2008 Medical Director's Updates to BSPC

- **January 2008 Update**
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- **May 2008 Update**
- **June 2008 Update**

County of San Diego

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Medical Director's Update for Base Station Physicians' Committee
January, 2008

New Deputy Health Officer: Dean Sidelinger, M.D. is the new deputy health officer in public health. Dr. Sidelinger was at UCSD in the Division of Community Pediatrics. In HHSA he will work on tuberculosis, border health issues, and community outreach activities, among other assignments. Welcome to Dr. Sidelinger.

8-hour hold changes: Changes to the California Health and Safety Code section 1799.111 "8-hour" were effective January 1st. On the good side, the length of the hold has been changed to 24-hours. On the bad side, use of the hold is limited to non LPS (non psychiatric service) hospitals. LPS hospitals will have to use the traditional 5150 mechanism for holds.

Fire Response: Everyone in the system should be proud of their part in the response to the fires. To recap—515,000 persons evacuated, 26,000 were in shelters, three hospitals and 12 nursing facilities were evacuated of 2,000 patients. There has been a great deal of praise for the response.

The spirit of volunteerism was remarkable as people flocked to assist those in shelters. The evacuations were smooth. The volunteer Medical Reserve Corp. responded to numerous shelters to provide medical assessments and care. The pharmacy emergency response group contributed in an important way by establishing medicine histories when necessary and obtaining assistance.

The Medical Operations Center or MOC created at EMS after the 2003 fires met expectations. The MOC served as a central point for information, communication, and coordination. The evacuations went smoothly due to the presence of the base nurses working with the ambulance coordinators to put together transfer packages of patients. Field ambulance coordinators were vitally important to the process. GIS maps created in the MOC helped assess what was happening and facilities that might be threatened next. The county's new emergency management software, WebEOC, served well.

Many facilities opened additional capacity to take patients. The community opened shelters as well to assist the evacuees.

The focus moved from planning the first day, evacuations the next, then evaluating and supporting shelters, followed by repatriation. Numerous public health issues were dealt with throughout.

UCSD ramped up its capacity and cared for all the burn patients. The medical staff, nurses, and administration at the Pomerado and Fallbrook did a great job getting patients ready for transfer. The nursing homes were good at taking the supplies and personnel they would need in shelters. Mt. Miguel, the rapidly evacuated facility in Chula Vista held a thank you ceremony afterward that was greatly appreciated.

Despite the fact the response went so smoothly, there are improvements we can make for the future. After action reports are being completed and improvements identified. We will then make the needed changes for improvements.

Again, thanks to everyone in the EMS system for everything you did no matter what your role.

STEMI: The cardiac system continues to go well. Door-to-balloon times for activated patients are excellent, the median around 59 minutes. This will have a definite impact on death rates and residual damage after STEMI. We will start looking more at overtriage and reasons for activations that turn out to be unnecessary. Remember that activation is important to maintain low door-to-balloon times, but we should not activate in the field if there are potentially false positive EKGs based on artifact or a poor quality EKG that is unreliable. Or, mimics such a paced rhythm, atrial flutter or in some cases atrial fibrillation, bundle branch blocks, or ventricular hypertrophy.

We will also be looking at activation differences between hospitals. The quality improvement indicators such as death, length of stay, and complications are all within expected limits, according to the Cardiac Advisory Committee.

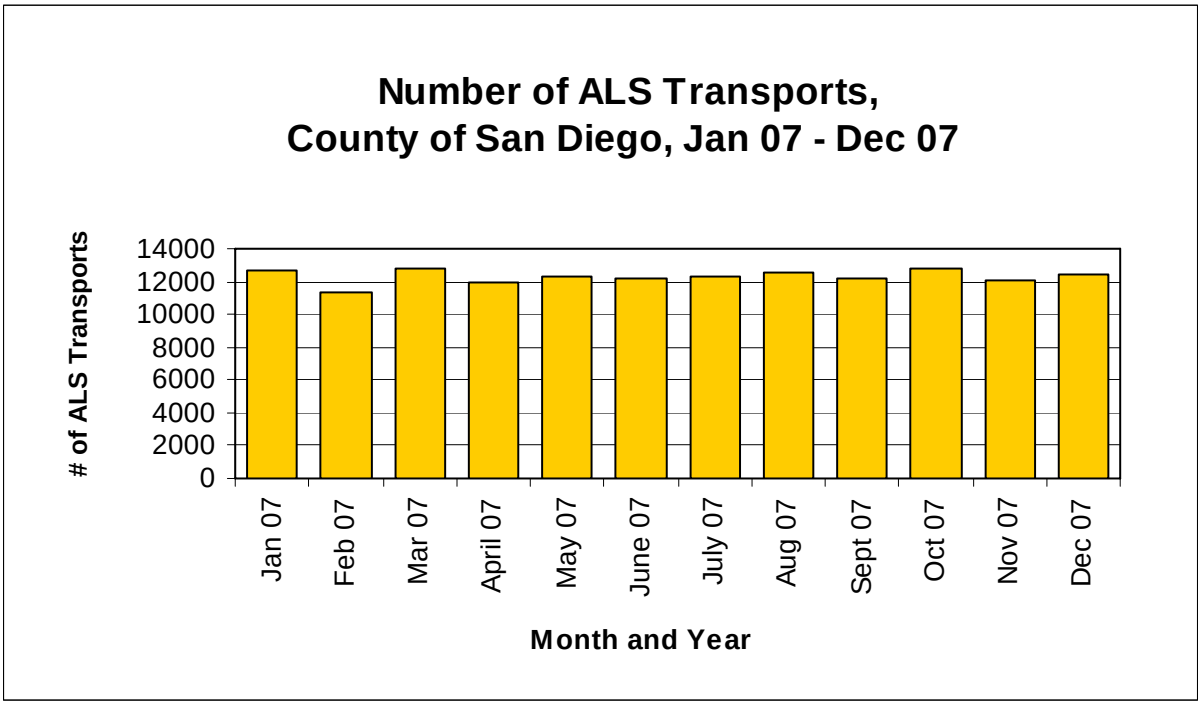
Stroke Triage Protocol: The destination protocol for acute stroke patients is ready for implementation. We are working on a review process for receiving hospitals to establish they meet the destination policy criteria. Training is being prepared.

Bypass: Bypass time and patient holds have jumped, despite a mild influenza year. EMS is monitoring the system and will institute the capacity plans as needed.

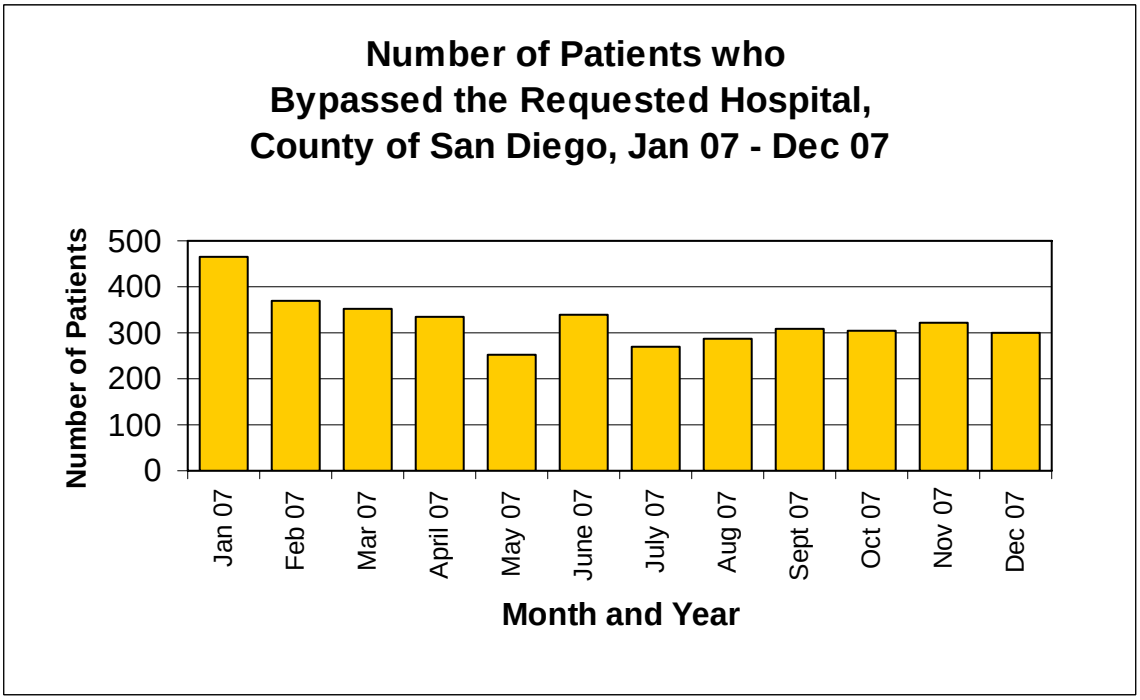
CPAP, In-service: This is an off year for protocol changes, but we will likely address two issues. One, CPAP demonstrates benefit for patients with cardiogenic pulmonary edema, and other causes of respiratory distress when used in the hospital. Most studies are in the ICU, but some are appearing having evaluated use in the ED. CPAP appears to lower deaths rate, prevent intubation, and lower complications such as ventilator associated pneumonia. There is some experience building in prehospital use and it seems successful in other parts of California. Three different devices have been evaluated by providers in the county and we will likely move forward by summer.

A broadened protocol for agitated delirium is being considered as well. This will focus on close assessment, attempts to prevent catastrophic deterioration, and use of midazolam for sedation.

Below are the patient destination data in graphic form:



Source: County of San Diego, Health and Human Services Agency, Division of Emergency Medical Services, MICN Records, Jan 2007 – Dec 2007 Note: Numbers based on Run Outcomes of Transport by Unit and Transport by Other



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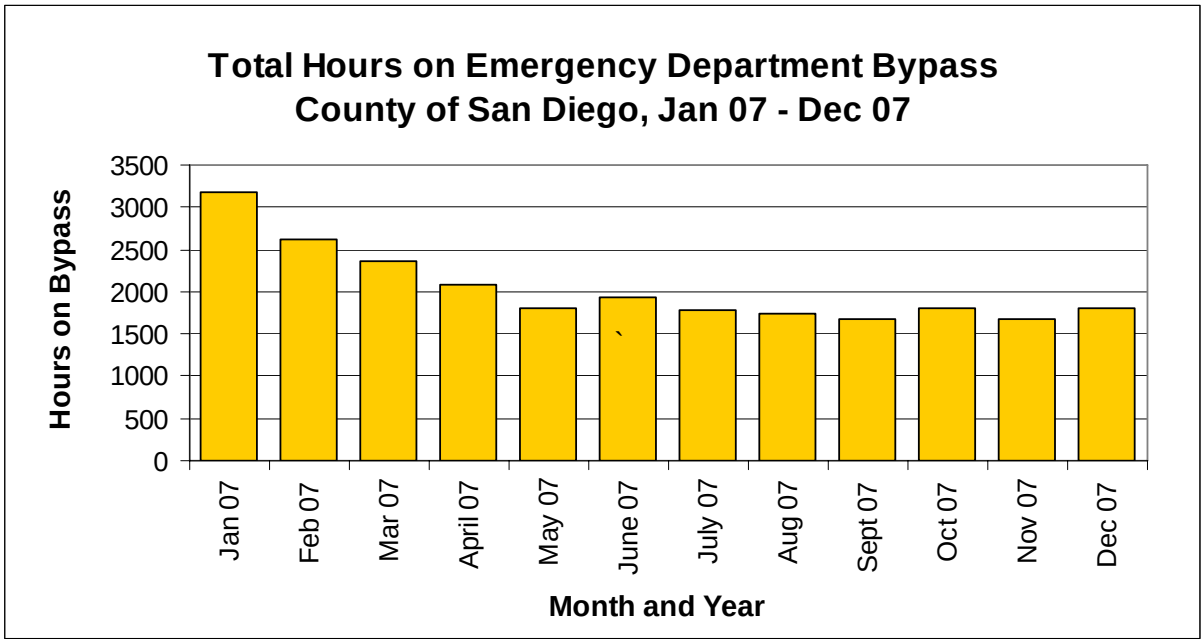

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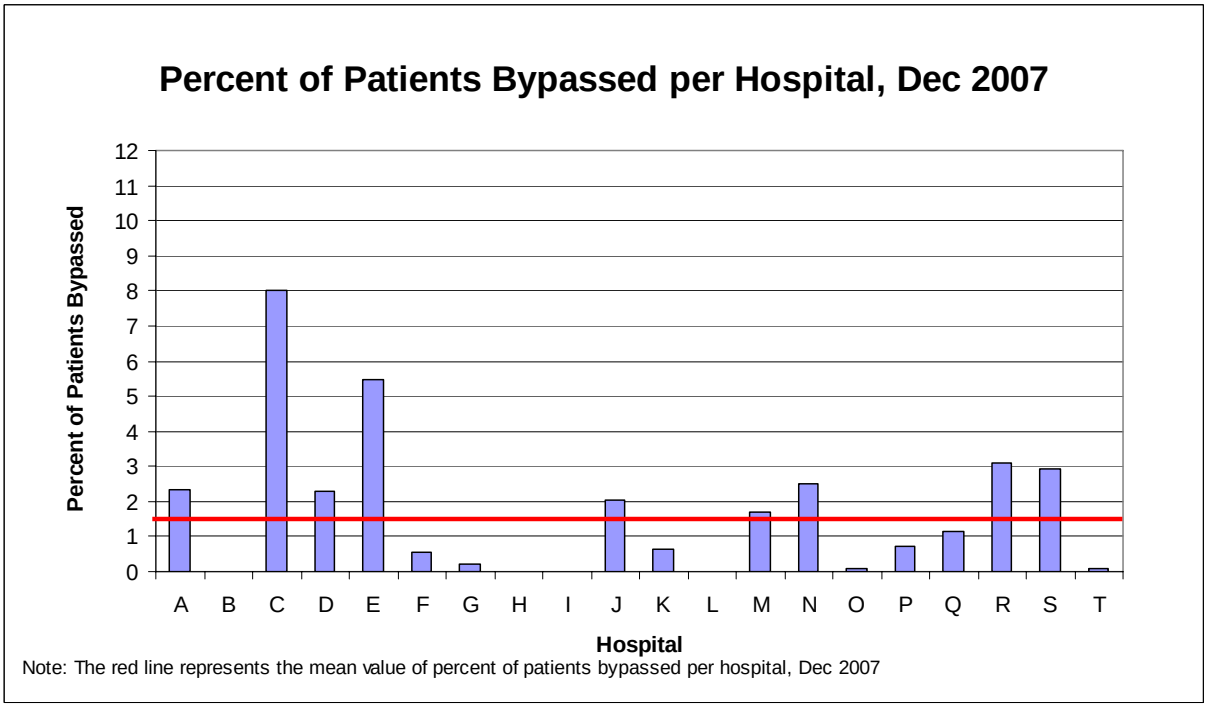

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Medical Director's Update for Base Station Physicians' Committee
March, 2008

Marcy Metz new EMS Chief: Join EMS in congratulating Marcy Metz as the new EMS Chief. You know Marcy in her role as acting chief and previously as Quality Improvement Specialist for prehospital programs. Marcy previously worked for Scripps Health including time as a Director of Emergency Services and Critical Care Services. Congratulations Marcy.

Barbara Byous our administrative secretary is retiring. Our thanks to her for all her hard work and contributions through the years. **Pauline Thomas** from Paradise Valley's ED has joined EMS in the disaster section working with facilities, including hospitals and skilled nursing facilities. An early goal will be following up on the fire response.

Bypass/Off Load Delays: The system has been busy. The attached graphs show fewer transports in February, but the number of calls to bases in the last few weeks has been substantial. We have experienced periods of high bypass and, of more concern, some off load delays in hospitals. The graphs show there are still substantial numbers of hours of bypass. The amount of true influenza suddenly rose several weeks ago, but has since receded. There is some influenza like illness, but ED visits for ILI have not been great in sentinel hospitals. Hospitals are reminded to use the Capacity Plan to maintain the ability to take patients, and hopeful, hold as few patients as possible for admission. We continue to work with the hospitals and field on specific issues.

Infectious Disease: EMS met with the public health laboratory and the medical examiner's office to streamline specimen collection and testing for exposures when patients die in the field. We will keep providers informed as this develops.

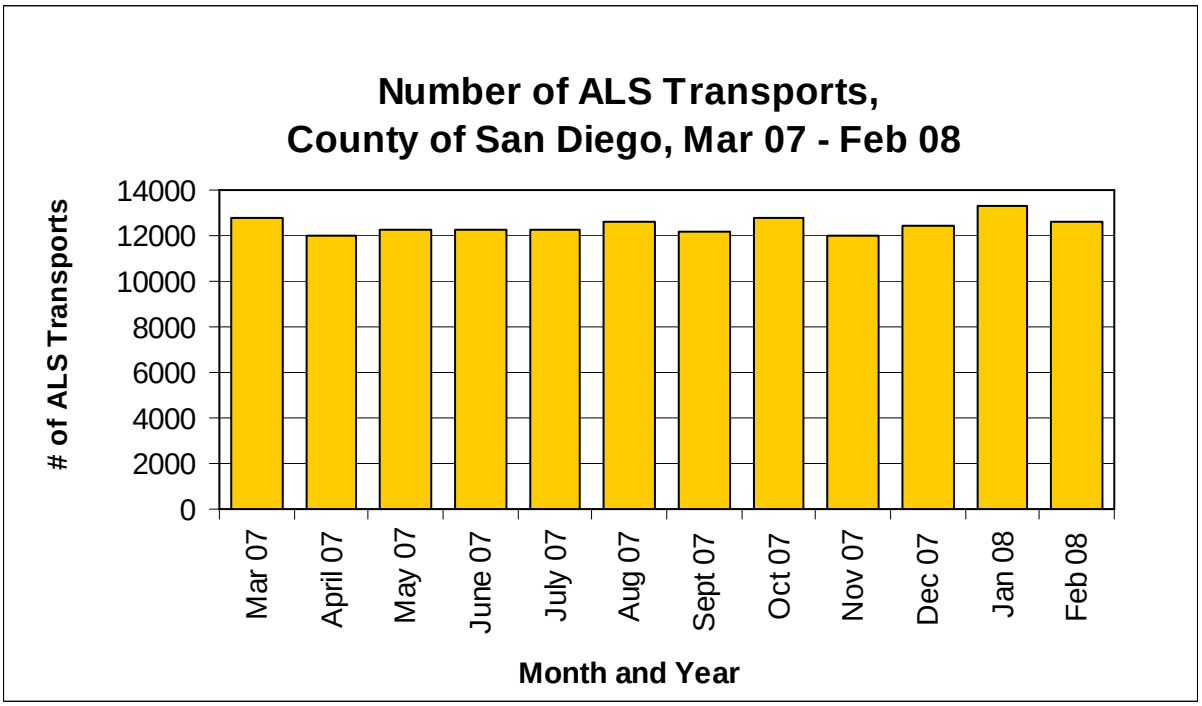
ROC: Some training remains to be completed, and some community consultation must be finished, but the ROC study should be underway in the City of San Diego in the near future.

STEMI: Door to balloon times are excellent for activated patients. Thank you for all your work on this. Remember that quality EKGs are important to avoid false positives. We encourage the field

to read the entire interpretation to give the base a chance to hear the complete interpretation. This also may help with false positives, or give important information. Mimics like atrial flutter and other SVTs also cause false positive EKGs. In addition, patients with symptoms that are not typical of MI are more likely to end up with false positive EKGs.

In-service: We plan on focusing on CHF treatment, especially on getting CHF patients early nitroglycerine, rather than initial treatment with albuterol and Atrovent. CPAP will be added as an optional skill, and will present another treatment option for the severe patient.

Below are the patient destination data in graphic form:



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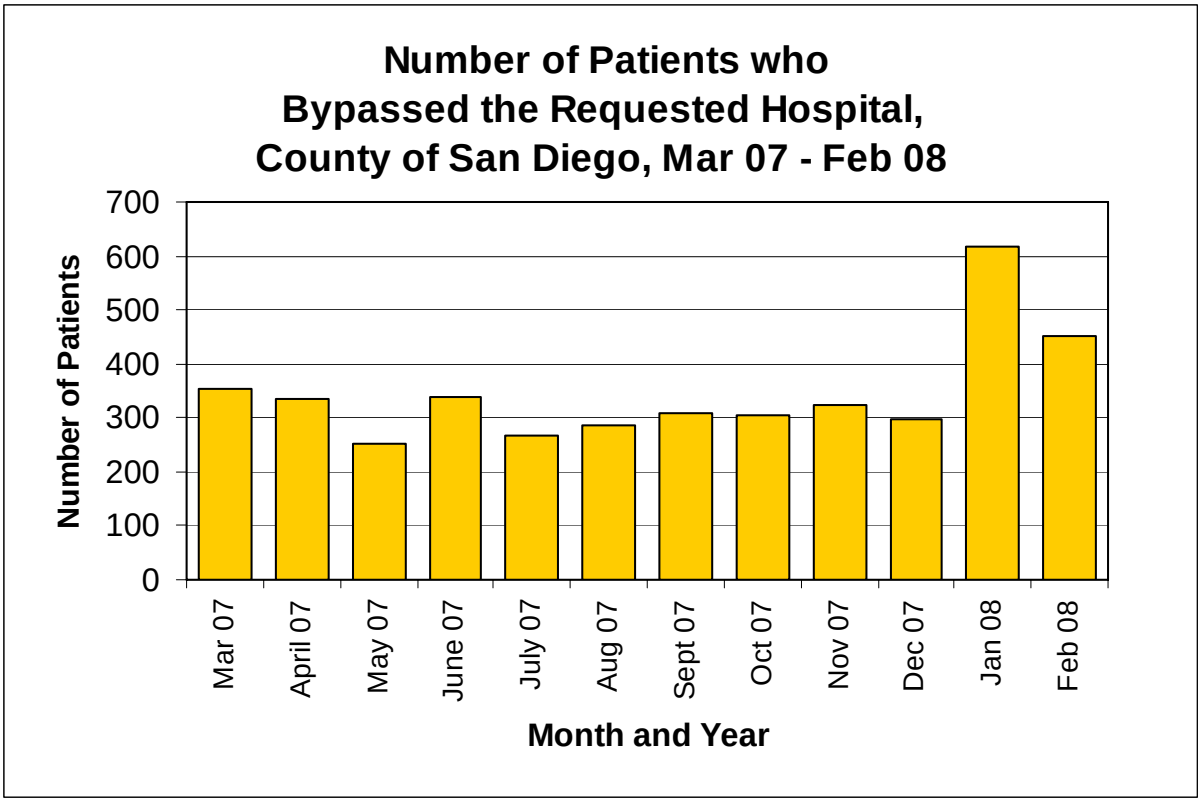

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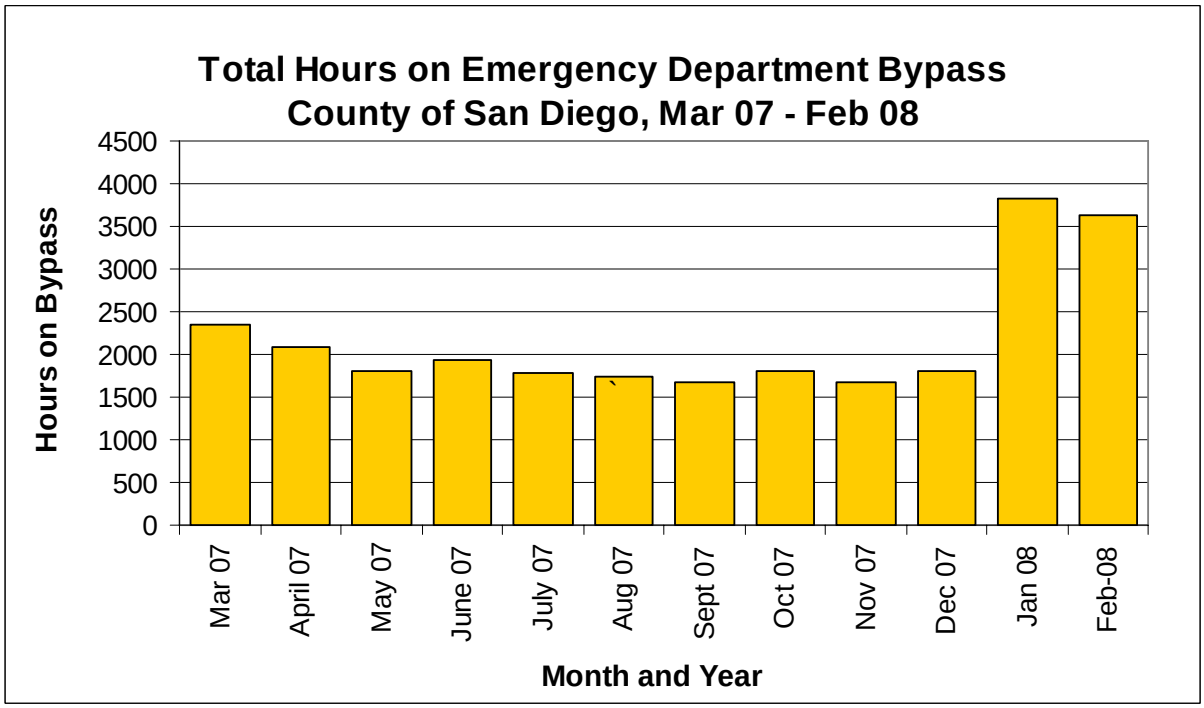

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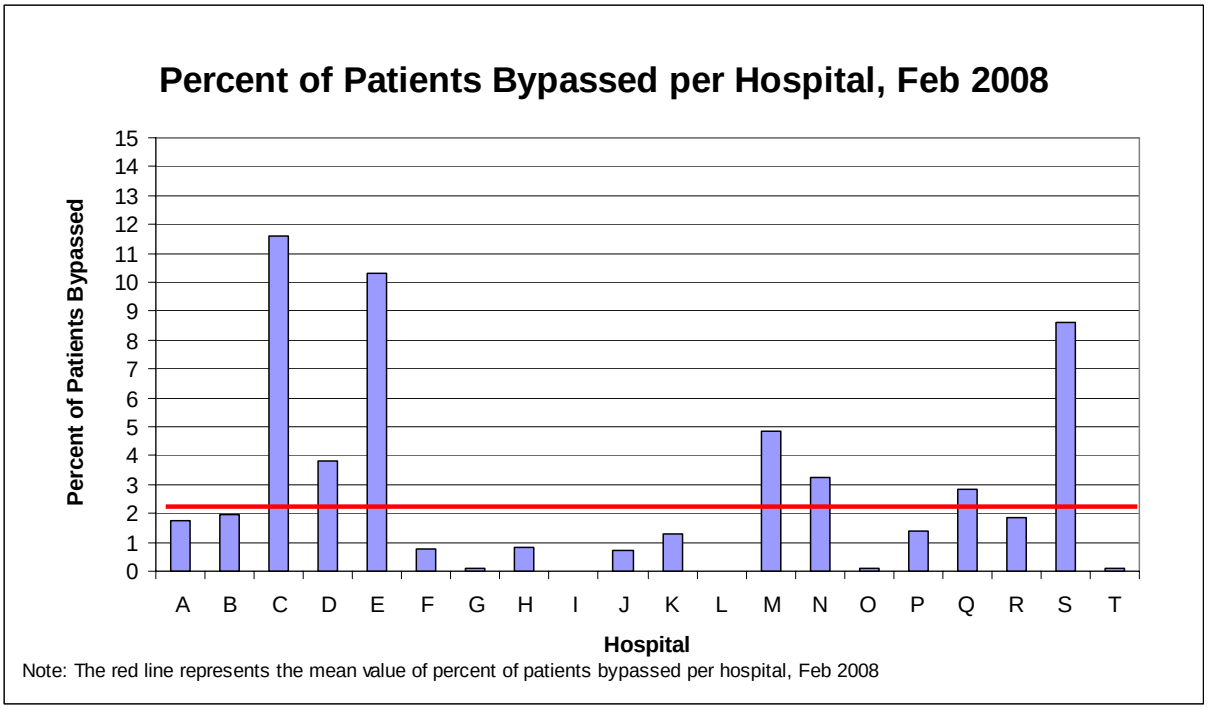

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Medical Director's Update for Base Station Physicians' Committee
April, 2008

Safe Surrender: The safe surrender program is scheduled to expand into fire stations at the end of April. This will allow a child's caretaker to surrender the infant anonymously within 72 hours of birth. The program seeks to prevent deaths of abandoned infants in restrooms, dumpsters and other locations. Training is underway and should include anyone stationed in a fire house so they can receive the surrendered infant if necessary. Procedures allow the infant to be identified by the mother or other surrendering caretaker for a period afterward, so they may reclaim the child. An important part of the surrender process is the family medical history document included in the supply packets. The surrender period may be the only time important family medical history is obtained, and a maximum effort should be made to get the family to complete the history form before they leave the station. The surrendering person has the right to take the form, complete it later, and mail it in. This seems less likely to result in a completed form, so I would encourage all personnel to get the family to complete the form in the station, or impress upon them the importance of returning the form if they do say they will complete it later.

Bypass/Off Load Delays: Bypass hours and the number of patients who bypass the requested hospital are down from earlier in the year, but still substantial. As mentioned last month, we have experienced some off load delays. Hospitals are taking a variety of actions to improve the situation and we are in frequent contact with them. Upon the suggestion of EMOC, EMS is looking at memorializing in the bypass policy some of the changes instituted in the last few years. Hospitals are reminded to use the Capacity Plan to maintain the ability to take patients, and hopeful, hold as few patients as possible for admission. Hospital staff should make every effort to greet arriving field personnel with eye contact and information about the current status. Hospital staff should also remember they are responsible for the patient upon arrival, both for assessment and ongoing treatment. We continue to work with the hospitals and field on specific issues. EMS thanks everyone, field and hospital based, working so hard to make the system work for patients. Thanks.

EMS: Please welcome Karen Crie as the new administrative assistant in EMS working with myself and Marcy. Karen comes to us from outside the county, with extensive experience in small

business.

AHA CPR: The American Heart Association changed its recommendations for bystander CPR two weeks ago in a science advisory designed to increase the number of arrest victims who receive bystander CPR. “When an adult suddenly collapses, trained or untrained bystanders should—at a minimum—activate their community emergency medical response system (eg, call 911) and provide high-quality chest compressions by pushing hard and fast in the center of the chest, minimizing interruptions” the advisory states. Bystanders not trained in CPR should provide “hands-only” CPR. A bystander previously trained in CPR could provide either conventional 30:2 CPR or hands-only CPR. Anyone not confidant in their ability to provide conventional CPR should perform hands-only CPR. Hands-only CPR should be continued until an AED arrives and is ready for use or EMS providers take over care of the patient. The advisory does not address professional rescuers. It focuses on adults or children with sudden collapse likely from a cardiac cause. The AHA encourages the public to obtain CPR training, since it includes skills applicable to those with asphyxial arrest, including children, and those with airway obstruction, drowning, respiratory diseases, apnea and other causes of hypoventilation.

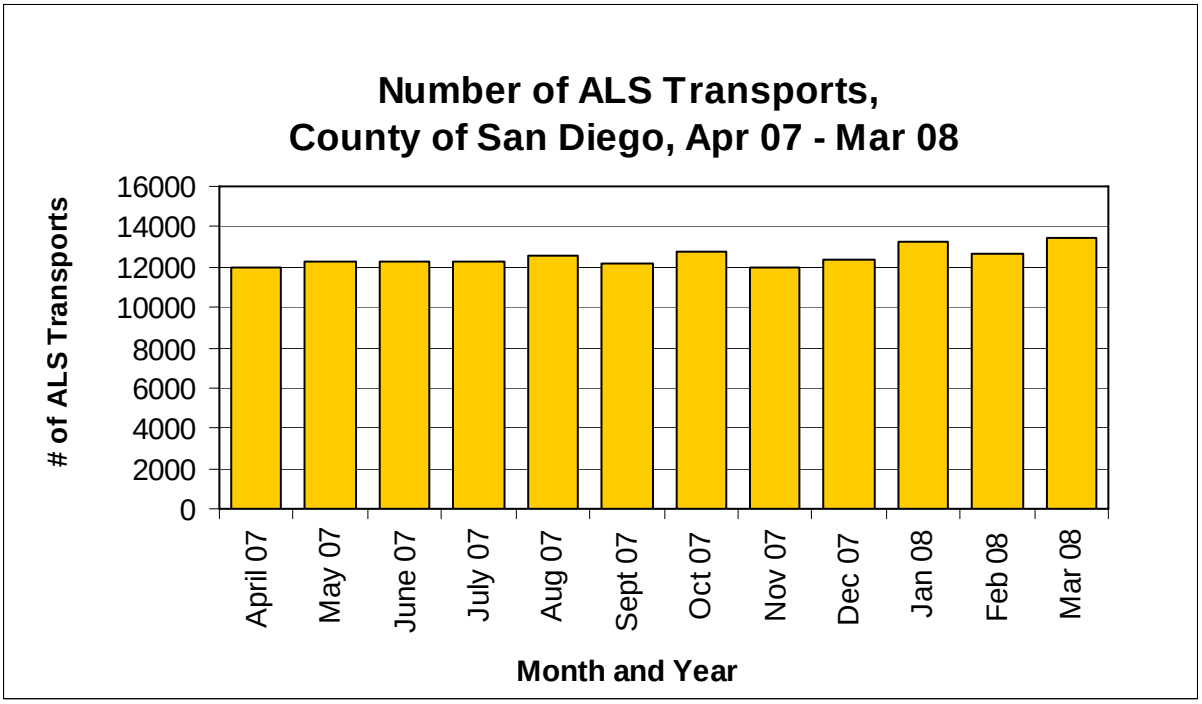
Infectious Disease: A new infectious disease exposure policy will be released soon. Please review that when it is out. Remember the first step is to ascertain there has been an exposure, defined as a contact that can result in transmission of the infectious agent. Another critical issue is the importance of starting prophylaxis for HIV within the first several hours of the exposure to minimize the chance of contracting the disease. New procedures are being developed for Designated Officers (field providers), the Medical Examiner, Public Health lab and EMS for exposures resulting from patients who are medical examiner cases. We will keep providers informed as this develops.

STEMI: Door to balloon times are excellent for activated patients. For the system’s first year, the median door to balloon time for activated patients was 62 minutes. That’s a remarkable achievement for both the field and the hospitals working together. The reduction in door to balloon times will lower death rates and improve outcomes of STEMI patients. Of all activated PCI patients, 89% had their procedure within 90 minutes. Thank you for all your work on this. Remember that acceptable quality EKGs are important to avoid false positives. There was a spike in false positive cases in the fourth quarter. We encourage the field to read the entire interpretation to give the base a chance to hear the complete interpretation. This also may help with false positives, or give important information. Mimics like atrial flutter and other SVTs also cause false positive EKGs. Pacemakers will frequently be read as STEMIs. In addition, patients with symptoms that are not typical of MI are more likely to end up with false positive EKGs.

In-service: CPAP will be added as a treatment for respiratory distress patients, with a particular focus on pulmonary edema. CPAC is working to select uniform CPAP equipment in the county. The focus on pulmonary edema includes getting CHF patients early nitroglycerine, reserving albuterol and Atrovent for patients with possible mixed pulmonary/cardiac disease, rather than initial focus on wheezing. Midazolam will be added as a treatment option for severely agitated patients, especially those with agitated delirium or stimulant intoxication. Information on Taser use will be included as well.

Stroke: Hospital reviews for the new destination policy will occur this summer. More information will be available then on any system impact or changes.

POLST: There is interest in a new intensity of treatment form called the POLST, or Physician Orders for Life-Sustaining Treatment. This is used in Oregon and is attracting interest here in California. The POLST has resuscitation preferences or DNR information, but also includes patient desires for comfort measures only, limited additional interventions, or full treatment. There are separate areas for antibiotics and artificially administered nutrition. We will keep you posted.
Below are the patient destination data in graphic form:



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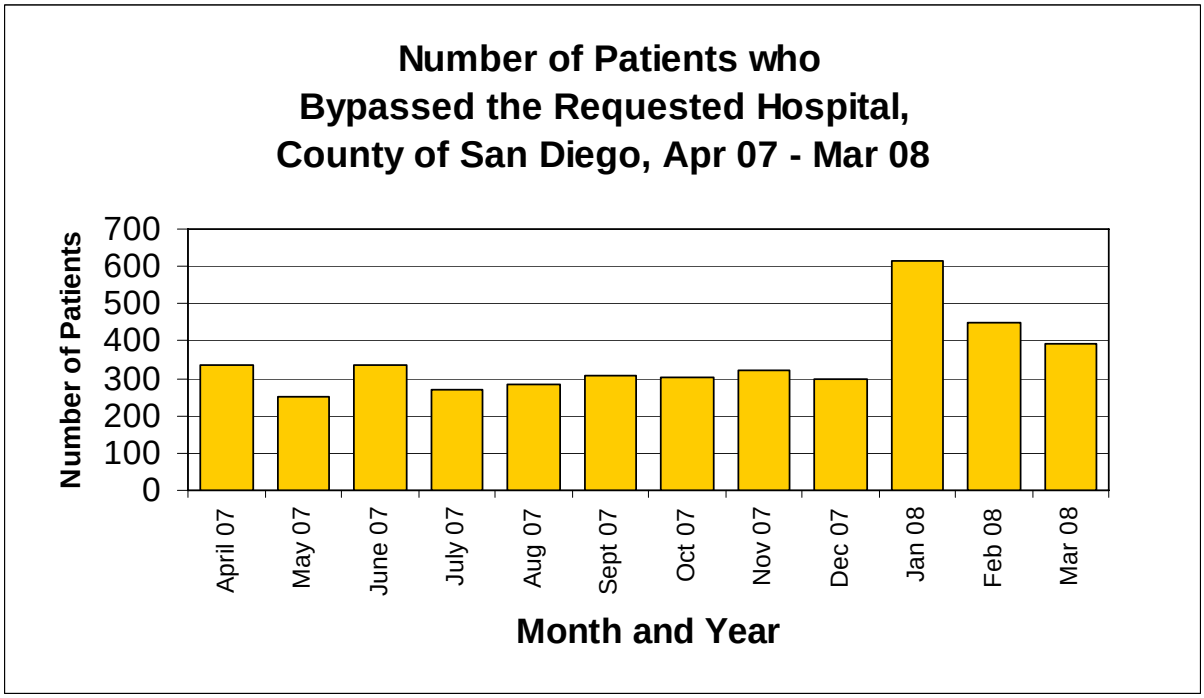

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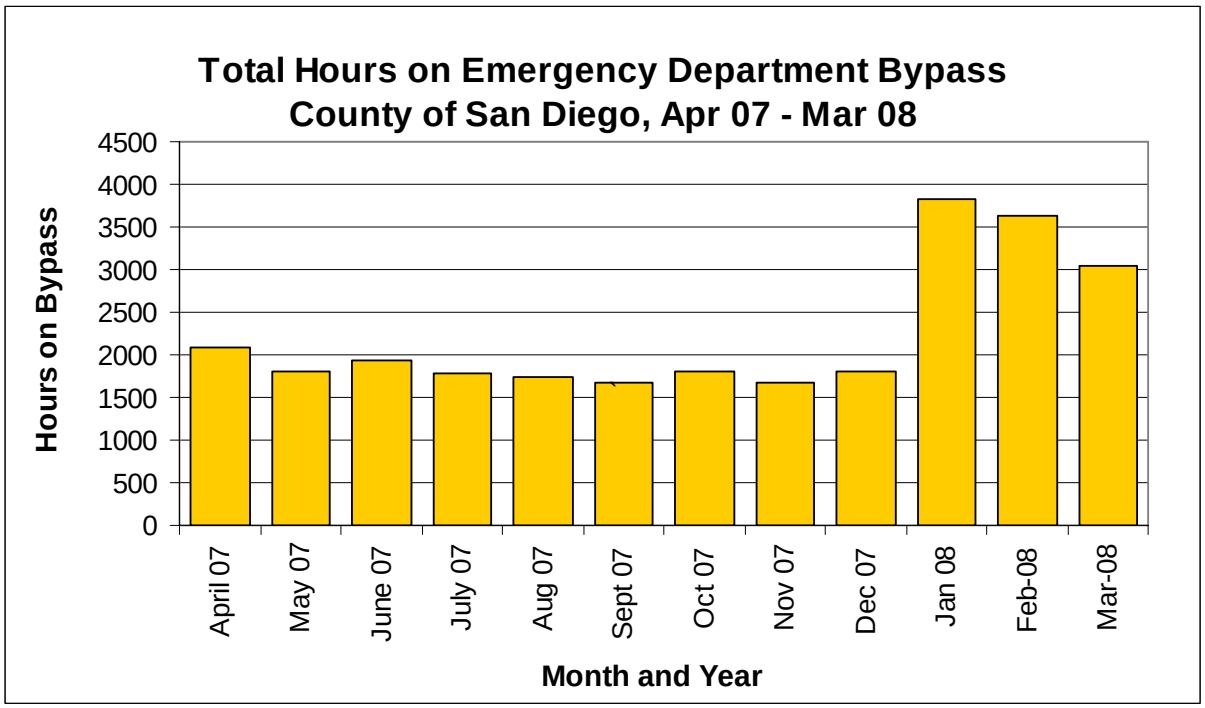

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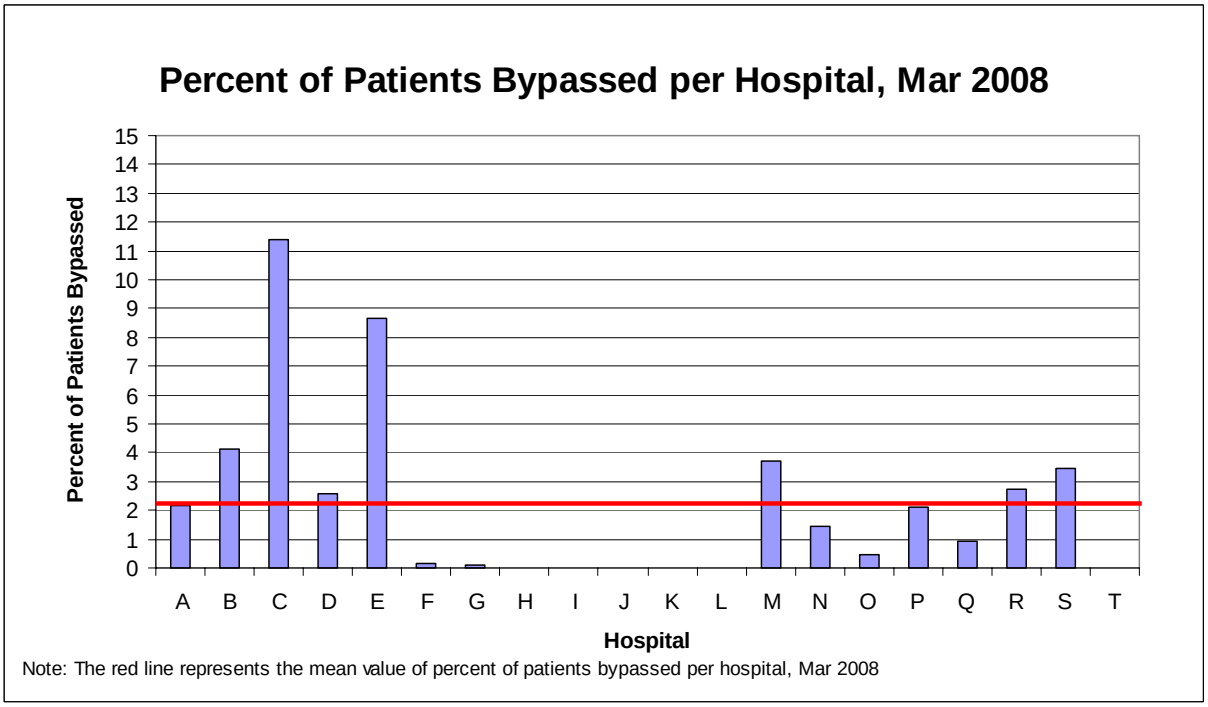

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In-service: This year's in-service will address changes in the respiratory distress protocol, as well as overdose and behavioral issues. We will focus attention on encouraging more specific treatment of CHF with nitrates, reserving bronchodilators for COPD/asthma, adding them to presumed CHF only when wheezing is prolonged and unresponsive to nitrates. Continuous positive airway pressure or CPAP is added to the protocol for CHF and COPD/asthma. Literature shows that in the hospital ICU setting CPAP prevents intubation and likely reduces mortality. The same is thought to be true for patients in the ED. There is little outcome experience with field use, but initial reports are encouraging and the benefits are likely to extend to field use as well. Morphine will be deleted, with the focus shifting to nitrates and CPAP.

Sedation with midazolam is being added to stimulant intoxication, agitated delirium, and severe agitation under the overdose and behavioral treatment guidelines. This will help improve patient care and protect both patients and rescuers. Field treatment of patients "Tasered" is added as well.

Stroke care will be reviewed in anticipation of the new stroke destination policy taking effect in the next few months that will direct acute stroke patients to approved hospitals. The trauma decision tree has been modified by MAC, based on changes in the American College of Surgeons' "Green Book."

Safe Surrender: Fire stations are now added to the locations where a mother or other person can surrender a newborn within 72 hours of birth. Please remember the importance of obtaining the family medical history if at all possible before the mother/caretaker leaves. The mother has the right to leave without completing the history, and to send it in later via mail. We are most likely to get this critical information if done at the time, however. The county protocol is on our website.

Bypass/Off Load Delays: Bypass hours and the number of patients who bypass the requested hospital are down from earlier in the year, but still above the previous baseline. EMS continues to look at off load delays.

New EMSA Director: Dr. Steven Tharratt was named the new state EMS Authority director by the governor. Dr. Tharratt is currently the medical director for the Sacramento EMS agency and the Sacramento City and County fire departments. He is on the faculty in the pulmonary/critical care section at the University of California, Davis School of Medicine, and has been active in the poison control center network. Dr. Tharratt is currently on the EMS Commission.

He has long been active in hazardous materials and disaster response preparedness, working in the EMS community, but also with state OES and national organizations. Dr. Tharratt is widely respected. Join us in congratulating Dr. Tharratt on his appointment.

OPALS Trauma Study: The OPALS study raised new questions about the benefits of ALS procedures in trauma victims. The Ontario Prehospital Advanced Life Support (OPALS) study is a before-after systemwide controlled clinical trial conducted in 17 Canadian cities. It evaluates the benefits of adding ALS care in a variety of clinical conditions, after systems are optimized for performance.

In this study, 1,373 BLS patients were compared to 1,494 ALS patients and found to be similar in baseline characteristics such as age, percent blunt injury, severity, and percent unconscious. Overall survival was the same in both groups, 81.1% BLS vs 81.8% ALS. Among unconscious patients (GCS <9), survival was significantly lower in the ALS group (50.9% vs 60.0%). The authors called for re-evaluation of the indications for and application of prehospital ALS measures in major trauma patients. One specific finding was that prehospital intubation was associated with higher death rates.

Dan Davis wrote the editorial which accompanied the OPALS report. He reviewed some of the reasons why intubation might be associated with worse outcomes, focusing on lessons learned about hyperventilation, oxygen levels, and the intubation process, and how those might be improved.

The take home message for now would emphasize not delaying transport for extended scene interventions in the severely injured patient. Also, ventilating patients slowly and carefully avoiding hyperventilation. We will keep you posted on further developments and analysis. The article may be found in the Canadian Medical Association Journal, April 22, 2008, (CMAJ 2008;178(9):1141-1152.)

Los Angeles 12-lead Study: An evaluation of early results from the Los Angeles cardiac receiving system says that the number of false positive EKGs could outnumber the true positives if the number of STEMIs is low. It is known that a positive test is likely to be false positive if the prevalence or occurrence of the disease is low. This evaluation of the LA system said that when patients had chest pain, the prevalence of STEMI was 6.6%. When the patient had “atypical” symptoms rather than chest pain, such as isolated shortness of breath, altered level of consciousness, syncope, weak and dizzy, abdominal pain, nausea and/or vomiting, seizure, head pain, or “other”, the prevalence of STEMI was 0.9%. At those levels, an EKG positive for STEMI was more likely to be false positive than true positive.

The authors point out that support for field triage and activation will erode if the majority of activations and triages are erroneous. They also say that human interpretation may not lead to substantial improvement over computer interpretation if the prevalence is low. (Youngquist et al,

Academic Emergency Medicine 2007;14:1165-1171. December 2007).

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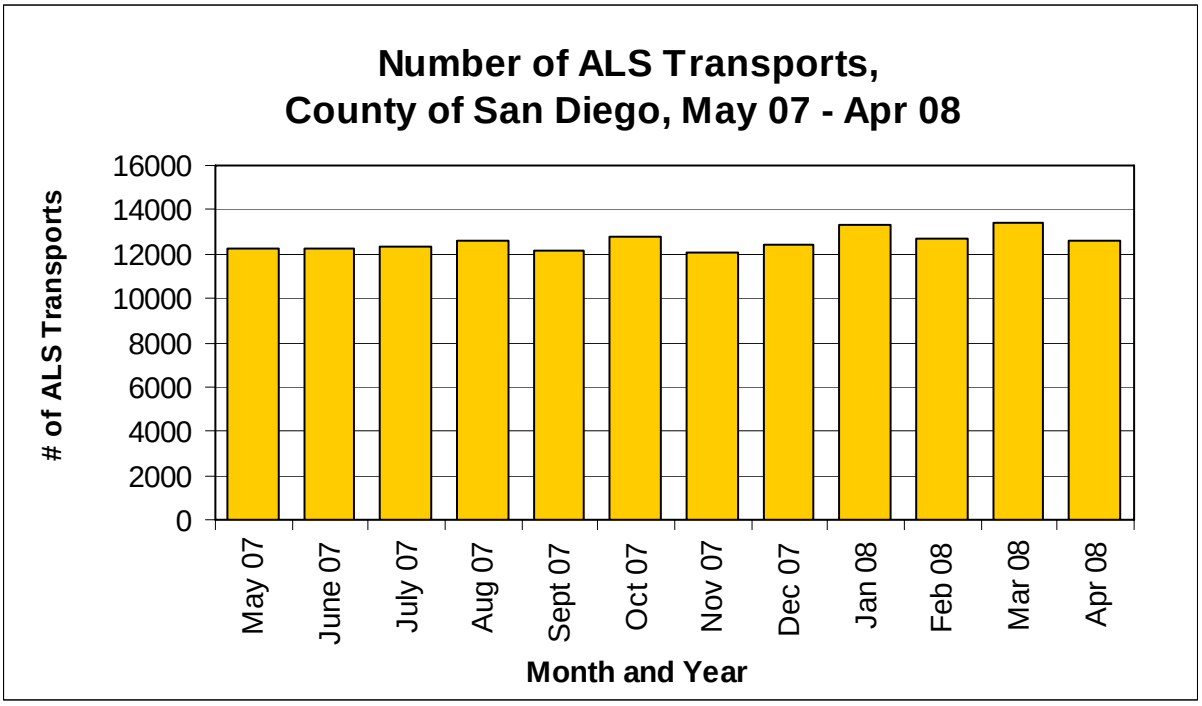

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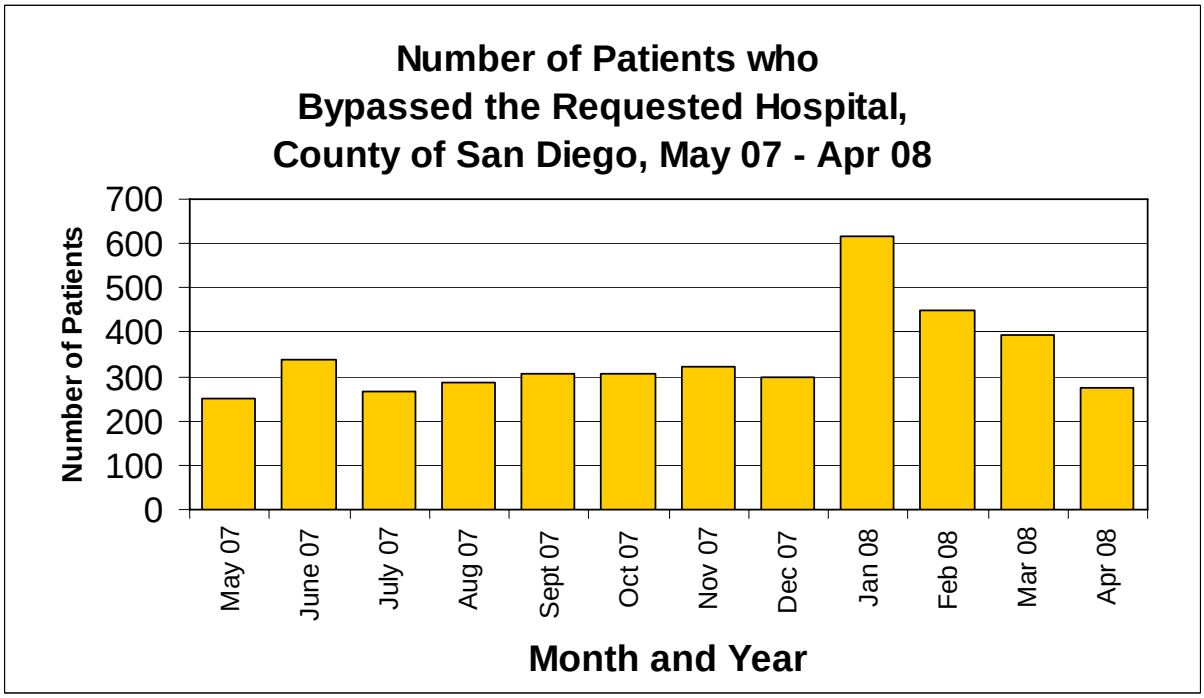

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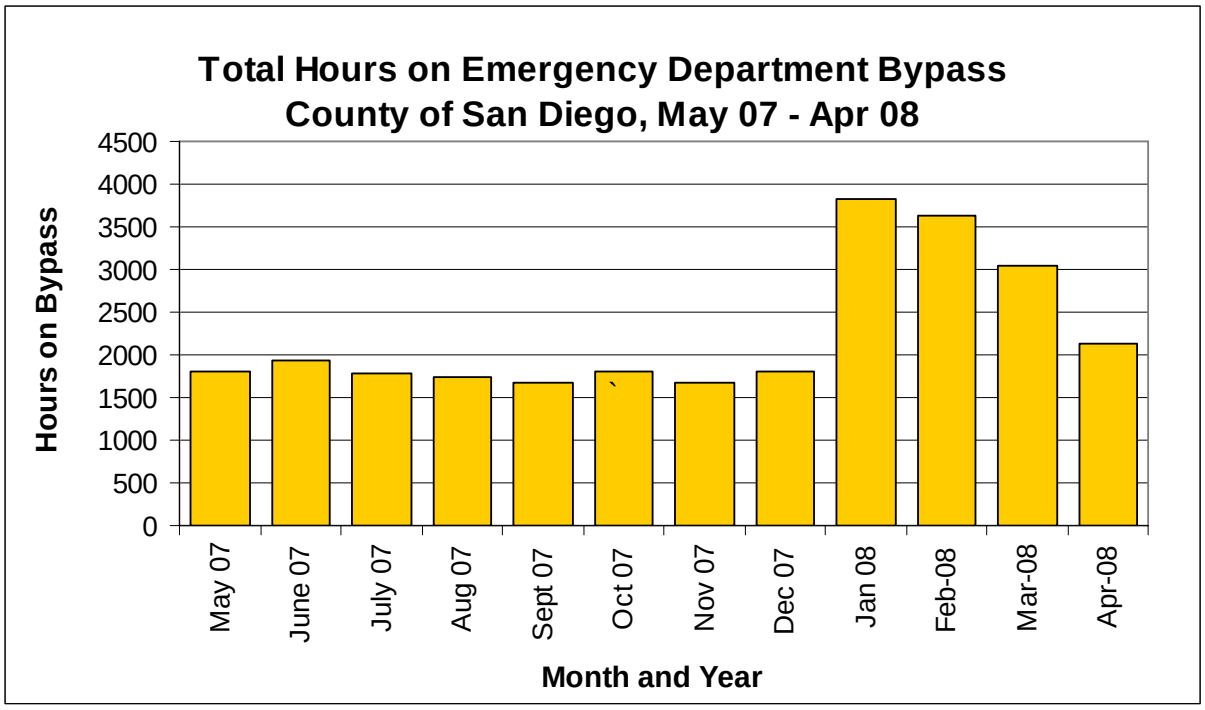

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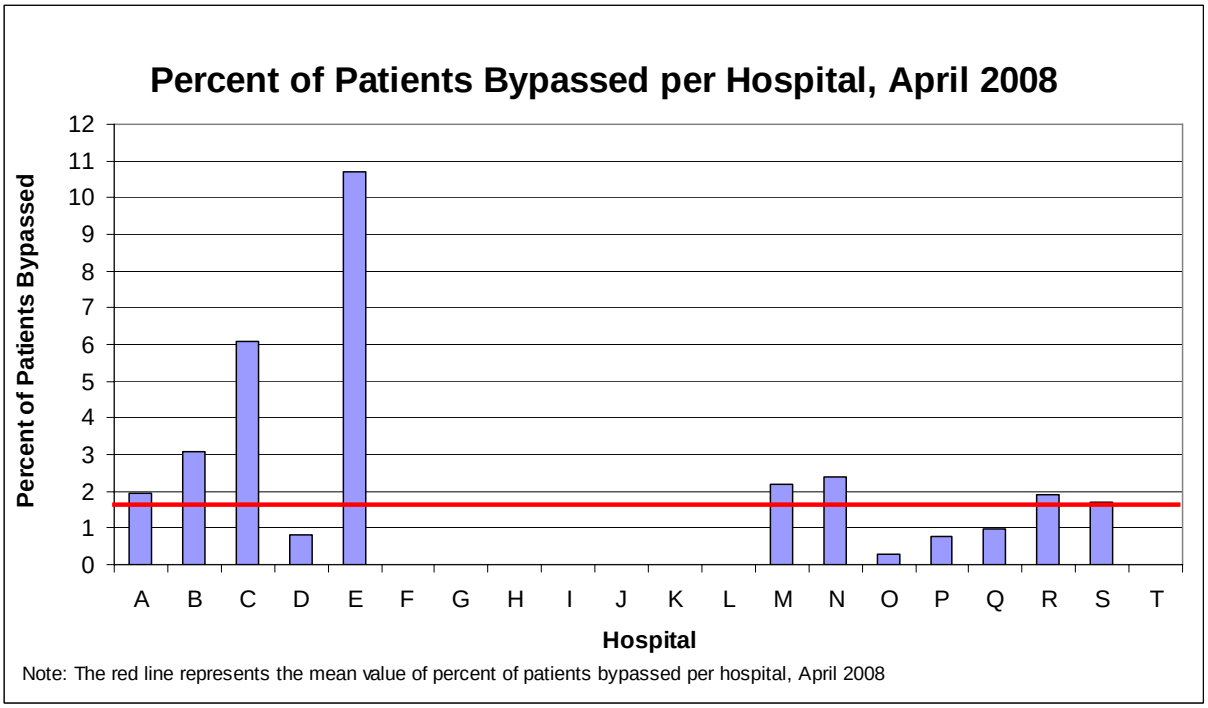

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Medical Director's Update for Base Station Physicians' Committee
June, 2008

New HHSA Director: Jean Shepard retired as the Director of the Health & Human Services Agency on June 5, 2008. She was honored that day by the Board of Supervisors, as well as former directors and staff, current staff and many others for her 32 years of service to the county. A wide range of individuals from the community lauded her for her contributions to the health and welfare of our community. EMS will miss her.

The new director is Nick Macchione who was the Agency Deputy Director/Regional Manager of the North Coastal Region for HHSA. As such, he has been involved in many of the health issues in the county. Macchione's background is in public health. He has a degree in biology from Rutgers State University, and Master's degrees from New York University and Columbia University.

In-service: Several issues deserve clarification from this year's in-service. The age for CPAP will be 15 years old and above. There should not be deviations to use it at younger ages, until we gain more experience with the treatment.

Remember that sedation with midazolam for behavioral use should be limited to cases where a patient's behavior is a threat to themselves or others. Patients, especially the elderly, should not be sedated for simple, controllable agitation. For stroke care, remember that a patient should be identified as an acute stroke patient only within the three hour time period, and with clear symptoms/signs of a new deficit. Generalized symptoms such as weakness or altered mental status do not qualify.

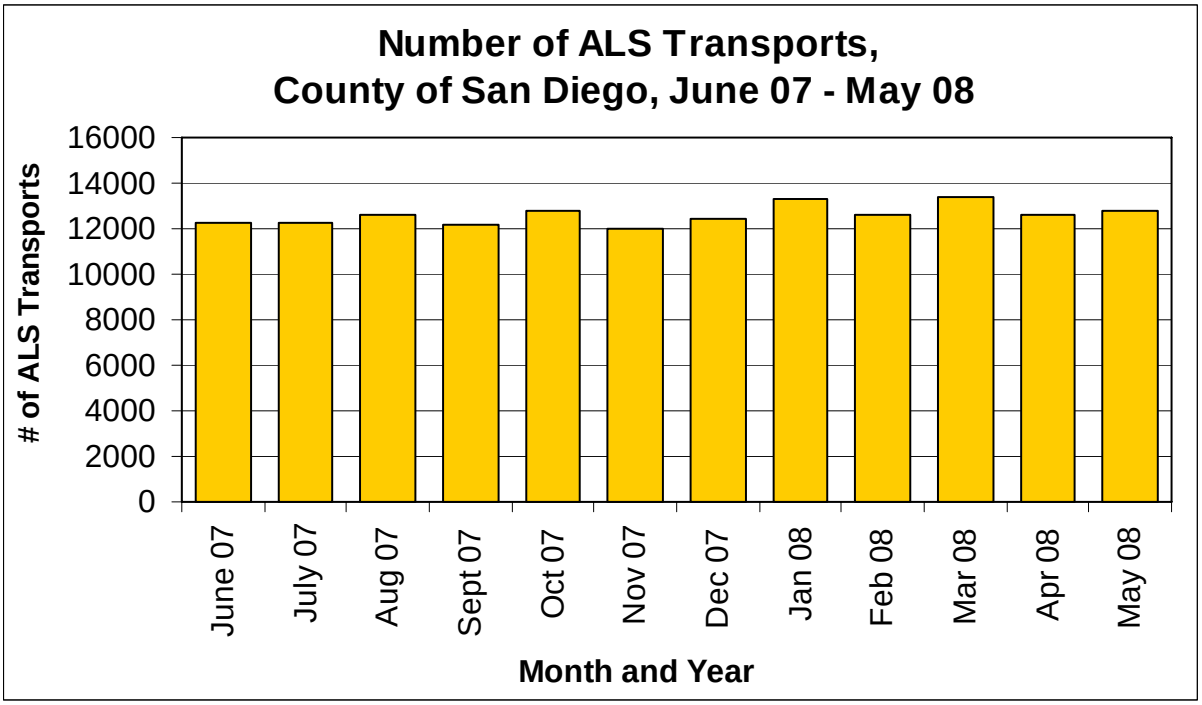
Bypass/Off Load Delays: See below for the most recent bypass numbers. We have included some historic data going back to 2000 which shows that early in the flu season it was busy compared to recent years. We will be reviewing and revising the Capacity Plan this summer, well before the winter flu season. One goal is to address off load delays, and include new information on ED/hospital "overcrowding" based on the new attention this subject is receiving at the national and state levels. Preventing off loads will be a focus.

Remember the EMOC Overcrowding Summit will be Wednesday October 8, 2008.

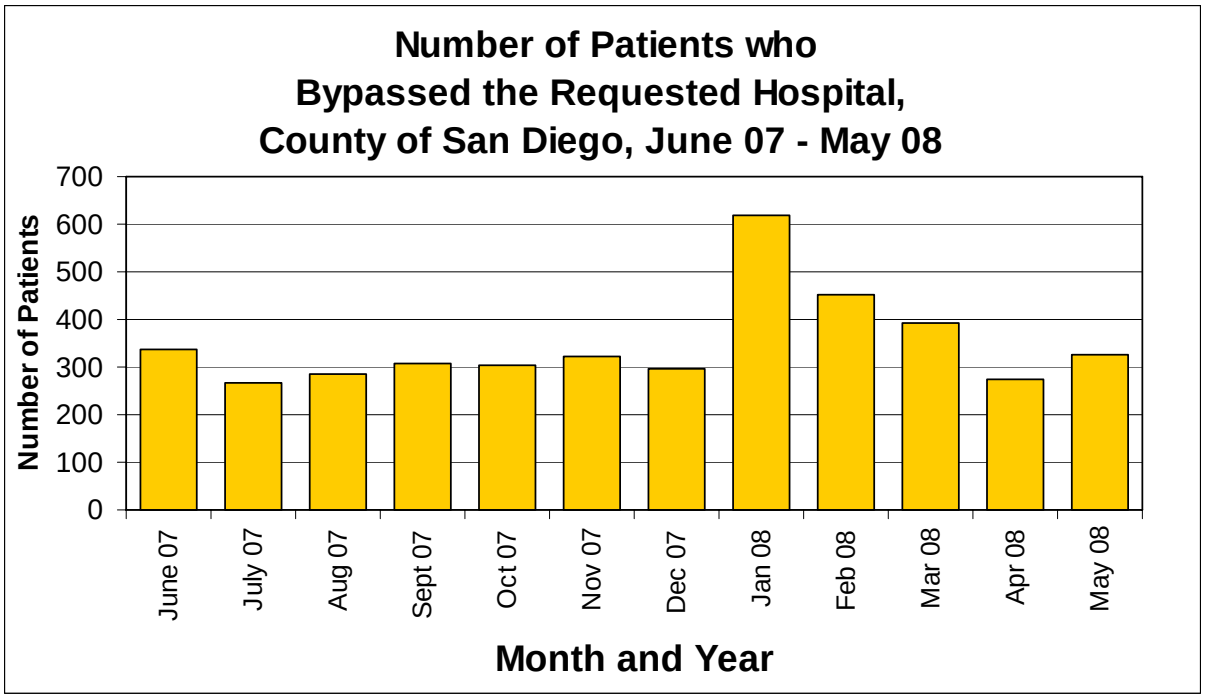
Earthquake Drill: This fall's disaster drill will be an earthquake scenario on the Southern San Andreas fault. This means San Diego will be serving as a reception area for casualties from surrounding counties. It is a good opportunity, however, to look at your own hospital preparedness for an earthquake, and focus on issues such as preventing and coping with non-structural damage, and continuing operations despite damage to the facility and community. I will address this more in future updates.

Stroke reviews: Hospital reviews for new the new stroke destination policy will occur this summer.

Below are the patient destination data in graphic form:



Source: County of San Diego, Health and Human Services Agency, Division of Emergency Medical Services, MICN Records, June 2007 – May 2008 Note: Numbers based on Run Outcomes of Transport by Unit and Transport by Other



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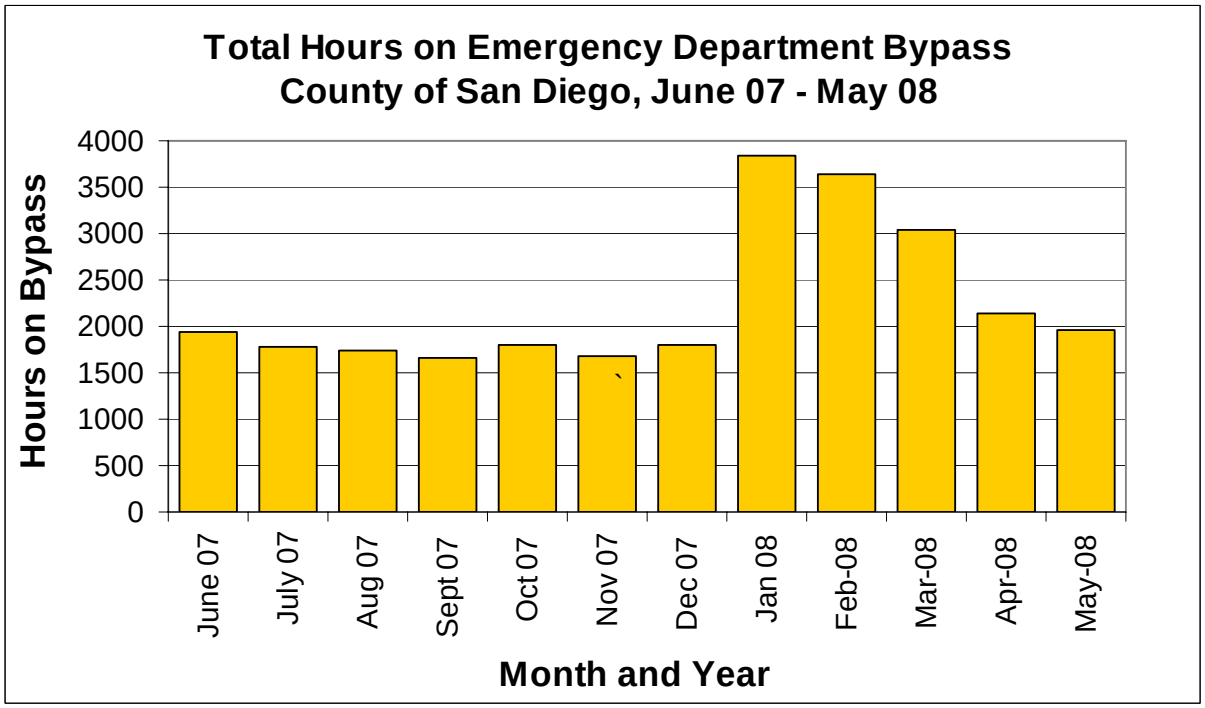
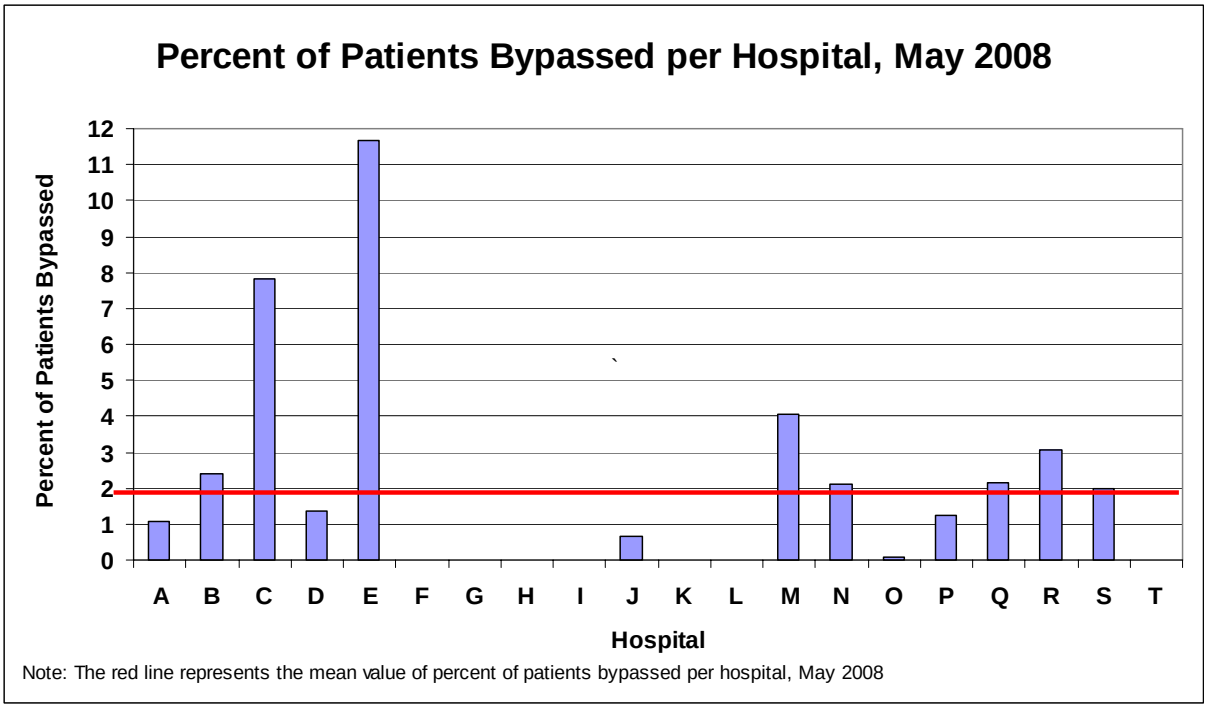
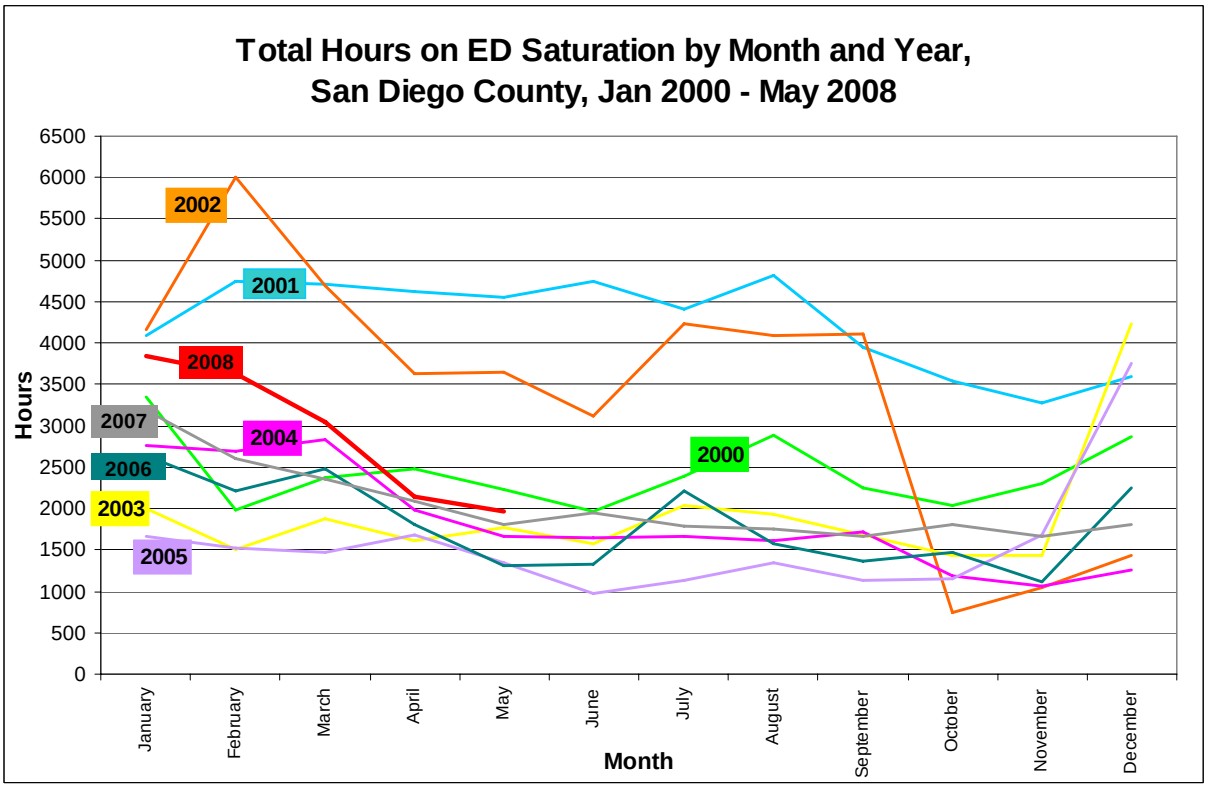


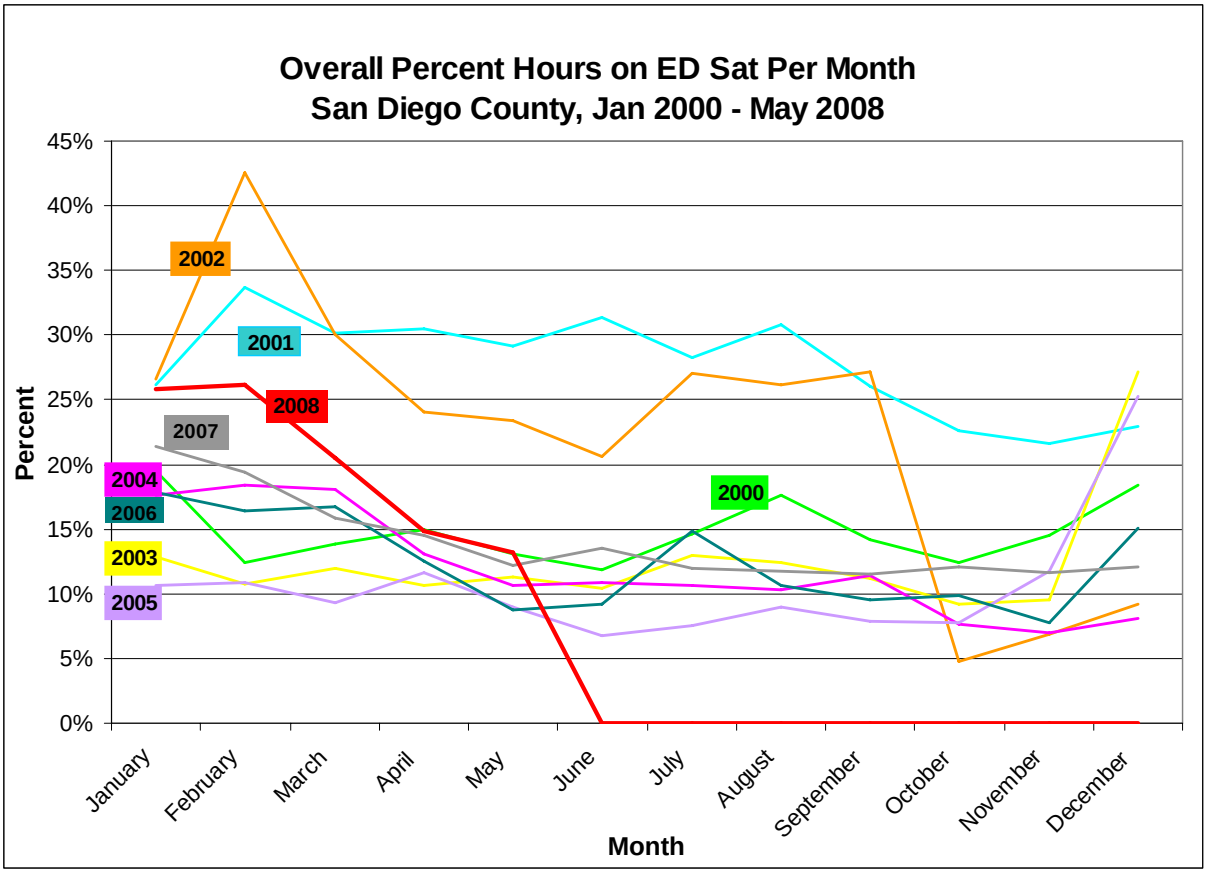
Source: County of San Diego, Health and Human Services Agency, Division of Emergency Medical Services, MICN Records, Jun 2007 – May 2008



Source: County of San Diego, Health and Human Services Agency, Division of Emergency Medical Services, MICN Records, May 2008 Note: Numbers based on Run Outcomes of Transport by Unit and Transport by Other



Source: County of San Diego, Health and Human Services Agency, Division of Emergency Medical Services, MICN Records, Jan 2000 – May 2008



Source: County of San Diego, Health and Human Services Agency, Division of Emergency Medical Services, MICN Records, Jan 2000 – May 2008

Note: 2008 line extended to June due to chart formula, no data for this future date