

10/21/2020 Medical Control Board (MCB)

1600 Dr Kim Pruett calls meeting to order

Attendees: Dr. Kim Pruett, Dr. Ian Medoro, Dr. Jot Khalsa, Dr. Dorothy Habrat, Chief Chris Ortiz, DC. Dave Chapek, Capt. Stephanie Perea, Fellow's Dr Spigner.

Approval of the Agenda motion by Dr. Jot Khalsa Second by Dr. Ian Medoro.

Motion to approved passed unanimously.

Reviewed last month's minutes and motion to approve by Dr. Khalsa second by Dr. Medoro

Motion to approved minutes passed unanimously.

Hospital Systems Reports

Lovelace- Nothing to report

VA- still setting up neuro stroke program

Presbyterian- Dr. Medoro-COVID numbers increasing, no problems last month with building the bridge. Expanded the ECMO program at Pres. with a new portable pump, not hand crank. Starting a transport process from Rust to Pres down town. We've been practicing with the ICU team, this is a critical care transport only. Developed to transport patients who meet ECMO criteria from Rust to Pres down town. We are able to do this now.

UNM- Volumes high last several weeks with lots of surprise Covid cases. Lots of boarding with trouble with discharges to homeless shelters and SNIFS due to the recent surge in cases. ICU volumes of this morning are 114% of normal with 37 Covid positives and 1 positive Ped.

Old Business

Nothing to report

New Business

PAC- Chief Ortiz-No new updates. Meet up again early Nov. Covered last meeting minutes last MCB

EOC: Looking at operationalizing something for those who are experiencing homelessness who are discharged from the hospital to be able to return to their congregate sites. The hotels or the (WAC) West side homeless. West side homeless shelter was shut down for a week due to large Covid outbreak. Ending Thrus., tomorrow, and we are trying to formalize a process to where the hospital care management teams would contact the EOC to let them know if they had someone experiencing homelessness who was either Covid positive, under suspicion, or just needed some sort of step down medical acuity. We would work with those facilities to find out what vacancies they have available and coordinate transfer from those facilities to the hotels. They had a lot of this built early on, and now there is an uptick they are trying to revamp it. We want to make a seamless process for the hospitals so the folks aren't sitting in the ED or as Admits when all they need is transfer back to the congregate sites.

Protocol Updates- Dr Kim Pruet: We are in the midst of overhauling the Procedure pages. Dr. Spigner is heading up that project. At the point that we will roll out small changes and big changes together in Jan. to minimize crews having to keep up with the changes all the time.

Opened for discussion-no discussion.

Research- Dr. Medoro- Working through the data use agreement for UNM and Pres for the Mosimo project. DUA started now so it should go quickly.

Public Comments

Chief Rose: BCFD is trying to get their ventilators calibrated to work asynchronous with compressions to work with the auto pulse. Trying to make sure that we are not throwing thoracic pressures through the roof. Otherwise we will use the manual function on the parapack in which we can set the vent rate and tidal volume and then manually deliver those ventilations on the upstroke of the mechanical device. Machine will not allow us to vent faster than the set rate but will get us the desired tidal volume.

Second Item-Law enforcement protocol for patients in custody. Our protocol states that (LE) is not permitted to transport to the hospital when the patient asked to be transported by ambulance. Exceptions for mental health, non-medical/non-traumatic ETOH, Sexual assault victims. We ran into a problem where the pt was in such a violent nature that LE would not unhand cuff him from behind his back. It put the crew in a difficult position as the crew wanted to transport the pt in a high fowlers position with their hands behind their backs but they ran into the language of the protocol. LE transported the pt who otherwise should have gone in by ambulance. Want to see if we can re-evaluate some of that as it denies LE the authorization to transport their in custody suspect or allow the provider to make a good faith judgment if it is going to create more harm to the patient, LE or providers by removing those restraints.

Dr. Medoro-We created the handcuffs guideline when Drew was medical director to clarify what medical restraint vs. in custody was.

Dr. Habrat-Discussing some of the wording. It sounds like there was not familiarity with this guideline. Some of the wording we might want to change to give some more leeway. In this situation we wanted to reposition the cuffs but LE would not allow the reposition since it was so hard get him in the handcuffs to begin with.

Dr. Medoro-Properly restraining a pt in the back with the cuff in the back cause a safety and compliance issue. Becomes a safety risk.

Dr. Habrat-Chemical restraint didn't readily apply

Dr. Medoro- What language change would make this more helpful in the future.

Chief Rose-Will the 5 point restraint be sufficient to transport with patient with hand cuffs in the back with LE in attendance.

Dr. Medoro-We can bring this up with our safety and compliance officer Deputy Chief Chapek.

Chapek- Dr. Froman had brought up the clinical aspect of potential cardiac arrest and how cuffs behind the back can cause delays in care.

Chief Rose- I would like to know how many patients go into cardiac arrest when they are restrained. Im sure that would be a difficult query. It puts the providers in a paradox as it states that

the patient can be transported with cuffs in front. LE says no and the guideline goes onto say LE "SHALL NOT" transport.

Dr. Medoro-It says when the "pt requests transport by ambulance" specifically when they are requesting transport that LE can't take that right away from the pt to be transported would cause the officer to assume a lot of liability when the pt has a medical complaint. I believe that is where that wording is coming from. I am fine with language changes for better clarification for this.

Chief Ortiz-There has been a big cultural shift with PD and us. From a clinical stand point there is a delay of care with the cuffs in the back. Providers know there is a civil rights issue as well. If the pt is under arrest cuffs are allowed but we are not to use LE restraints as a means to restrain the pt from a LE perspective. I feel that there is potential, by taking away the "shall not's", for it to be taken advantage of and can turn into the "pigeon chesting" on scene. We will not have as much to stand on without the hard and fast statement in there. For our organization we would not want to see changed any time soon. That's my two cents obviously this is a medical director decision.

Dr. Medoro- Interesting challenge that the 3 of us can talk about to get some clarification.

Dr. Habrat-Chief when you say that they're using this to get leeway later. These are our EMS protocols and I'm sure there has to be an equivalent in the LE SOP's for this type of situation right.

Chief Ortiz- the discussions we have had with APD is that when they call out EMS the pt is ours, and that has been made clear to APD. Irrespective of whatever SOP's they have; We try to avoid the "pigeon chesting" on scene. The pt is either going by us or they are signing a refusal. If there is no resolve on scene then crews can call their battalion commander and EMS supervisor to get that resolved. You're right they probably do have something addressing this.

Kim Pruett-Good discussion and timing. The 3 of can get together to look over the language for that and have further discussion. Chief Rose you spoke about the parapack, if you find anything in your research funnel that to Dr. Habrat as we are developing the procedure page for that right now and some of the training let us know so we can get that together for everybody. Any other public comments?

Being none motion to adjourn by Dr. Khalsa second by Dr. Medoro