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

August 2, 2023 – 9:00 A.M.

MEMBERS PRESENT

Michael Holtz, MD, CCFD, Chair
Jessica Leduc, DO, HFD
Chief Frank Simone, NLVFD
Jim McAllister, LVMS
Samuel Scheller, GEMS
Chief Stephen Neel, MVFD
Nate Jenson, DO, MFR
Kelly Morgan, MD
Mike Barnum, MD, AMR
Chief Shawn Tobler, MFR
Nathan Root, HFD (Alt)
John Osborn, CA
Derek Cox, LVFR
Sean Collins, CCFD (Alt)

MEMBERS ABSENT

Josh Barrone, BCFD
Troy Biro, AirMed Response
Jeff Davidson, MD, MWA
Karen Dalmaso-Hughey, AMR
Alicia Farrow, Mercy Air
Sydni Senecal, OptimuMedicine

SNHD STAFF PRESENT

Christian Young, MD, EMSTS Med. Director
Roni Mauro, EMSTS Field Representative
Stacy Johnson, EMSTS Regional Trauma Coordinator
Nicole Charlton, EMS Program/Project Coordinator
John Hammond, EMSTS Manager
Edward Winder, Associate General Counsel
Rae Pettie, Recording Secretary

PUBLIC ATTENDANCE

Sandra Horning, MD
Matthew Dryden
Michael Denton
Carlos Laos, MD
Jason Perlmutter
James "Bud" Adams
Daniel Perez
Maya Holmes
Ryan Young
Aaron Goldstein
Stephanie Teague

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

Chairman Michael Holtz called the meeting to order at 9:03 a.m. and stated the Affidavit of Posting was posted in accordance with the Nevada Open Meeting Law. All Committee members joined the meeting by teleconference and the roll call was administered by Nicole Charlton 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: June 7, 2023

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

III. REPORT/DISCUSSION/POSSIBLE ACTION

A. Discussion of the Use of Mechanical CPR Devices in Pregnancy

Dr. Holtz reported this action item was tabled at the previous meeting so they could discuss revisions made to the handout. He referred the committee to the draft pearls to address mechanical chest compression devices, specifically the LUCAS mechanical Chest Compression System, which can be used on visibly pregnant women. He noted there's a new certification named Obstetric Life Support and stated that staff support recommends mechanical CPR devices. Dr. Holtz directed everyone's attention to the first bullet point under the 4th bullet point which states "Use device per manufacturer's guidelines – if a device is not approved for use in pregnant patients, it may not be utilized." He stated the first part, "Use device per manufacturer's guidelines" is a common statement throughout the protocol manual for other devices. The second part "if a device is not approved for use in pregnant patients, it may not be utilized" will be struck because the FDA doesn't approve the device specifically for a pregnant patient. Other revisions emphasize the use of the "pit crew" approach for cardiac arrest. Dr. Holtz stated he obtained the verbiage "Crews should consider utilizing a "pit crew" approach with predefined roles and crew resource management principles" from the Los Angeles protocols, specifically about obtaining vascular access above the diaphragm using manual leftward lateral displacement of the uterus, and also obviously rapid transport to the E.D. for what is now called Resuscitative Cesarean Delivery.

Dr. Holtz commented that going forward they need to ensure they are prudent in researching which organizations approved a device, so they know what's allowed by the FDA. It's difficult to get things approved for pregnancy because nobody does studies on pregnant patients. This is the case for drugs, devices, and pretty much everything. You're never going to get a manufacturer to say that a device is specifically approved for pregnant patients. Rather, the manufacturer will say that it's not contraindicated in pregnant patients.

Mr. Cox referred the committee to the third bullet point that states, "Continuous waveform capnography should be monitored throughout resuscitation….." He asked if that verbiage is necessary because if there's an ET tube, continuous capnography is the gold standard; in the absence of an equipment malfunction, all intubations should be monitored continuously. Dr. Holtz stated that the way it's written, it also recommends waveform capnography when there is not an advanced airway present. The committee discussed the need to look at ambiguity and inconsistency throughout the protocol manual.

A motion was made by Dr. Holtz, seconded by Chief Simone and carried unanimously to approve the draft pearls as written, with the exception of the line "if a device is not approved for use in pregnant patients, it may not be utilized."

B. Discussion of Change in the Scope of Practice to Allow EMTs to Perform Vascular Access

Mr. Hammond referred the committee to the Vascular Access protocol and stated that he would like to add C. under "Indications for Peripheral Vascular Access" to read, "EMTs holding an EMT-IV endorsement, only when

directed by an AEMT or Paramedic on scene." Mr. Cox asked for the history of the decision to allow EMTs to start an IV. Mr. Hammond noted they already approved the change in scope of practice in previous meetings. Henderson Fire Department has been doing so since the early 2000's under a previous agreement with SNHD. A request was made by Boulder City Fire Department to allow their EMTs to perform intravenous cannulation as part of their expanded scope of practice. They researched other systems who are also allowing this practice; sometimes it's done based on licensure, and sometimes it's based on endorsement. We have chosen to base it on endorsement. Through the process of getting this passed through, he broached the subject with Dr. Leguen, the District Health Officer, the individual ultimately responsible for the clinical practice of EMTs, AEMTs and Paramedics, who agreed with the safety guidelines we're putting in place for this particular activity and endorsement. So, we added it to the scope of practice for EMTs for those agencies who agree to the endorsement, similar to the critical care endorsement. Mr. Hammond stated that the issue was then referred to the Education Committee, who is currently in the process of developing the educational outline for the endorsement. The DDP will discuss the appropriate revisions that need to be made to all related protocols, starting with Vascular Access. They will need to integrate the EMT with IV endorsement to indicate that an EMT can provide that function of cannulation only. Any agency that desires to allow their EMTs to perform IV cannulation must provide training pre-approved by the OEMSTS. The actual cannulation is the only skill that will be approved for the expansion of scope of practice and will be performed only under the direct observation and direction of an AEMT or Paramedic while physically on scene. The EMT will be starting cannulation for either a saline lock or for fluid but will not adjust the flow rate or administer through an IV. Exclusions will include no external jugulars or IOs. Each agency will need to develop and submit a QI program for monitoring the new expansion to the OEMSTS. Mr. Hammond noted that for the time being there will be no application fee for adding the endorsement. Documentation of successful completion of the training will be required prior to endorsement. The endorsement will expire upon expiration of the license, at which time the EMS provider will need to apply for renewal of the endorsement.

A motion was made by John Hammond, seconded by Chief Neel, and carried to revise the Vascular Access protocol to add "C. EMTs with an IV endorsement, only when directed by an AEMT or Paramedic on scene" under Indications for Peripheral Vascular Access. Mr. Cox was the only Board member who was opposed.

A motion was made by Dr. Barnum, seconded by Chief Neel, and carried to revise the first line of the Vascular Access protocol to read: "Level: AEMT/Paramedic, EMTs holding an EMT IV endorsement (only when directed by a licensed AEMT or Paramedic on scene." Mr. Cox was the only Board member who was opposed.

C. Discussion of the Use of Bi-Level CPAP Masks - Tabled

D. Discussion of the Trauma Field Triage Criteria Protocol

Mr. Hammond referred the committee to the first page of the draft TFTC protocol that was promulgated by the ACS Committee on Trauma as a change to their schema for TFTC patients. He noted the reason for this meeting is to discuss only those items on the front page, specifically Red Injury Patterns, Red Mental Status & Vital Signs, Yellow Mechanism of Injury, and Yellow EMS Judgment. Mr. Hammond stated that this particular method is currently being used by trauma centers throughout the nation. Our trauma centers would like to use it as well, so we get the same type of information going to the National Trauma Data Bank (NTDB) as everybody else. In previous discussions under Yellow EMS Judgment, they added anti-platelet use as one of the signs, along with the anticoagulant. In reference to the same section, Mr. Cox asked whether Michael O'Callahan Military Medical Center is prepared to accept pediatric patients who meet the criteria. Mr. Hammond stated that O'Callahan is not receiving pediatric trauma patients at this time. The catchment area for this subset of patients will be defined at a later date. He clarified that the same four steps are now differentiated into the red/yellow injury patterns, and the decision to take a patient to the trauma center is still "consider" as opposed to "must."

Dr. Holtz asked if there is a QI process in place to monitor whether these patients are being transported to an appropriate facility, so we don't see an increase in morbidity and mortality because of an inappropriate transport. Mr. Hammond stated that the Trauma Medical Audit Committee looks at the data quarterly to make that determination.

A motion was made by Mr. Hammond, seconded by Mr. Scheller, and carried unanimously to accept the revisions made to page 1 of the draft Trauma Field Triage Criteria protocol.

IV. INFORMATIONAL ITEMS/ DISCUSSION ONLY

None.

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 9:48 a.m.