CIEMSD Minutes

1. Helland -1830
2. Intro
3. Presentation:
    a. Advanced circulatory – Melissa Bahr
        i. IPR Therapy: Advanced Circulatory http://www.advancedcirculatory.com/
        ii. ResQGuard
            1. http://www.advancedcirculatory.com/products/resqgard-itd/resqgard-product-overview/
        iii. ResQPod
            1. http://www.advancedcirculatory.com/products/resqpod-itd/resqpod-itd-product-overview/
    b. Community Education for special population –Ellen Hayes
        i. Deaf or hard of hearing
        ii. Federal law mandates that we provided interpreter services in the healthcare setting. Please notify the hospitals as early as possible if interpretation services are needed.
        iii. VRI: video remote interpretation – Service available to utilize on scene for deaf or hard of hearing populations:
        iv. **** Hand out material *****
4. Approval of Agenda
5. July 2014 minutes
6. Treasures:
    a. Savings: $15,259.19
    b. Checking: $1,147.51
        i. Debts: $1540.78
        ii. Credits: $1200.12
    c. PayPal: $2,061.41
7. Training Committee:
    a. CIEMESD Refresher:
    b. Round Table Scheduled for Thursday October 16th @ 1830
    c. EMS Systems Standards grant: deadline was Sept 18th
        i. Increased the funds available to approx. $10,000.00. Shortened the timeframe of use and must meet the specifications for systems standards and quality improvement.
        ii.
    d. Updating the Shared Textbook resources and the books are available at the Polk Co. EMA for departments to check out.
    e. Next meeting is Thursday, October 2 @ 1330
    f. Midwest Ambulance is hosting a Guest speaker on October 16th @ 1800. Please contact Scott Nelson for more information: scottnelson@midwestambulance.com

8. STEMI Committee:
    a. Health systems are sharing data on STEMI patients and begin to reach out to collect data from EMS agencies when tags are not being used. Outreach education is now going out to clinics, rural hospitals, and agencies.

b. Heart Association is beginning to reach out to facilities and EMS agencies for data, (i.e. first medical contact) and how that impacts patient outcomes for STEMI.
c. Committee will also be looking in to public education and how / when to recognize s/s of acute MI.

9. Operations Committee:
    a. How effective Synergy is? Yes, but starting next Wednesday will look at starting a Facebook site to be managed by the operations committee.
    b. Will potentially take on some of the roll out of the education to the clinics from the STEMI committee
10. EMS Data Project:
    a. Mr. Perrin has been talking with John Becknell, PhD. In Organizational Psychology & Aaron Rinehart . In that aspect of what is the future of EMS systems? Would we motion to cover the expense for them to come to discussion the challenges of EMS sustainability, Fire/EMS depts., and volunteer. They would be available the Sunday / Monday November 9th & 10th.
11. IDPH:
    a. QASP (Helland): Proposed wording for the protocol on "selective spinal immobilization" Please review the draft protocol and forward any comments, questions or suggestions to Brian Helland. Next QASP meeting in is two weeks.
12. Coverdell Stroke Project:
    a. Forms are on the website. http://www.ciemsd.org/?page_id=163
    b. Iowa Stroke Alert Form should be completed on all patients that present with stroke like symptoms. Instructions on how to complete the form are on the website and where the form should be sent out.
13. Membership Committee:
    a. Memberships were suspended until this fall when agencies are going to be invoiced for the 2015 year.
14. NDMS drill:
    a. Good to see the variety of EMS agencies there to assist with the event. Reduce the time that EMS resources have to arrive prior to transporting pts from 2 hours to 1 hour prior to roll out. Triage tags were the older style of tag as opposed to the SMART tags that we have introduced to the hospitals.
15. Communication Center Report:
    a. WHFD has been upgraded to the P25 system with anticipation the remaining county to be transition over the next 8 to 12 months.
    b. MICS systems has been beneficial recently with events using various departments and resources (West Des Moines / Des Moines, and triathlon)
16. Polk Co. Chiefs:
    a. Tour of the Johnston Fire Dept.
    b. Addition of Polk Co EMA on the third alarm for Polk County departments.
17. IEMSA
    a. Conference November 6-8 http://www.iemsa.net/conference.htm
    b. Legislative projects: nothing currently on the table
        i. AJ Mumm- CIEMSD have a way to work with Senators, regarding the EMS essential Service piece and volunteers. Or look at meeting with legislators to discuss future concerns and maintain an open line of dialogue.
18. Metro Trauma

a. Did not meet this month and appears that this committee will be dissolving due to time commitments and direction of the group.

19. Metro ED Committee:
    a. Next meeting is October 23, @ 0800 at the Iowa hospital Association Office
20. Polk Co EMA
    a. Bad news: 2011 & 12 MMRS grants are wrapped up closed out and over with. This funding source is no longer available to us for funding projects or resources.
    b. Potential for incident action plan could be 90% complete after the NDMS exercise for use in the event of future event should take place.
21. Polk Co ME:
    a. Trailer: (at Polk Co ME/ EMA) inventory was taken on the trailer and found to have 95 heavy duty body bags that have been replaced with lighter weight body bags. Looking for a good home for body bags.
    b. Certifications at the ME office: All Staff at the ME office are now certified. Congratulations to the Medical Examiner's office.
22. Hospital Reports:
    a. Unity Point:
        i. Construction Project is in full swing. Will continue to forward updates on status of projects to the group
        ii. Karen Jones: Trauma alert criteria changed in June 2014
            1. America College of Surgeons require the trauma centers triage appropriately. Reviewing guidelines and data from various agencies Unity Point has made changes to the trauma triage criteria. Triage criteria is posted in the hallway at Unity Point
            2. **** Unity Point Criteria ****
            3. American College of Surgeons will be in the state of Iowa in 2015 reviewing the state's trauma system.
    b. Mercy:
23. County Reports;
    a. Boone Co:
        i. Nothing to report from the county.
    b. Dallas Co:
        i. Nothing to report from the county
24. New Business:
    a. Bylaws:
        i. Page # 1, The change would be removing "pre-hosptial" to "out of hospital" Motion-Prowant, 2nd-Hill. Motion approved:
    b. Infections:
        i. Klein:
25. Announcements:
    a. Upcoming Training: October 10th: Kids in Crisis at Mercy Medical Center
        i. Recent training: Chemical Assisted Suicide by Chief Patava was held at Pleasant Hill. Very good course and communication on scenario such as this. He will be at Clive FD on October 1st and Ames on October
    b. Hiring:
        i. Norwalk is hiring:
        ii. Ankeny is opening process for POC and civil service list
        iii. Clive: open process for Part Time

c. Fund Raising:

26. Adjourn: 2050

CHI Interim Infection Prevention recommendations for patients suspected or known to have Ebola Hemorrhagic Fever

Background

CDC is working with the WHO, the ministries of health of Guinea, Liberia, and Sierra Leone, and other international organizations in response to an outbreak of Ebola Viral Disease (EVD) in West Africa. This is the first and largest outbreak of EVD ever documented in West Africa.

EVD is characterized by sudden onset of fever and malaise, accompanied by other nonspecific signs and symptoms, such as myalgia, headache, vomiting, and diarrhea. Patients with severe forms of the disease may develop hemorrhagic symptoms and multi-organ dysfunction, including hepatic damage, renal failure, and central nervous system involvement, leading to shock and death. The fatality rate can vary from 40-90%.

In outbreak settings, Ebola virus is typically first spread to humans after contact with infected wildlife and is then spread person-to-person through direct contact with bodily fluids such as, but not limited to, blood, urine, sweat, semen, and breast milk. The incubation period is usually 8–10 days (ranges from 2–21 days). Asymptomatic individuals do not transmit EVD. EVD patients can transmit the virus while febrile and through later stages of disease, as well as postmortem, when persons touch the body during funeral preparations.

Core Recommendations

The core recommendations are based on the latest CDC guidelines and are established as MINIMUM expectations if dealing with a confirmed or possible case of EVD. At any time using Standard precautions facilities can elevate isolation precautions based on facility or patient assessment.

Patient Evaluation

Establish a process to identify overseas travel on all patients. Evaluate suspected patients for EVD if they have recent travel to Sierra Leone, Liberia, Guinea, or Nigeria,

1. Fever of greater than 38.6° C or 101.5° F, and additional symptoms such as severe headache, muscle pain, vomiting, diarrhea, abdominal pain, or unexplained hemorrhage;
   AND
2. have had contact with blood or other body fluids of a patient known to have or suspected to have EVD; residence in—or travel to—an area where EVD transmission is active; or direct handling of bats, rodents, or primates from disease-endemic areas within 21 days before symptom onset.

3. Continue to evaluate patients for other diseases endemic to the region as clinically indicated (e.g., malaria, typhoid, etc.) following standard laboratory procedures. If patient meets high-risk criteria (see below) contact your local health department prior to laboratory procedures.

If patient meets above criteria ask about contact with ill individuals or cases of EVD, and types of activities during their travel (e.g., exposure to healthcare facilities, caring for ill individuals, wildlife exposure) to determine their risk for EVD (see risk categories below). **Initiate isolation precautions.**

EVD Testing Criteria

Testing patients with suspected EVD will be guided by their exposure risk level below (e.g., high-risk, low-risk, and no known exposure). If evaluating a patient suspected to have EVD, contact your local health department.

High-Risk: High-risk exposure for EVD includes any of the following 21 days before fever onset:

1. percutaneous or mucous membrane exposure or direct skin contact with body fluids of a person with a confirmed or suspected case of EVD without appropriate personal protective equipment (PPE),
2. laboratory processing of body fluids of suspected or confirmed EVD cases without appropriate PPE or standard biosafety precautions,
3. participation in funeral rites or other direct exposure to human remains in the geographic area where the outbreak is occurring without appropriate PPE.

Testing for EVD is recommended if the patient had high-risk exposure.

For patients with a high-risk exposure but without a fever or fever is less than 38.6° C or 101.5° F, testing is recommended only if there are other compatible clinical symptoms present and blood work findings are abnormal (i.e., thrombocytopenia <150,000 cells/µL and/or elevated transaminases) or unknown.

Asymptomatic persons with high-risk exposures should be monitored daily for fever and symptoms for 21 days from the last known exposure and evaluated medically at the first indication of illness.

Low-Risk: Low-risk exposure for EVD includes any of the following 21 days before fever onset:

1. spending time in a healthcare facility where EVD patients are being treated (including healthcare workers who used appropriate PPE, employees not involved in direct patient care, or patients who did not have EVD and their family caretakers),
2. household members of an EVD patient without high-risk exposures as defined above
3. patients with direct unprotected contact with bats or primates from EVD-affected countries

Testing for EVD in a patient with low-risk exposure is only recommended if blood work findings are abnormal (i.e., thrombocytopenia <150,000 cells/µL and/or elevated transaminases) or unknown. Testing for EVD in a patient with low-risk exposure is also recommended if blood work findings are abnormal and patient has fever only (other symptoms absent).

Asymptomatic persons with low-risk exposures should be monitored daily for fever and symptoms for 21 days from the last known exposure and evaluated medically at the first indication of illness.

No Known Exposures: No known exposure for EVD includes a patient who has no known exposure as listed above but has visited an EVD-affected country 21 days before fever onset.

Testing may be indicated for patients with no known exposures who have:

1. fever (≥ 38.6° C or 101.5° F)with other symptoms AND
2. no other diagnosis AND
3. abnormal or unknown bloodwork (i.e., thrombocytopenia <150,000 cells/µL and/or elevated transaminases).

If evaluating a patient suspected to have EVD, call your local health department. If EVD testing is indicated after consultation, A minimum volume of 4mL whole blood preserved with EDTA, clot activator, sodium polyanethol sulfonate (SPS), or citrate in ***plastic*** collection tubes can be submitted for EVD testing. Do not submit specimens to CDC in glass containers. Do not submit specimens preserved in heparin tubes. Specimens should be stored at 4°C or frozen. Specimens other than blood may be submitted upon consult with the CDC by calling the Emergency Operations Center at 770-488-7100.

Standard labeling should be applied for each specimen. The requested test only needs to be identified on the requisition and CDC specimen submission forms.

If evaluating a patient for a pre-travel visit to an affected region, see CDC travel advisories (Guinea:

Healthcare Worker Evaluation

1. Prior to travel to Africa HCW's should be given the most recent CDC travel Alerts.
2. HCW's that have been working in a healthcare setting while in Africa they should be evaluated for potential exposures and that CDC be consulted prior to returning to work in the healthcare environment.
3. Asymptomatic HCW's who are returning from vacation or mission from endemic areas of EVD in Africa that did not perform healthcare services while traveling should be informed to place themselves on a 21 day symptom watch.

Recommended infection control measures

U.S. hospitals can safely manage a patient with EVD by following Standard, Contact, and Droplet precautions. Additional precautions may be instituted on a case-by-case basis in consultation with local health departments.

Please refer to CDC's Infection Prevention and Control Recommendations for Hospitalized Patients with Known or Suspected Ebola Hemorrhagic Fever in U.S. Hospitals (http://www.cdc.gov/vhf/ebola/hcp/infection-prevention-and-control-recommendations.html) document for details.

A summary of these recommendations includes:

- **Patient placement:** Patients should be placed on Standard, Droplet, and Contact Isolation. Patients should be placed in a single patient room (containing a private bathroom) with the door closed. A log should be, maintained of all individuals entering the room. Only essential personnel should be allowed into the room.
- **Healthcare worker protection:** Healthcare workers should wear: gloves, gown (fluid resistant or impermeable), shoe covers, eye protection (goggles or face shield), and a facemask. Additional PPE might be required in certain situations (e.g., copious amounts of blood, other body fluids, vomit, or feces present in the environment), including but not limited to double gloving, disposable shoe covers, and leg coverings.
- **Equipment:** Should be single-use or dedicated to the patient. Any equipment not single-use should be carefully cleaned after use following manufacturers guidelines using an approved disinfectant.
- **Aerosol-generating procedures:** Avoid aerosol-generating procedures if possible. If clinically essential PPE for these procedures should include respiratory protection (N95 respirator or PAPR); perform in an Airborne Infection Isolation Room.
- **Environmental infection control:** Diligent environmental cleaning and disinfection and safe handling of potentially contaminated materials is essential, as blood, sweat, emesis, feces and other body secretions represent potentially infectious materials. Disinfectants for Ebola virus include 10% sodium hypochlorite (bleach) solution, or hospital-grade quaternary ammonium or phenolic products. Remember cleaning must precede disinfection. Healthcare workers performing environmental cleaning and disinfection should wear recommended PPE (described above) and consider use of additional barriers (e.g., shoe and leg coverings) as needed. Face protection (face shield or facemask with goggles) should be worn when performing tasks such as liquid waste disposal that can generate splashes. Follow standard procedures, per hospital policy and manufacturers' instructions, for cleaning and/or disinfection of environmental surfaces, equipment, textiles, laundry, food utensils and dishware.
- **Hand hygiene**: Perform hand hygiene frequently, including before and after all patient contact, contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves.

General practices

All PPE should be readily available for use by the end-users and all appropriate staff should have training on how to don and safely remove necessary PPE.

Respiratory etiquette should be strictly enforced with stations stocked and available in all waiting areas.

Resources

http://www.cdc.gov/vhf/ebola/index.html

http://wwwnc.cdc.gov/travel/notices

http://www.cdc.gov/vhf/ebola/hcp/clinician-information-us-healthcare-settings.html

http://www.cdc.gov/vhf/ebola/hcp/infection-prevention-and-control-recommendations.html

http://www.cdc.gov/vhf/ebola/hcp/interim-guidance-specimen-collection-submission-patients-suspected-infection-ebola.html

http://www.cdc.gov/vhf/ebola/hcp/monitoring-and-movement-of-persons-with-exposure.html

http://www.cdc.gov/vhf/ebola/hcp/patient-management-us-hospitals.html