MEDICAL CONTROL BOARD EASTERN AND WESTERN DIVISIONS EMERGENCY PHYSICIANS FOUNDATION

The regular scheduled meeting of the Medical Control Board was held by videoconference, pursuant to Okla. Stat. tit. 25 & 307.1, On Wednesday January 14, 2015 10:00 A.M. at the following locations:

EMSA Eastern Division Headquarters in the Conference Room
1417 N Lansing Ave., Tulsa, OK
EMSA Western Division Headquarters in the Conference Room
1111 Classen Dr., Oklahoma City, OK

NOTICE AND AGENDA for the regular 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, January 12, 2015, and in the Office of the City Clerk of the City of Oklahoma City, January 12, 2015, more than 24 hours prior to the time set for the regular meeting of the Medical Control Board.

1. **Roll Call** disclosed a quorum at 10:03 A.M. and the meeting was called to order by Dr. Mike Smith.

MEMBERS PRESENT:

Dr. Mike Smith
Dr. Justin Fairless
Dr. Jeff Dixon
Dr. John Nalagan
Dr. Chad Borin
Dr. Brandon Boke
Dr. Curtis Knoles
Dr. Micheal Fowler
Dr. Mark Blubaugh
Dr. David Smith

MEMBERS ABSENT:

Dr. Roxie Albrecht

OTHERS PRESENT:

Michael Baker, TFD
Matt Cox, AMR
Sonny Geary, AMR
Dr. Jeffrey Goodloe, OMD
David Howerton, OMD
Jeff Hanlin, OKCFD
Russell Martin, AMR
Duffy McAnallen, OMD
Alf Zeilinger, AMR
Howard Reed, OMD
Dinorah Rivera, OMD
Jimmie Travis, OKCFD
Brian Davis, EFD
Jim Winham, EMSA
Stephen Williamson, EMSA
Liz Groover, Ad. Circulatory
Terry Provo, Ad. Circulatory

2. EMSA President Report

Mr. Williamson introduced Jim Winham as the new COO of EMSA.

Mr. Williamson reported on response time compliance reports for the months of October and November 2014 for Eastern and Western Divisions with exclusion summaries. Mr. Williamson explained compliance standards to the MCB.
Mr. Williamson gave a brief summary to the MCB about OSDH EMS Rules & Regulations have been pushed back to 2016 for approval.

Dr. Borin asked Mr. Williamson about the staffing shortage in Oklahoma City, the crews not having time to leave PCR's at the receiving facilities. Dr. Borin voiced not leaving these PCR's is a patient safety issue. Mr. Williamson addressed some of the staffing issues, and expressed EMSA is concerned as well, AMR does have an academy with 15 paramedics. Dr. Knoles asked when the academy would be released. AMR stated it would be around March 1st. Mr. Williamson finished off with they do care about the safety of the staff, and EMSA does patient/customer satisfaction reports and those are all positive.

3. Medical Director Report

Dr. Goodloe began his report by reviewing the narcotic theft at EMSA in Tulsa.

Dr. Goodloe was enthusiastic to note the progress on the Cardiac Arrest Resuscitation Data Analysis by the OMD office. Mr. Howard Reed and Ms. Dinorah Rivera have worked diligently. Cardiac Arrest data performance sheets are being given back to the crews with detailed data for them to see their performance.

Dr. Goodloe will be at the National Association of EMS Physicians Meeting in the next couple of weeks to present data from our EMS system. Dr. Goodloe is grateful to highlight the wonderful work we are doing in this EMS system today.

Dr. Goodloe reviewed divert reports for November & December 2014. Also reviewed were the Patients Diverted Report for November & December 2014. VA in Oklahoma City showed the largest number of diverts. OU-Presby numbers are also high, but Dr. Goodloe explained OU is still taking P-1 Trauma when they are on divert.

Dr. David Smith brought up for discussion strategy planning for decompression and thru put issues with the hospitals and come up with the data to show our EMS cost for holds and bed waits. Data should be collected to show patient safety concerns and show the cost that occurs to the facility and EMS agency. This is not an ED issue, it is a hospital thru-put issue.

Dr. Mike Smith brought to the attention of the MCB & EMSA the November & December 2014

divert report showed Hillcrest with 14 hours of divert and showed no patients diverted for those hours. After further review, there were no patients diverted during Hillcrest 14 hours of divert.

5. Discussion and Employment Action on Associate Medical Director

Dr. Goodloe brought up for discussion and approval the employment of an Associate Medical Director. Dr. Sabina Braithwaite was introduced to the MCB. Dr. Goodloe explained the time that has been taken to find an Associate Medical Director. Dr. Goodloe reviewed Dr. Braithwaite's CV with the MCB, explained the position would be part-time, and would be a position of the Office of the Medical Director and work for the MCB. The hire date would be February 15, 2015.

Upon motion by Dr. Chad Borin and seconded by Dr. Curtis Knoles, the Medical Control Board voted to approve Dr. Sabina Braithwaite for Associate Medical Director.

AYE: Dr. Mike Smith, Dr. Chad Borin, Dr. Jeff Dixon, Dr. Brandon Boke, Dr. Justin Fairless, Dr. John Nalagan, Dr. David Smith, and Dr. Mark Blubaugh, Dr. Curtis Knoles, Dr. Micheal Fowler

ABSTENTION: None

ABSENT: Dr. Roxie Albrecht

6. Review and Approval of the EMS System Metropolitan Oklahoma City and Tulsa 2015 Medical Control Board Treatment Protocols.

Dr. Goodloe brought the summary of changes to the MCB for approval. Changes to specific protocols are listed for 2015.

Review and Approval of the following protocol changes:

1. Consideration of max methylprednisolone dosing in pediatric asthma. Current max dosing is IV 2mg/kg to 125mg. Dr. Knoles has suggested discussion of max dosing to 60mg. Effectively, given our methylprednisolone is packaged in 125mg vials, it would be more pragmatic for Paramedic dosing to say a max of 62.5mg.

   Dr. Knoles asked to look into this more before making the change and this was agreed by the MCB.

2. Additional clarifying information in the pacemaker management protocol that in the setting of sustained, symptomatic rapid pacing suspected to be related to overpacing that sensor-driven pacing from motion may be controlled by limiting patient motion, either by calming the patient's body motion and/or controlling any extraneous ambulance motion if during transport of the patient. Additional comment to be added that newer generation pacemakers often produce subtle pacemaker spikes on ECG

rhythms, both on electronic monitor and on paper printout displays. Final notation that Medtronic branded pacemakers with impending battery failure will default pace at exactly 65 beats per minute to indicate such impending battery failure in the days to come. Such rate of pacing limitation could explain patient symptoms of fatigue, weakness, lightheadedness or other related sensations.

3. Dextrose 50% administration for hypoglycemia remains a perfectly viable standard of care, but there are situations in precarious peripheral vascular access and in times of dextrose 50% shortage where administration of dextrose 10% (25 grams in 250 mL of NS) would prove advantageous. Many large, urban systems have made this change or additional option in times of dextrose 50% shortage in the past 1-2 years or for difficult peripheral venous states to avoid very high tonicity extravasation consequences. As this is becoming more prevalent, can better see the advantages of the option and those utilizing such report minimal change in effective response of the hypoglycemic patient, often without having to give excessive dextrose load. This would remain at the EMT-I, Advanced EMT, and Paramedic levels.

4. Addition of advisory regarding icodextrin (Extraneal® by Baxter Healthcare) in peritoneal dialysis solution may cause falsely elevated blood glucose readings to the glucometry and dialysis related protocols. This change reflects concern noted from rare, but present, patient care interactions that have occurred in the system over the past year. Blood samples containing maltose, galactose, or xylose can result in erroneous elevated blood glucose readings in glucometers using the glucose dehydrogenase pyrroloquinolinequinone (GDH-PQQ) enzyme/indicator test method. In the instances such confounding substance(s) are encountered or suspected and the glucometer utilizes the GDH-PDQ method, EMS professional(s) treating the patient should either utilize a non-GDH-PDQ method glucometer (patient's own glucometer utilization permitted in such circumstance) and/or treat the patient by clinical assessment and not GDH-PDQ method glucometry reading.

5. Suspected opiate overdose/altered mental status therapy with naloxone: As most are aware, Oklahoma legislative action that took effect on November 1, 2013 allowed naloxone to be administered by all EMS professionals as well as concerned laypersons. We have heretofore not rushed a change in protocol because frankly the clinical need has not been apparent. Nothing has effectively changed, but realistically, given how wide open the use of naloxone is becoming across Oklahoma and other states, I believe it best to allow for EMR/EMT personnel to administer naloxone via the IN or IM routes. IV/IO administrations would remain at the Advanced EMT and Paramedic levels. EMT-Intermediate is being phased out slowly and I believe it best to keep IV administration at the Advanced EMT level. No change in dosing is recommended. Changes reflective of EMR/EMT allowance for these administrations would be indicated for the protocol covering IN and IM administrations and EMR/EMT personnel in the system would be required to complete focused training on such administration technique along with naloxone education prior to ability to utilize this change.

   Dr. Fairless suggested IM routes for EMT-I and higher, and IN only route for EMR/EMT.

6. Epinephrine autoinjector added to the EMR level of care for anaphylaxis/serious allergic reaction with corresponding change reflected in all allergy protocols. This would not be a change in dosing or use of epinephrine beyond indicated patients, simply a slight change from EMT to include the EMR as well. To promote the use of epi when indicated, addition of

treatment priority notation of "Epi First – Epi Fast – Epi Safe" to counter the typical EMS professional hesitation of using epi until other options have been given on the allergy protocols, again for anaphylaxis/serious allergic reaction patients. Addition of notifying hospitals of an "Anaphylaxis Alert" via radio encode to promote a higher readiness for these patients for continuing assessment on ED arrival. Individual EDs will interpret this as to their likings, but as an EMS system we should be highlighting the cardiopulmonary level of concern in these patients.

7. Addition of pediatric trauma tranexamic acid administration. The utilization remains low in the adult population, but has been in accordance with protocol directives and without clinical detriment or complication to date. Emerging literature is supportive of pediatric tranexamic acid utilization and this is already standard of care at Saint Francis Hospital in Tulsa and supported by the head of pediatric trauma at OU Medical Center in Oklahoma City. The dosing would be 15mg/kg up to the adult dose of 1 gram IVPB over 10 minutes. Criteria would be in peds at least 10 years of age with clinical suspicion/evidence of hemorrhagic shock via internal and/or external hemorrhage with sustained tachycardia above 120 beats per minute and sustained systolic blood pressure 90mmHg or less (utilizing the 70 + 2x years in age formula for abnormal systolic in pediatrics). The MCB may wish to discuss adding younger years of age.

8. Addition of pictorial images to the childbirth protocols to illustrate normal and abnormal fetal positions as well as to demonstrate appropriate provider interventions during normal and abnormal childbirth. The current text/flowchart instructions would remain unchanged. This would simply allow for better EMS professional understanding of the instructions themselves. The pictorial images would be wholly or primarily plastic simulation model based.

Dr. Goodloe expressed as with 2013 and 2014 protocol sets, he has performed an exhaustive PubMed based literature search in the interim period since the last wholesale review of the protocol set by the MCB. We will add those relevant reference citations in the Reference Version of the protocols. For relative brevity sake, these evidence-based medicine citations are excluded from the Field Version of the protocols. Both versions will be made available to all EMS professionals in the system via the okctulomd.com website.

9. Saint Anthony's Healthplex will brought all together as one description of facility type in categorization table.

10. Integris Edmond change Cardiology from a two to a one.

Upon motion by Dr. Brandon Boke and seconded by Dr. David Smith, the Medical Control Board voted to approve MCB 2015 Protocols with the changes noted above.

AYE: Dr. Mike Smith, Dr. Brandon Boke, Dr. Justin Fairless, Dr. John Nalagan, Dr. David Smith, and Dr. Mark Blubaugh, Dr. Curtis Knoles, Dr. Micheal Fowler

ABSTENTION: None

ABSENT: Dr. Roxie Albrecht, Dr. Chad Borin, Dr. Jeff Dixon

7. Review and Approval of October and November 2014 Medical Control Board Financial Statements.

Submitted for the MCB's review and approval, Dr. Goodloe gave details regarding the October and November 2014 unaudited Financial Statements. The Financial Statements stem right on target with projected expenses for this fiscal year thus far. The OMD staff will continue to use frugal measures to stay on target for the OMD budgeted year.

Upon motion by Dr. Chad Borin and seconded by Dr. David Smith, the Medical Control Board voted to approve October and November financial statements with request of a new format for future financial statements.

AYE: Dr. Mike Smith, Dr. Brandon Boke, Dr. Justin Fairless, Dr. John Nalagan, Dr. David Smith, and Dr. Mark Blubaugh, Dr. Curtis Knoles, Dr. Micheal Fowler

ABSTENTION: None

ABSENT: Dr. Roxie Albrecht, Dr. Chad Borin, Dr. Jeff Dixon

8. New Business

Dr. Goodloe introduced Terry Provo and Liz Groover from Advanced Circulatory. Ms. Provo presented data and a slide presentation about the active compression decompression CPR ResQCPR system.

9. Next Meeting – March 11, 2015

10. Adjournment

Upon Motion by Dr. Mike Smith and seconded Dr. John Nalagan, the Medical Control Board voted to adjourn the meeting at 12:15 pm.

Approved By:
Chad Borin, DO
MCB Secretary

Date Approved: