



MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DIVISION OF COMMUNITY HEALTH

DRUG/DEVICE/PROTOCOL (DDP) COMMITTEE

April 3, 2019 – 9:00 A.M.

MEMBERS PRESENT

Mike Barnum, MD, AMR, Chairman
Karen Dalmaso-Hughey, AMR
Chief Kim Moore, HFD
Frank Simone, NLVFD
Derek Cox, LVFR
Jim McAllister, LVMS
AprilLynn LeBaron, MFR (Alt)

Chief Troy Tuke, CCFD
Jim Kindel, MFR
Steve Johnson, MWA
Chelsea Monge, CA
Devon Eisma, RN, OM
Samuel Scheller, GEMS

MEMBERS ABSENT

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
Mark Calabrese
Michael Schrader
August Corrales
Brett Olbur
Daniel Shinn
Sabrina Taylor

Jessica Leduc, DO
Jeff Davidson, MD
Michael Pigiel
Chris Stachyra
Alyssa Ball
Leslie Kosak
Laura Hennum

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, April 3, 2019. Chairman Mike Barnum called the meeting to order at 9:09 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.

Dr. Kevin Slaughter stated that when the divert policy was eliminated, EMS did a great job of level loading the system. He recommended they re-examine the current process.

Jason Jones, MD, director of the Dignity Health micro-hospitals, stated he would like to have discussions related to expanding the vital sign requirements for bringing patients to the micro-hospitals. He explained that when Emerus and Dignity Health entered into their joint venture it was to help provide relief to some of the receiving facilities where EMS providers have been experiencing extended wait times to offload patients. Dr. Jones noted that many of those patients can be taken care of at a micro-hospital. To date, they have seen greater than 92,000 patients in the valley. He would like the committee to consider expanding the vital sign requirements in a safe and effective manner.

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: March 6, 2019

Chairman Barnum asked for a motion to approve the March 6, 2019 minutes of the DDP meeting. A motion was made by Chief Tuke, seconded by Frank Simone and carried unanimously to approve the minutes as written.

III. REPORT/DISCUSSION/POSSIBLE ACTION

A. Review/Discuss Draft DDP Bylaws

Laura Palmer stated three additional agencies expressed an interest in serving on the DDP: Mt. Charleston Fire Protection District; Moapa Valley Fire District; and AirMed Response, formerly Life Guard International. Ms. Palmer noted that the revision to the bylaws would raise the membership to a total of 17.

A motion was made by Chief Tuke to increase the Drug/Device/Protocol membership to 17. The motion was seconded by Dr. Slattery and carried unanimously.

Dr. Slattery suggested they consider including a PharmD (Doctor of Pharmacy) to the DDP membership. He stated a PharmD's input would be invaluable for the discussions that take place related to medications and dosing for both adult and pediatric patients. The committee discussed whether the PharmD should serve in an advisory-only capacity.

A motion was made by Dr. Slattery to add a Doctor of Pharmacy to serve on the Drug/Device/Protocol Committee in an advisory-only capacity. The motion was seconded by Chief Tuke and carried unanimously.

John Hammond stated he will send out nomination forms to the committee members and voting may be done via secret ballot at the next meeting.

B. Review/Discuss Formulary and Protocol Revisions for Metaclopramide (Reglan)

C. Review/Discuss Formulary and Protocol Revisions for Prochlorperazine (Compazine)

Ms. Palmer referred the committee to the formulary and protocol changes where Zofran was substituted with Reglan and Compazine. She explained that the alternative medications were put in place in the event they were unable to obtain Zofran.

Dr. Davidson suggested they consider removing Droperidol in the future since the hospitals are no longer using it. Dr. Slattery noted that UMC uses Droperidol and stated he feels it's a better antiemetic than Reglan and Compazine. In his opinion Droperidol got a bad rap after the black box warning, which he feels was not based on good evidence. Dr. Davidson stated he is not debating its efficacy as an antiemetic, but he hasn't seen it used in our EMS system in several years. Dr. Slattery noted he would like to keep Droperidol as an option so he can continue to use it as opposed to Reglan and Compazine.

A motion was made by Chief Tuke to revise the Prochlorperazine dose to read, "...up to 10 mg IV/IM." The motion was seconded by Frank Simone and carried unanimously.

A motion was made by Frank Simone to approve the formulary and protocol revisions for Metaclopramide (Reglan) and Prochlorperazine (Compazine). The motion was seconded and carried unanimously.

[Jim Kindel dismissed himself from the meeting at 9:30 a.m.]

D. Review/Discuss Formulary and Protocol Revisions for Methylprednisolone (Solu-Medrol)

Ms. Palmer referred the committee to the formulary and protocols where Solu-Medrol would be utilized. Mr. Johnson remarked that although the AEMTs currently administer Benadryl, Solu-Medrol will be a paramedic-only drug. Dr. Slattery questioned why they would replace Benadryl, an antihistamine, with Solu-Medrol, a steroid. Mr. Hammond explained Solu-Medrol was suggested as a potential solution for the drug shortage. Dr. Davidson noted it is not as fast-acting as an antihistamine and they have suitable solutions with liquid and chewable Benadryl. Dr. Young related that he discussed the issue with the PharmD at UMC who recommends they switch to a different agent as Solu-Medrol can result in further complications for the patient.

After much discussion the committee agreed to withdraw Solu-Medrol from consideration and revisit it in the future if necessary.

E. Review/Discuss the Use of Epinephrine in Adult and Pediatric Anaphylaxis and Shock Protocols

Dr. Krebs noted his recommendations have evolved after consulting with other pediatric specialty services which includes emergency critical care and cardiology. He recommended they strike push dose Epi or IV Epi from the pediatric allergic reaction and shock protocols and move to IM Epi which has a broader safety profile alternative. For pediatric allergic reaction with anaphylaxis and shock, reemphasize the administration of IM Epi, along with aggressive fluid resuscitation. A lot of the patients will be fluid responsive if you're getting adequate IM Epi, and the patients who aren't are going to be better served with initial fluid on board if they need to get an IV route for rare, extreme allergic reactions. Dr. Krebs stated that at some point going forward they should look at augmenting the Epi 1:1,000 IM dosing and max it at 0.5 and re-administer every 5-10 minutes instead of 15, which is in line with most common practice for the treatment of acute allergic reaction.

Referencing shock, Dr. Krebs stated that in further review of the literature and discussions with other specialty services, the literature is not there yet. The indications as advocated by the 2018 AHA review is 1 mcg/kg for use specifically for hypotension and persistent bradycardia, and high-risk myocardium. Even more so as a bridge to definitive intervention taken off of pericardial effusion, re-vascularizing a surgical shunt or maybe even bridge into ECMO; the language wasn't intended to be generalized to all corners of shock, pre-arrest hypotension or bradycardia.

A motion was made by Derek Cox to remove push dose Epinephrine from the pediatric Allergic Reaction and Pediatric Shock protocols and replace it with "Epinephrine 1:1,000, 0.01 mg/kg IM; max single dose of 0.5; may repeat every five minutes to a max dose of 1.5 mg/kg." The motion was seconded by Steve Johnson and carried unanimously.

F. Review/Discuss Information and Cost Analysis for Alternative Forms of Benadryl

Mr. Johnson referred the committee to the cost analyses for chewable and liquid Benadryl. He noted the costs were extraordinarily low. He emphasized they would like to include PO as an alternative route as they did with Zofran ODTs. Dr. Young noted they would need to add it to the pediatric dosing as well. Dr. Steve Krebs (UMC peds) stated the pediatric ER doctors prefer an oral dosing.

A motion was made by Ms. Dalmaso-Hughey to add a PO route for Benadryl throughout the protocol manual, and to include the following dosing:

0-6 years of age: 12.5 mg

6-12 years of age: 25 mg

Over 12 years of age: 50 mg

The motion was seconded by Mr. Johnson and carried unanimously.

Mr. Scheller asked if the committee would support allowing EMTs to administer PO Benadryl. The rationale being that there are EMT level providers at special events; it's counterintuitive that you can buy Benadryl at 7-11 but not get it from an ambulance. The same goes for the rural providers who may respond with an EMT unit. The committee agreed to revisit the discussion in the future.

G. Review/Discuss Destination Criteria for Outpatient Remote Emergency Departments

The committee agreed to forward the discussion to the Quality Improvement Directors committee for further review of the capabilities of the remote EDs and safety/operational metrics that may need to be put in place prior to making a decision.

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 10:04 am.