MEDICAL CONTROL BOARD
EASTERN AND WESTERN DIVISIONS
EMERGENCY PHYSICIANS FOUNDATION

The regularly scheduled meeting of the Medical Control Board was held, pursuant to Oklahoma Statute, Title 25 & 307.1 on Wednesday, September 13th 10:00 am at the following locations:

EMSA Eastern Division Headquarters in the Conference Room
1417 N. Lansing Avenue, Tulsa, OK

EMSA Western Division Headquarters in the Conference Room
1111 Classen Drive, Oklahoma City, OK

NOTICE AND AGENDA for the regularly scheduled meeting of the Medical Control Board of the Emergency Physicians Foundation, Eastern and Western Divisions, was posted in the Office of the Deputy City Clerk of Tulsa, Monday, September 11th, 2017 and in the Office of the City Clerk of the City of Oklahoma City on Monday, September 11th, 2017 more than 24 hours prior to the time set for the regularly scheduled meeting of the Medical Control Board.

1. **Roll Call** disclosed a quorum at10:03 am and the meeting was called to order by Dr. Mike Smith.

MEMBERS PRESENT:	MEMBERS ABSENT
Dr. Russell Anderson	Dr. Roxie Albrecht
Dr. Mark Blubaugh	Dr. Brandon Boke
Dr. Barrett Bradt	Dr. Chad Borin
Dr. Jeffrey Dixon	Dr. Keri Smith
Dr. David Smith	
Dr. John Nalagan	
Dr. Mike Smith	

OTHERS PRESENT:

Dr. Jeffrey Goodloe, OMD
Dr. Curtis Knoles, OMD
Jennifer Jones, OMD
David Howerton, OMD
Duffy McAnallen, OMD
Matt Cox, OMD
Jamil Rahman, OMD
Jim Winham, EMSA
Sonny Geary, AMR
Rick Ornelas, AMR
Michael Kisler, AMR

2. Review and Approval of July 2017 MCB Meeting Minutes

MOTION: Dr. Nalagan

SECOND: Dr. David Smith

Aye:
Dr. Russell Anderson
Dr. Mark Blubaugh
Dr. Barrett Bradt
Dr. Jeffrey Dixon
Dr. David Smith
Dr. John Nalagan
Dr. Mike Smith

ABSENT
Dr. Roxie Albrecht
Dr. Brandon Boke
Dr. Chad Borin
Dr. Keri Smith

3. EMSA President Report

Mr. Williamson did not attend the meeting. Mr. Winham gave compliance, late call graph, exclusion summary, and destination hospital reports for June 2017 and July 2017.

Mr. Winham thanked the OMD for working with AMR for changing the narcotic exchange at the Mustang station versus personnel having to go back to EMSA Post 41 at the end of each 12 hour shift. AMR is also reworking shifts to better handle multiple emergencies at the same time in the Sand Springs area of metropolitan Tulsa. Dr. David Smith asked "Are there areas that compliance was not met?" Mr Winham explained AMR was indeed out of compliance in some areas. He explained that the current exclusion criteria is more stringent than in prior contracts, which results in a larger number calls that may now be considered out of compliance. Dr. David Smith voiced concerns of not meeting response time compliance standards. Dr. David Smith stated that a lot of time is giving to our protocols and if we cannot get the medics there to take care of the patients in a timely manner we have a problem.

4. Medical Director Report

Dr. Goodloe shared that the divert reports are posted for MCB physician review and asked that each MCB physician closely review the data for their represented hospital.

Dr Goodloe shared he attended a two day meeting in Washington D.C. last week about the use of fentanyl and the myth of this drug causing immediate deaths in public safety personnel. He is working on a national workgroup, led by DHS OHA and NHTSA on fentanyl concerns in emergency services. The message from the DEA roll call video is that fentanyl will more or less kill you. The workgroup discussed such false news, implied news and news stories of fentanyl causing near death. Dr. Goodloe explained he will be putting out a memo to field personal on exposure to street fentanyl.

Dr. Goodloe along with the OMD team will be in a two day strategic planning meeting in Tulsa next week. MCB members are welcome to attend as well. Wichita-Sedgwick County and Johnson County in Kansas will also be joining us in a regional medical oversight strategic planning meeting.

5. Review and Approval of 2018 Medical Control Board Treatment Protocols

Dr. Goodloe reviewed the changes to the 2018 protocols. All MCB members were encouraged to send peer-reviewed articles to Jen Jones as they come across them for future protocol reviews.

The effective date for the changes will be January 15, 2018 to allow for training on these changes. The OMD team has personally reviewed each and every protocol in this process. Other than minor grammar/"housekeeping" format changes, the protocol changes are:

Protocol 2H – Nasal Intubation Under Indications: added hypoxia and/or hypoventilation refractory to non-invasive airway/respiratory management, including refractory to NIPPV.

Multiple Protocols Changed all protocols listed below with "per protocol 2G" added to the instructions in the EMT-I/AEMT and Paramedic scopes of practice for intubation if indicated per applicable protocols

- Respiratory Arrest (3A)
- Dyspnea – Uncertain Etiology (3B)
- Dyspnea – Asthma (3C)
- Dyspnea – Congestive Heart Failure (3D)

Protocol 3F - Dyspnea – Brief Resolved Unexplained Event (BRUE) Pediatric Less Than 1 Year of Age : Medication assisted intubation if indicated per protocol 2G was added to the paramedic scope of practice.

Protocol 3G – Pulse Oximetry Under indication #3 changed ALTE to BRUE.

Protocol 3H – Waveform Capnography The statement was added under critical comment, trouble shooting tip chart and to the corrective action box: "adjust EtCO2 scale to 0-20 and print 6 second strip for verification of waveform capnography."

Protocol 3I – Oxygen Administration Use in acute condition to include changed ALTE to BRUE.

Protocol 3J – Nebulization Therapy Under technique changed Bi/CPAP to NIPPV.

Protocol 3K – Non-Invasive Positive Pressure Ventilation (NIPPV) In the CPAP box added (if COPD titrate to SpO2 88-92%) and in the Bi-Level PAP box added (if COPD titrate to SpO2 88-92%).

Protocol 4A – Resuscitation (CPR) specified use of metronome and ResQPUMP within 2 minutes.

Protocol 4B – Resuscitation Team Roles In the P2 box, specified use of metronome and ResQPUMP within 2 minutes.

Protocol 4C – Automated External Defibrillation (AED) Added continue chest compressions while AED is charging and removed continue CPR while applying pads.

Multiple Protocols Added "deploy ResQCPR within 2 minutes"

- Asystole (4F)
- Ventricular Fibrillation/Pulseless Ventricular Tachycardia (4G)
- Pulseless Electrical Activity (4H)
- Specific Causes of Cardiac Arrest (4I)

Protocol 4G - Ventricular Fibrillation/Pulseless Ventricular Tachycardia

- If 100 kg or greater weight, initiate double sequential defibrillation after the first 360J defibrillation
- Changed epinephrine to: repeat every 3-5 minutes to a maximum cumulative dose of 3mg (this is for VF only, asystole and PEA remains without max)

Protocol 4I – Specific Causes of Cardiac Arrest Added to treatment priority box that calcium chloride is the first medication given for suspected hyperkalemia.

Protocol 5A – Chest Pain Uncertain Etiology

- "O2 if indicated" was removed from the treatment priority box
- Treatment priority box changed from "3 in 5 minutes" of patient contact to "2 in 5 minutes" of patient contact
- In the EMT scope of practice the word ONLY was added to O2 via NC or NRB **ONLY** if dyspnea or pulse ox <94% at room air.

Protocol 5B – Acquiring & Transmitting 12-Lead ECGs added under contraindication: "If transferring facility has already obtained 12-lead ECG confirming STEMI prior to EMS arrival, transport is not to be delayed in an effort to obtain additional 12-lead ECG by arriving EMS professionals. Serial 12-lead ECG(s) for transmission to receiving facilities is/are to be obtained during transport."

Protocol 5C – Acute Coronary Syndrome

- "O2 if indicated" was removed from the treatment priority box

- **Avoid** O2 by NC unless dyspnea or pulse ox <94% at room air
- Added Team Roles Diagram – new role specification for treatment efficiency
- Changed the reference of 16F to 16HH

Protocol 6A – Stroke In the EMT scope of practice the word ONLY was added to O2 via NC or NRB **ONLY** if dyspnea or pulse ox <94% at room air.

Protocol 16N – Epinephrine 1mg/mL (1:1000) & 0.1mg/mL (1:10,000) Added to Ventricular Fibrillation/Pulseless Ventricular Tachycardia - Adult (4G) 0.1mg/mL (1:10,000) 1 mg IVP/IOP Repeat every 3 - 5 minutes while resuscitating cardiac arrest, cumulative maximum 3mg.

Protocol 9B – Sepsis

- Removed "fever" from the title of protocol
- Changed treatment priority box from "IVF if hypotension" to "IV fluid resuscitation"
- Changed under pediatric fluid bolus to: IV NS 20 mL/kg bolus if no signs of pulmonary edema, with a repeat of bolus once to total of 40 mL/kg

Protocol 9E – Dialysis – Related Issues Added to treatment priority box that calcium chloride is the first medication given for suspected hyperkalemia.

Protocol 9L – Nasogastric/Orogastric Tube Under indications added: decompression of ventilated air in stomach (reduction of gastric distention) in the cardiac arrest patient. (may be placed pre or post intubation).
Protocol 10D – Chest/Abdomen/Pelvis Injury Changed to cover sucking chest wounds with vented seal instead of non-vented seal presently used.

Protocol 11A – Heat Illness "Early cooling therapy" was added to the treatment priority box.

Protocol 11D – Water Submersion Events Removed the word "cold" from water submersion cardiac arrest. Changed to water submersion cardiac arrest initiate resuscitation and transport with rewarming if submersion time less than:

1. 60 minutes if water temperature estimated to be greater than 6 degrees Celsius (42.8 degrees F)
2. 90 minutes if water temperature estimated to be less than 6 degrees Celsius (42.8 degrees F)

Multiple Protocols Removed "Fever" from "Fever and Sepsis"

- Dopamine (16L)
- Norepinephrine (Levophed) (16II)
- Ondansetron (Zofran) (16JJ)

Reference Updates:

- **Protocol 2F – Oral Intubation**
- **Protocol 2H – Nasal Intubation**
- **Protocol 4C – Automated External Defibrillation (AED)**
- **Protocol 4E – Double Sequential External Defibrillation**
- **Protocol 4G - Ventricular Fibrillation/Pulseless Ventricular Tachycardia**
- **Protocol 5A – Chest Pain Uncertain Etiology**
- **Protocol 5C – Acute Coronary Syndrome**
- **Protocol 5M – Ventricular Assist Device (VAD) Management**
- **Protocol 6B – Altered Mental Status**
- **Protocol 9B – Sepsis**
- **Protocol 9K – Medication Administration**
- **Protocol 10I – Hemostatic Agents**
- **Protocol 10P – Blast Injury**
- **Protocol 11D – Water Submersion**

MOTION: Dr. Bradt

SECOND: Dr. Nalagan

Aye:
Dr. Russell Anderson
Dr. Mark Blubaugh
Dr. Barrett Bradt
Dr. Jeffrey Dixon
Dr. David Smith
Dr. John Nalagan
Dr. Mike Smith

ABSENT
Dr. Roxie Albrecht
Dr. Brandon Boke
Dr. Chad Borin
Dr. Keri Smith

6. Review and Approval of MCB 2018 Meeting Calendar

MOTION: Dr. David Smith

SECOND: Dr. Bradt

Aye:
Dr. Russell Anderson
Dr. Mark Blubaugh
Dr. Barrett Bradt
Dr. Jeffrey Dixon
Dr. David Smith
Dr. John Nalagan
Dr. Mike Smith

ABSENT
Dr. Roxie Albrecht
Dr. Brandon Boke
Dr. Chad Borin
Dr. Keri Smith

7. Review and Approval of June 2017 and July 2017 MCB Financial Statements

Dr. Goodloe reviewed the financial statements for June and July 2017. He explained that our revenue would be down from losing Yukon and American Airlines are not needing us as much in training as they have in the past. Dr. Mike Smith asked about the Communication/Information Technology line item and why it had doubled. Dr. Goodloe and Jennifer Jones explained the purchase of needed computers for several OMD personnel.

Dr. David Smith asked Mr. Winham about fines levied on AMR for response time non-compliance and how much of those that the MCB receives. Mr. Winham explained how EMSA assesses such fines and that the MCB does not receive those monies.

MOTION: Dr. Bradt

SECOND: Dr. Anderson

Aye:
Dr. Russell Anderson
Dr. Mark Blubaugh
Dr. Barrett Bradt
Dr. Jeffrey Dixon
Dr. David Smith
Dr. John Nalagan
Dr. Mike Smith

ABSENT
Dr. Roxie Albrecht
Dr. Brandon Boke
Dr. Chad Borin
Dr. Keri Smith

8. Discussion of Ketamine

Dr. Goodloe discussed that he reached out to a colleague in the Minneapolis/St. Paul, Minnesota area and reviewed a study they were releasing for publication. Out of approx 2000 patients that received EMS-administered ketamine within the 6 year study period, 38 patients had an adverse effect from ketamine. He reviewed their EMS system's indications and policies related to ketamine and noted the limitation they did not follow patients through their hospital stay for ED treatment time adverse events.

Dr. Mike Smith stated that he would not want to put ketamine on our rigs without knowing the outcomes in the emergency department times of treatment.

9. New Business

Dr. David Smith stated that PCR's are not being left at his facility. He has been seeing a decrease in PCR's not being left. Dr. Smith asked "What is going on with the medics? Why are we not seeing the PCR's?" Dr. Smith stated that his communication with AMR field supervisors is apparently not being shared.

Dr. Nalagan stated that he just quit looking for PCR's as they were not being left. Dr. Curtis Knoles stated that he also quit asking for them as they were not leaving them at OU Children's hospital as well.

Sonny Geary and Rick Ornelas both stated that this was the first they had heard of the PCR issue and would address it immediately.

Mr. Winham explained that EMSA has purchased new tablets, making it easier to print and being able to fax from the tablet without sending to a supervisor.

Dr. Goodloe requested a direct response from AMR as to why this timely PCR issue is not happening. Dr. Mike Smith asked Mr. Winham to make sure this happens from AMR as compliance and good care alone are not an excuse. Mr. Winham stated he would make sure that this happened.

10. Next Meeting – November 8, 2017

11. Adjournment

Upon Motion by Dr. Bradt and seconded by Dr. David Smith the Medical Control Board voted to adjourn the meeting at 11:30am

Approved By:
David Smith, MD
MCB Secretary

Date Approved: