



MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DIVISION OF COMMUNITY HEALTH

DRUG/DEVICE/PROTOCOL (DDP) COMMITTEE

March 6, 2019 – 10:00 A.M.

MEMBERS PRESENT

Mike Barnum, MD, AMR, Chairman
Jessica LeDuc, DO, HFD
Chief Troy Tuke, CCFD
Karen Dalmaso-Hughey, AMR (Alt)
Shawn Tobler, MFR
Mark Calabrese, CCFD
Paul Stepaniuk, HFD (Alt)
Jim Kindel, BCFD
Chelsea Monge, CA (Alt)

Scott Scherr, MD, GEMS
Jarrod Johnson, MD, MFR
Michael Holtz, MD, CCFD
L. Cole Sondrup, MD, CA
Matthew Horbal, MD, MCFD
Chief Kim Moore, HFD
Frank Simone, NLVFD
Steve Johnson, MWA
Derek Cox, LVFR (Alt)

MEMBERS ABSENT

K. Alexander Malone, MD, NLVFD
Jeff Davidson, MD, MW

Corbin King, Mercy Air

SNHD STAFF PRESENT

John Hammond, EMSTS Manager
Laura Palmer, EMSTS Supervisor
Rae Pettie, Recording Secretary

Christian Young, MD, EMSTS Medical Director
Gerry Julian, EMSTS Field Representative

PUBLIC ATTENDANCE

Steve Krebs, MD
Michael Denton
Kevin Slaughter, DO
Sam Scheller
Derek Minyard
Devon Eisma
Jim McAllister
Daniel Shinn

Don Abshier
Chris Racine
Brett Olbur
Larry Johnson
Donald Bennett, MD
Carl Bottorf
Ryan Fraser

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The Drug/Device/Protocol Committee (DDP) convened in the Red Rock Conference Room at the Southern Nevada Health District on Wednesday, March 6, 2019. Chairman Mike Barnum called the meeting to order at 10:00 a.m. and stated the Affidavit of Posting was posted in accordance with the Nevada Open Meeting Law. Dr. Barnum noted that a quorum was present.

I. PUBLIC COMMENT

Public comment is a period devoted to comments by the general public on items listed on the Agenda. All comments are limited to five (5) minutes. Chairman Mike Barnum asked if anyone wished to address the Board pertaining to items listed on the Agenda. Seeing no one he closed the Public Comment portion of the meeting.

II. CONSENT AGENDA

Chairman Barnum stated the Consent Agenda consisted of matters to be considered by the DDP that can be enacted by one motion. Any item may be discussed separately per Committee member request. Any exceptions to the Consent Agenda must be stated prior to approval.

Approve Minutes for the Drug/Device/Protocol Committee Meeting: February 6, 2019

Chairman Barnum asked for a motion to approve the February 6, 2019 minutes of the DDP meeting. A motion was made by Mark Calabrese, seconded by Steve Johnson and carried unanimously to approve the minutes as written.

III. REPORT/DISCUSSION/POSSIBLE ACTION

A. Review/Discuss the Termination of Resuscitation (TOR) Protocol

The DDP discussed the need to include language in the TOR protocol to refer providers to the DNR/POLST protocol when presented with a valid DNR/POLST order.

A motion was made by Troy Tuke to make the following revisions to the TOR protocol:

1. Strike the first sentence in #1 that reads, "Resuscitation that is started in the field by licensed EMS personnel CANNOT be discontinued without a physician order."
2. Add #2 "Resuscitation should be terminated or not initiated if a valid DNR, POLST or physician written order is provided without telemetry contact."
3. Revise #3 to read, "Resuscitation started in the field may be discontinued only by telemetry physician order when the following conditions have been met:"

The motion was seconded by Frank Simone and carried unanimously.

[Dr. Scherr dismissed himself from the meeting at 10:35 a.m.]

B. Review/Discuss Cost and System Impact for the Use of Metaclopramide (Reglan) and Prochlorperazine (Compazine) and Possible Development of a Protocol

Steve Johnson remarked it has become increasingly difficult to obtain certain medications because of the nationwide drug shortages. He referred the DDP to the "Application for Petition for Addition of New Drug/Equipment to the EMS Inventory" for Reglan and Compazine as possible alternatives for antiemetics such as Zofran. He stated that in doing the cost analysis he found Compazine to be extremely expensive as compared with Reglan which is very affordable. He noted that last year AMR and MW combined gave approximately 6700 doses of Zofran, the second most commonly given medication in the field after Aspirin and Albuterol. He acknowledged that it is also safe for OB patients as outlined in the studies he included in their meeting packets. Also included were protocols from various agencies around the country that currently use both medications.

A motion was made by Jim Kindel to add the antiemetics Reglan and Compazine to the formulary as alternative agents, and to revise the protocols as necessary. The motion was seconded by Steve Johnson and carried unanimously.

C. Review/Discuss Cost and System Impact for the Use of Dexamethasone (Decadron) and Methylprednisolone (Solu-Medrol) and Possible Development of a Protocol

Steve Johnson stated that it has also become increasingly difficult to obtain Benadryl, which includes the injectable. He explained that some of the medications they give have a potential for dystonic reaction that requires Benadryl, so they need to seek other alternatives. Mr. Johnson stated they are proposing adding Solu-Medrol to the formulary to be used strictly for anaphylaxis and allergic reaction. He noted that unlike Compazine and Decadron, Solu-Medrol is affordable. Chief Tuke expressed concern that the crews will give

Solu-Medrol even though they have Benadryl on hand. Mr. Johnson reassured the DDP that should sterile injectable Benadryl become abundant they would disallow the use of Solu-Medrol. Dr. Barnum remarked that the concern is they may eventually lose medications such as Benadryl. He added that there are transports that are longer in duration and both EMS and the receiving hospitals will suffer if they have no alternative. If they are having difficulty obtaining antihistamine agents, it would be of benefit to get the steroids on board in advance. The hope is that for patients who are administered Solu-Medrol, in some cases, 45 minutes in advance, by the time they arrive at the hospital and are triaged and assessed, it may be beneficial. However, it is obviously not recognized as an equivalent agent. Dr. Johnson acknowledged the importance of ensuring Solu-Medrol does not become a substitute for Benadryl as it is not an adequate replacement. In the face of having nothing else, it's not unreasonable. He asked if PO Benadryl is available as it would be an even better substitute than giving Solu-Medrol. Mr. Johnson responded that it would require a formulary change because it is currently not addressed in the protocols. Ms. Dalmaso-Hughey stated they have been unable to find liquid Benadryl in a single dose that is cost effective. Dr. Barnum noted they should explore alternate routes such as Hydroxyzine, keeping in mind antihistamine agents have their own issues associated with them.

Dr. Young related he has overheard comments from crews coming in with patients with asthma or shortness of breath saying, "I wish we had Solu-Medrol. I would have given that, too." He expressed concern that if we put that tool in the toolbox, unless it's very specifically limited to this indication, it may be given off-label. From a QI standpoint it's a concern. Dr. Sondrup asked if the agencies would be required to carry Solumedrol. Dr. Young responded it would be optional. Mr. Calabrese asked if anyone has researched the cost of liquid Benadryl. Mr. Johnson stated he will research the cost of alternate forms of Benadryl.

A motion was made by Steve Johnson to add Solu-Medrol to the formulary as an alternative agent to be used strictly for allergic reaction should they be unable to obtain Diphenhydramine. Use for any other purpose will require notice of a protocol deviation to the Health District. The motion was seconded by Ms. Dalmaso-Hughey and carried unanimously.

Chief Tuke asked whether Solu-Medrol will be added to the Allergic Reaction protocol. Ms. Palmer answered in the affirmative and stated the formulary will also designate the protocol.

D. Review/Discuss the Use of Epinephrine in Anaphylaxis and Shock Protocols (Adult and Pediatric)

Ms. Palmer outlined the housekeeping changes that were made after the last meeting. There was concern that the pediatric Allergic Reaction protocol is weight based and exceeds the adult maximum dose. Dr. Krebs reported that a 2018 pediatric critical care study advocated for push dose pressors in patients in pre-arrest shock. When they looked at the dosages they came up with 1 mcg/kg. He stated that IM Epi has a wide safety to it, and repetitive doses are well tolerated. Although the literature doesn't mention a ceiling he believes it's something that's going to be considered. The most common age to jump to the adult algorithm is about 14 years of age when most kids are going to be pretty much adult sized, starting at about 40+ kg. It's a route that's gaining traction, but it's still not a commonly established practice. He questioned why there's a ceiling for the adult dose, and if there is a concern for older people with unhealthy hearts who may end up with an unstable tachycardic arrhythmia. Dr. Barnum stated there is good data that shows that people who received high dose Epi don't do any better. The concern on the pediatric side is that they are going to get very large kids and they could very quickly get up into doses that would be higher than they would be giving to an adult patient, which makes people uncomfortable.

Dr. Sondrup questioned why they couldn't just adopt the same dose for both pediatric and adult patients in this population. At the very worst it's going to under-dose the bigger kids. You can repeat the dose every minute if you want. Otherwise, he agrees it's probably way too complex to have people doing weight-based dosing with Epi on children. They should consider removing it and just giving IM Epi. Dr. Holtz stated that in general pediatric doses should be weight-based. If they wanted to move in that direction, they should give the weight-based dosing up to a maximum of the adult dose; that would probably argue that the adult dose is too low. Dr. Sondrup remarked that the reason it is weight based is because we don't want to overdose the kids. But in this case, the adult dose is so low there's really no chance of overdosing the kids unless they're newborns. Even then, it's not a significant amount.

The committee agreed to table the agenda item to see if they could find a way to get some consistency between the pediatric and adult doses. Derek Cox agreed to work with Dr. Slattery and bring something back to the next meeting.

E. Review/Discuss DDP Bylaws

Laura Palmer referred the DDP to Article III, Section 1 of the draft bylaws which currently states the membership shall be comprised of no more than 12 members. She expressed that although she welcomes the increased participation, the concern is that the group has become too large and unruly. She noted there are currently 14 agencies in the EMS system and all should be given the opportunity to be represented. She proposed they revise the bylaws to allow for a maximum of 14 members. In addition, draft language was included in Article III, Section 6 which states, "A motion shall be passed by a simple majority. Voting shall be done by roll call vote." She explained that this will provide for a more equitable way to control the votes. Ms. Palmer stated that additional housekeeping changes were made to Sections 1 and 4 of Article III, and Article V, Section 3.

A motion was made by Troy Tuke to accept the revisions made to the BBP bylaws as written. The motion was seconded by Frank Simone and carried unanimously.

Dr. Barnum distributed a member list and asked that each agency choose the primary member and up to three alternates so the membership can be consolidated prior to the next meeting.

IV. INFORMATIONAL ITEMS/ DISCUSSION ONLY

None.

V. PUBLIC COMMENT

Public comment is a period devoted to comments by the general public, if any, and discussions of those comments, about matters relevant to the Committee's jurisdiction will be held. No action may be taken upon a matter raised under this item of this Agenda until the matter itself has been specifically included on an agenda as an item upon which action may be taken pursuant to NRS 241.020. All comments are limited to five (5) minutes. Dr. Barnum asked if anyone wished to address the Board. Seeing no one he closed the Public Comment portion of the meeting.

ADJOURNMENT

There being no further business to come before the Committee, Chairman Barnum called for a motion to adjourn. A motion was made to adjourn the meeting at 11:04 am.