Draft Minutes of Meeting – Subject to Change Upon Approval by the Drug/Device/Protocol Committee at their next regularly scheduled meeting

MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DIVISION OF COMMUNITY HEALTH

DRUG/DEVICE/PROTOCOL (DDP) COMMITTEE

April 1, 2026 – 9:00 A.M.

MEMBERS PRESENT

Mike Barnum, MD, Chair
Jessica Leduc, DO, HFD
Nate Jenson, DO, MFR
Capt. James Whitworth, BCFD
Chief Kim Moore, HFD
Chief Daylon Woolbright, CCFD
Kat Fivelstad, MD, LVFD (Alt)
Samuel Scheller, GEMS
Chief Ryan Thornton, NFR
Brandon Miles, Mercy Air
Michael Holtz, MD, CCFD
Mario Perkins, Guardian Flight (Alt)
Chief Ryan Thornton, MFR
Derek Cox, LVFR
Michael Whitehead, AMR
Jim McAllister, LVMS
John Osborn, CA

MEMBERS ABSENT

Jeff Davidson, MD, MW
Stephen DuMontier, DO, NLVFD
Chief John Lansing. NLVFD
Chief Stephen Neel, MVFD
Sydni Senecal, OptimuMedicine

SNHD STAFF PRESENT

John Hammond, EMSTS Manager
Laura Palmer, EMSTS Supervisor
Stacy Johnson, EMSTS Regional Trauma Coordinator
Kristen Anderson, EMSTS Program/Project Coordinator
Christian Young, MD, EMSTS Medical Director
Dustin Johnson, EMSTS Field Representative
Devin Atwood, Sr Admin Assistant
Edward Wynder, SNHD Legal Counsel

PUBLIC ATTENDANCE

Sandra Horning, MD
Erik Grismanauskas
Jon Wiercinski
Sarita Lundin
Todd Ford
Braiden Green
Major Matthew Figlewicz, MOMMC
Stacy Pokorny
Sean Friedland
Maya Holmes
Rebecca Carmody
David Obert, DO
Justin Peck

I. CALL TO ORDER AND ROLL CALL

The Drug/Device/Protocol (DDP) Committee convened in the Red Rock Conference Room at the Southern Nevada Health District on Wednesday, April 1, 2026. Chair Michael Barnum, MD, called the meeting to order at 9:02 a.m.

and stated the Affidavit of Posting was posted in accordance with the Nevada Open Meeting Law. All committee members joined the meeting via teleconference. Dr. Barnum noted that a quorum was present.

II. DIRECTIONS FOR PUBLIC ACCESS TO MEETINGS

Members of the public may attend and participate in the Drug, Device, and Protocol Committee meeting over the telephone by calling (702) 907-7151 and entering access code 428 474 531#. To provide public comment over the telephone, please press *5 during the comment period and wait to be called on. To provide public comment over Teams please click on the hand icon to raise your hand during the comment period and wait to be called on.

III. FIRST PUBLIC COMMENT

Members of the public are allowed to speak on Action items after the Committee's discussion and prior to their vote. Each speaker will be given five (5) minutes to address the Committee on the pending topic. No person may yield his or her time to another person. In those situations where large groups of people desire to address the Committee on the same matter, the Chair may request that those groups select only one or two speakers from the group to address the Committee on behalf of the group. Once the action item is closed, no additional public comment will be accepted. Dr. Barnum asked if anyone wished to address the Board concerning items listed on the agenda. Seeing no one, he closed the public comment portion of the meeting.

IV. ADOPTION OF THE FEBRUARY 4, 2026 AGENDA

A motion was made by Derek Cox, seconded by Jim McAllister, and carried unanimously to adopt the April 1, 2026 Agenda as written.

V. CONSENT AGENDA

Items for action to be considered by the Drug/Device/Protocol Committee which may be enacted by one motion. Any item may be discussed separately by Committee Member request before action. Any exceptions to the Consent Agenda must be stated prior to approval.

Approve Minutes: February 4, 2026 Drug/Device/Protocol Committee Meeting

A motion was made by Derek Cox, seconded by Jim McAllister, and carried unanimously to approve the February 4,2026 minutes as written.

VI. REPORT / DISCUSSION / ACTION

A. Discussion and Approval of the General Adult Assessment Protocol

Laura Palmer introduced the current protocol, noting that due to the changes passed in the last Medical Advisory Board meeting, there was no longer a consensus in the protocol manual calling for oxygen for patients with O2 saturation less than 94%. The new Chest Pain/STEMI protocol states providers should not deliver oxygen unless O2 sats are below 90%. She has concerns about leaving the General Adult Assessment protocol as it stands due to a lack of consistency. Dr. Barnum asked if the change to the Chest Pain protocol stemmed from the American Heart Association's position that oxygen should not be given to chest pain patients unless their O2 sats are below 92%, and this was confirmed. Dr. Barnum stated that he does not feel giving oxygen to these patients causes them grievous harm, and that he feels the spirit of the changes in the protocol were not to withhold oxygen, but to give it to patients who demonstrated that it was needed, like active STEMI patients, or those demonstrating acute distress. Dr. Young suggested a change in the Pearls section of the protocol to indicate the exception as opposed to trying to carve out language to work around the one protocol that does not fit the otherwise consistent suggestions for oxygen therapy.

A motion was made by Jim McAllister, seconded by Sam Scheller and carried unanimously to add the following Pearl to the General Adult Assessment protocol: "Consider oxygen administration in patients with cardiac chest pain when oxygen saturation is below 90%".

B. Discussion and Approval of the Non-Invasive Positive Pressure Protocol

Dr. Holtz explained to the committee that the changes needed in this protocol are minor and stem from the newly adopted pediatric respiratory distress protocols. The new protocol calls for non-invasive positive pressure ventilation

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(NIPPV) for pediatric patients, but the current NIPPV protocol restricts use to ages 18 and over. His suggestion was to remove the language in the indications section of the protocol that specify age.

A motion was made by Dr. Holtz, seconded by Chief Woolbright and carried unanimously to make the following changes to the Non-Invasive Positive Pressure Ventilation protocol:

1. *Removal of the phrase "18 years or older"*
2. *Under Indications, change the phrase "and pneumonia" to "or pneumonia"*

C. Discussion and Approval of the Adult Respiratory Distress Protocol - Tabled.

D. Discussion and Approval of the Pediatric Respiratory Distress-Wheezing Protocol- Tabled.

E. Discussion and Approval of the Use of Ketamine in Refractory Status Seizure

Todd Ford stated that after the last Qi Directors Committee meeting, all agencies were tasked with examining their patient care reports for seizures to see if there were issues with refractory seizures, if the underdosing of midazolam was an issue, and to examine whether or not something like Ketamine was in fact needed. Mr. Ford stated that after examining their data, they did not see a need for a secondary medication at this time. After discussion with their medical director and EMS staff, they have decided to remove their request at this time. While they feel that Ketamine may be beneficial in other systems, particularly in rural areas with extended transport times, the data did not support moving forward in Clark County. Committee members agreed, and the issue was tabled.

F. Discussion and Approval of the OB-Uncomplicated Childbirth Protocol

Laura Palmer stated that the committee had recently passed three new OB protocols, one for stable patients, and two for patients in different types of OB-related distress. All three protocols ended up with language specifying that OB patients should be transported to an adult emergency department of the receiving facility for initial evaluation. This has been causing throughput issues for some of the facilities, especially those systems who have completely different admitting systems for their OB departments. Jon Wiercinski, EMS Director for HCA, spoke on behalf of the three HCA facilities in the valley. He acknowledged that some facilities have a more streamlined geography which allows for a better flow for EMS to get from the ER to L&D without issue. He understands that in the bigger facilities like Sunrise, multiple hallways and elevators create issues, especially with a patient who may be in distress. He feels that bringing all of these patients to the Adult ED for evaluation is not the best answer for the system, acknowledging that it creates multiple issues for his facilities including duplicate registration and account creation. Dr. Barnum agreed that the current language creates some concerns for the Valley Health System side. He stated that when a patient arrives in the ED, it creates an obligation to register the patient into the system, for a clinician to get involved, and to create documentation. That is a great deal of effort and duplication of work for a stable OB patient who is to be transported directly to Labor & Delivery. If it is an unstable patient, they are more than happy to assist in the ER, but stale patients don't truly need to have an initial ER evaluation. Dr. Young agreed, stating that patients in extremis requiring acute resuscitation or intervention would be best served in the ER department. The hospitals have procedures in place to get specialized teams from L&D down to the ER for these cases. He acknowledged that the change created by this protocol means that very sick L&D patients are now going to be coming to the ER, where before they were often taken to L&D. ER staff must accept this, and work on streamlining their internal processes to ensure they are ready to serve these patients. He also acknowledged that the process of getting EMS from the ER up to L&D must be streamlined, whether it is through better signage, badges for EMS, or staff escorts. Chief Woolbright agreed with the concept of staff escorts, particularly for the patient that is a potential imminent delivery. He feels that the goal of the language in the protocol needs to be providing EMS providers with simple, easy to memorize destinations to deliver patients to in these facilities, and the ability to have staff available if the patient condition deteriorates. Erik Grismanauskaus agreed, stating that it is unreasonable to expect EMS to memorize the footprint for every single facility. Turnover in EMS is high, and having an escort would be beneficial. In the case of Sunrise, simply removing the word "adult" in front of ER as the destination would be a positive change, since their L&D is closer to the Peds ER. Dr. Horning asked the committee if they felt that early telemetry notification to the L&D staff would be helpful. That would provide the L&D team with time to come down to the ER and evaluate the patient. If the patient is stable to continue to L&D, the experts are there with EMS for the hallways and elevators. Mr. Wiercinski said he does not feel that it's feasible to expect L&D staff to come down for every EMS transport. The Committee acknowledged that they do not have the authority to dictate facility behavior and can only attempt to develop language that best serves everyone. All members felt that the subject needs more discussion, and that offline meetings with facilities for further input need to occur. Mr. Wiercinski felt that removing the word "adult" from the ER destination is a step in the correct direction while more discussion is held. Derek Cox said that he finds it interesting that the direction that was received from crews was that they wanted to take patients to one location within

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the hospital. Crews wanted something easy to navigate and easy to remember. The medics run into communication issues and location issues within the facilities, and they have no control over what occurs once they're on property. They wanted something consistent and reliable for the crews and for the patients. He feels like the conversation has moved since the option of taking everyone to the ED was introduced. The initial language was meant to be for patients in extremis. There is room for cooperation on both sides of this issue.

Dr. Barnum acknowledged that the committee was running out of meeting time and asked if the group wanted to make a motion to amend language based on the discussion that had been held.

A motion was made by Dr. Barnum, seconded by Chief Woolbright, and passed unanimously to make the following change to the OB-Uncomplicated Childbirth Protocol pearls:

1. *Remove the word "Adult" from the phrase "Adult Emergency Department".*

G. Discussion and Approval of Transport Destinations for Sexual Assault Patients

John Hammond stated that while SNHD has been moving forward with discussions with individuals in Clark County who conduct sexual assault forensic examinations, we are continuing to have issues with transporting adult patients in need of these examinations to UMC exclusively as the protocol is written. He stated that it must remain as written in protocol until we have a better understanding of the MOUs between facilities and organization offering the needed forensic examinations. He understands the frustrations of the clinicians, but they are still able to treat these patients and are still an acceptable destination. He acknowledged that EMS is only one portion of this discussion. He is hopeful that more hospitals enter MOUs with the organization conducting examinations so that the protocol may be amended to state that adult sexual assault patients may go to the facility of their choice. Until then, crews can continue to follow the protocol and fill out a protocol deviation if the patient requests transport elsewhere. The committee agreed to wait until the issue has been resolved by the facilities before finalizing any protocol changes.

VII. BOARD REPORTS

No report.

VIII. SECOND PUBLIC COMMENT

Members of the public are allowed to speak on Action items after the Committee's discussion and prior to their vote. Each speaker will be given five (5) minutes to address the Committee on the pending topic. No person may yield his or her time to another person. In those situations where large groups of people desire to address the Committee on the same matter, the Chair may request that those groups select only one or two speakers from the group to address the Committee on behalf of the group. Once the action item is closed, no additional public comment will be accepted. Dr. Barnum asked if anyone wished to address the Board concerning items listed on the agenda. Seeing no one, he closed the public comment portion of the meeting.

IX. ADJOURNMENT

There being no further business to come before the Committee, the meeting was adjourned at 10:28 a.m.

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