Advisory 16-09 Collaborative Protocols

To: All Providers

From: Jeremy T. Cushman, MD, MS, EMT-P
Regional Medical Director

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Monroe-Livingston joined every upstate region to participate in the Collaborative Protocols earlier this year. This is an important advance in the care and safety of our protocols and since the approval of the protocols in the spring, the goal has been to roll out those protocols this fall. Unfortunately, due to circumstances beyond our control, that rollout will be delayed. We anticipate rollout will occur first quarter 2017 and until that time the existing MLREMS Standards of Care remain effective.

Once available, the rollout will include mandatory, on-line training for all EMT and Paramedic providers in the region. For EMT's, this will include a BLS Update and Patella Reduction training. For Paramedics, this will include an ALS Update, Patella Reduction, and Ketamine training. There will be an assessment built into the training to verify understanding of the changes and the training will be eligible for CME.

In the meantime, due to ALS formulary changes, the following accommodations are acceptable:

> Methylprednisolone (Solumedrol) may continue to be used until the new protocols are in effect. Dexamethasone (Decadron) 10 mg may be used in place of Methylprednisolone 125 mg as indicated in the current protocols, provided the entire agency stock is changed over at the same time and agency providers are made aware of the dosing change. If due to this change there is a brief absence of medication availability, this is acceptable. The indications and contraindications for steroid use does not change as a result of this substitution.
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> Promethazine (Phenergan) is not a required medication. Agency stock may be transitioned over to Ondansetron (Zofran) progressively as existing stock is used/expired. The indications and contraindications for anti-emetic use does not change as a result of this substitution.
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> Procainamide is not a required medication and need not be replaced if used/expired.
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> Dextrose 10% may be used in lieu of Dextrose 50%. Up to 25 grams (250 mL) of IV Dextrose 10% may be given for symptomatic hypoglycemia in an adult where oral glucose is contraindicated. For pediatrics, 5 mL/kg of IV Dextrose 10% using a syringe (Dextrose 10% may not be administered via drip in pediatrics) may be given for symptomatic hypoglycemia in a pediatric patient where oral glucose is contraindicated. It is not required that every patient gets 25 grams or 5 mL/kg of dextrose – the clinical endpoint is the patient's regaining of consciousness and once this is achieved, dextrose may be held to allow for reassessment. The patient's condition should continue to improve to the point they are able to take oral sugar sources. Should their clinical improvement not occur, additional Dextrose 10% may be given.

These formulary accommodations are effective immediately. With any questions, please do not hesitate to contact this office and I thank you in advance for your understanding.

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