County are working together on CCT-P policies to have the same policies in both Counties. There will be additional education for CCC CCT-P's with the addition of Ventilators and Amniodarone to their scope of practice.

#### **Quality Improvement:**

- Next Meeting February 10<sup>th</sup>
- System Data will include Cardiac Arrest and Intubation data.