MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DIVISION OF COMMUNITY HEALTH

DRUG/DEVICE/PROTOCOL (DDP) COMMITTEE

April 5, 2023 – 9:00 A.M.

MEMBERS PRESENT

Michael Holtz, MD, CCFD, Chair
Jeff Davidson, MD
Mike Barnum, MD, AMR
Nate Jenson, DO, MFR
Jim McAllister, LVMS
Samuel Scheller, GEMS
Steve DePue, CCFD
Ryan Fraser, AirMed (Alt)
Kelly Morgan, MD
Jessica Leduc, DO, HFD
Chief Frank Simone, NLVFD
Chief Shawn Tobler, MFR
Todd Ford, HFD (Alt)
Chief Stephen Neel, MVFD
Derek Cox, LVFR
Sydni Senecal, OptimuMedicine

MEMBERS ABSENT

Nigel Walton, BCFD
John Osborn, CA
Karen Dalmaso-Hughey, AMR
Alicia Farrow, Mercy Air

SNHD STAFF PRESENT

Christian Young, MD, EMSTS Med. Director
Laura Palmer, EMSTS Supervisor
Stacy Johnson, Regional Trauma Coordinator
Rae Pettie, Recording Secretary
John Hammond, EMSTS Manager
Scott Wagner, EMSTS Field Representative
Roni Mauro, EMSTS Field Representative
Edward Winder, Associate General Counsel

PUBLIC ATTENDANCE

Sandra Horning, MD
Michael Denton
Rebecca Carmody
Fernando Juarez, RN
Benjamin Hartnell
Scott Phillips
Andrew McWhorter
Emily Keener
Kenneth Chang, DO
Aaron Goldstein
James "Bud" Adams
Ryan Young

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The Drug/Device/Protocol (DDP) Committee convened in the Red Rock Conference Room at the Southern Nevada Health District on Wednesday, April 5, 2023. Chairman Mike Holtz called the meeting to order at 9:00 a.m. and stated the Affidavit of Posting was posted in accordance with the Nevada Open Meeting Law. Some Committee members joined the meeting via teleconference and the roll call was administered by Laura Palmer, EMSTS Supervisor, who noted that a quorum was present.

I. 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. Holtz 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

Dr. Holtz stated the Consent Agenda consists 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 1, 2023

A motion was made by Dr. Morgan, seconded by Chief Neel, and carried unanimously to approve the Consent Agenda as written.

III. REPORT/DISCUSSION/POSSIBLE ACTION

A. Discussion of Pediatric Respiratory Distress Protocol – Tabled

B. Discussion of Adult/Pediatric Ventilation Management Protocols

Dr. Young stated the post-intubation sedation medications differ on the adult and pediatric Ventilation Management protocols. He noted there are also differences related to endotracheal intubation as far as sequence. He asked the agencies if they have been approached by the crews as to the disparities. Dr. Holtz agreed the two protocols should be in sync in terms of medication recommendations. Dr. Morgan suggested they remove the drug dosages from all of the procedures since they are already included in both the formulary and the respective protocol. Dr. Young noted when we first added Ketamine into the system it was done very judiciously, so it may be a good time to standardize it across the board. Dr. Holtz suggested they concentrate on standardizing the adult/pediatric Ventilation Management protocols for now rather than making a wide-scale change. Dr. Horning stated that although it's a controversial subject, they may want to place a maximum dose for Ketamine, perhaps using ideal weight as a base in light of a rise in a pediatric population who is larger in size. Dr. Holtz stated it may be difficult for the prehospital providers to calculate that weight quickly. Dr. Young agreed that ideal body weight is something they're more familiar with in a hospital setting and they need to make it as easy as possible for the field providers when transporting a sick patient. When Ketamine first came on board, they knew it was okay to intubate with, but they stuck with Versed and Valium for post-intubation. Dr. Holtz agreed it would require more evaluation before adding it to the protocol. Mr. Hammond noted they will need to look at post-sedation analgesics versus post-intubation analgesics for adult ventilation management. Dr. Horning stated she would be happy to research the literature.

Dr. Young stated the pearls are extensive in the ventilation management protocols. He noted the pearl stating that "Cricoid pressure and BURP maneuver may assist with difficult intubations. They may worsen view in some cases" has been disproven, and that external laryngeal manipulation is the updated term on what to do to get a good view. Mr. Cox noted that ventilatory rate and End Tidal CO_2 in most of the protocols is a QI metric, not a pearl. He suggested they consider adding QI metrics to the Ventilatory Management protocols when it comes to ventilation or airway. Dr. Barnum suggested they consider adding Midazolam as an induction agent. It's only currently limited to pediatrics, but they could add it as an option for adult induction. He noted it would not be added as a first-line agent, but as a backup in light of the shortages they are currently experiencing. Dr. Holtz had concerns about the hemodynamic stability of using Versed alone. Dr. Barnum responded it would be a consideration, and not something that would prevent him from using it in the event of the absence of other agents; he recommended they use it combined with an opiate.

After much discussion, the committee agreed to table the discussion of using Versed for induction.

A motion was made by Dr. Barnum, seconded by Chief Neel and carried unanimously to add Midazolam 0.1 mg/kg up to a max dose of 10 mg for post-intubation sedation to the Pediatric Ventilation Management Protocol, and make the following revisions to the Adult Ventilation Management Protocol:

1. *Add Midazolam 0.1 mg/kg up to a max dose of 10 mg for post-intubation sedation;*
2. *Add Ketamine for post-intubation sedation;*
3. *Add Fentanyl 100 mcg; and*
4. *Remove the pearl that states, "Cricoid pressure and BURP maneuver may assist with difficult intubations. They may worsen view in some cases."*

C. Discussion of AEMTs Performing Pediatric IOs

Dr. Hodnick stated he represents the Moapa Valley Fire Department and Mt. Charleston Fire Protection District in rural areas where they don't have many paramedics. He proposed they allow AEMTs to perform pediatric IOs in the field, which is currently a paramedic-only skill in our EMS system. He noted it's much harder to get an IV in for pediatrics, especially if they have a low blood pressure, and IO is a great route. He noted the AEMTs practice the skill every year. Dr. Hodnick stated it would be a great help to the paramedic if they can rely on the AEMT to do the IO while they're focusing on ventilating a sick child.

Dr. Young noted the 2019 National EMS Scope of Practice Model includes the IO skill at the AEMT level. He noted when we first added IOs into our system, Mercy Air did a pilot project that was all positive, but it was approved for adults only. Dr. Holtz asked if they had any idea of how many times pediatric IOs would be required in the field. Dr. Hodnick responded he didn't think there would be a high frequency, but it would be a game changer for the rural communities when they are unable to obtain IV access and they're having to wait for a higher level of care to respond in the field.

A motion was made by Dr. Hodnick, seconded by Dr. Morgan, and carried unanimously to allow AEMTs to perform pediatric IOs.

Mr. Cox asked for clarification on whether there is a need to revise the Vascular Access protocol which currently states, "Indications for Intraosseous Access (Paramedic for Adult and Peds, AEMT for Adult Only)" and whether AEMTs will be allowed to administer lidocaine to a patient responsive to pain. Mr. Hammond stated that the questions being raised were valid and they may need to gather more information prior to making a decision. The committee discussed including only the unconscious, unresponsive pediatric patient. Dr. Holtz stated his understanding was their only goal was to add pediatric IO to the AEMT scope of practice. Dr. Hodnick agreed that that was the intent, but for the unconscious pediatric patient, because trying to get an IV in one of those patients is difficult, even in the hospital. Dr. Morgan stated she would like to amend the previous motion to include "unconscious, unresponsive pediatric patients."

[Note: It was later identified that there was no vote following the amendment to the initial motion. This agenda item will be placed on the next meeting's agenda for discussion.]

D. Discussion of AEMTs Administering Epinephrine 1:10,000

Dr. Hodnick proposed they allow AEMTs to administer Epinephrine 1:10,000 for cardiac arrest to take the burden off the paramedic to perform higher level tasks, especially when it comes to airway management. He noted the AEMTs are familiar with it as they are currently permitted to administer the drug for anaphylaxis, although it would be used for a different indication/concentration. Chief Neel noted there was a study published in October 2021 showing an increase in survival rate with early administration of Epinephrine by AEMTs in the prehospital setting. Dr. Morgan stated the adult and pediatric dose would need to be calculated differently. She expressed concern about the difficulty of the pediatric dose as composed to the adult dose. Chief Neel stated he is agreeable to allow it just for adults as there is a greater chance of the AEMT making an error in the calculation for the pediatric patient.

A motion was made by Dr. Hodnick and seconded by Mr. Walton to allow AEMTs to administer Epinephrine 1:10,000 to adults for cardiac arrest.

[Note: It was later identified that there was no vote following the motion and second. This agenda item will be placed on the next meeting's agenda for discussion.]

IV. INFORMATIONAL ITEMS/ DISCUSSION ONLY

Dr. Holtz reported there has been a desire to work at standardizing the protocol manual. He proposed they form a workgroup for the future. Ms. Palmer noted that no policy-making decisions can be performed in that forum.

Dr. Morgan stated that bi-level masks are available on the market that allow bi-level ventilation without the need for a ventilator. Las Vegas Fire & Rescue would like to move forward with piloting the product. Mr. Hammond stated the OEMSTS will send her the procedure that outlines what is required.

V. 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. Holtz 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.

VI. ADJOURNMENT

There being no further business to come before the Committee, the meeting was adjourned at 10:02 a.m.