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

June 5, 2024 – 9:00 A.M.

MEMBERS PRESENT

Kelly Morgan, MD, Chair
Jessica Leduc, DO, HFD
Chief Kim Moore, HFD
Chief Jennifer Wyatt, CCFD
Chief Stephen Neel, MVFD
Chief Shawn Tobler, MFR
Michael Whitehead, AMR/MW
Mike Barnum, MD, AMR
Jeff Davidson, MD, MWA (Alt)
Chief Frank Simone, NLVFD
Jim McAllister, LVMS
Samuel Scheller, GEMS
Derek Cox, LVFR
Sydni Senecal, OptimuMedicine

MEMBERS ABSENT

Troy Biro, Guardian Flight
John Osborn, CA
Alicia Farrow, Mercy Air

SNHD STAFF PRESENT

Christian Young, MD, EMSTS Med. Director
Stacy Johnson, EMSTS Regional Trauma Coordinator
Nicole Charlton, Recording Secretary
Roni Mauro, EMSTS Field Representative
Kristen Anderson, Senior Admin. Assistant
Edward Wynder, Associate General Counsel

PUBLIC ATTENDANCE

Sandra Horning, MD
Asher Gordon
Braiden Green
Bree Young
Don Abshier
Mike Denton
Erik Grismanauskas
Collin Sears
Damien Harris
Danny Perez
Emily Leon
Jared Van Aken
Jordan Salloum
Kady Dabash Meininger
Matthew Dryden
Paul Stepaniuk
Stacy Pokorny
Todd Ford
Kristen Purcell
Sean Collins
Ashley Tolar
Breanna Ellison
Brittany Corn
Rebecca Carmody
Justin Peck
Christopher Hughes
Craig Faria
Daniel Shinn
David Bolshazy
Gabe Gonzalez
Jason Perlmutter
Karla Estrada
Marty Hannon
Maya Holmes
Ryan Young
Stephanie Teague
Hunter Anderson

I. CALL TO ORDER AND ROLL CALL

Chairman Kelly Morgan, MD, 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.

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 (415)655-0001 and entering access code 2556 178 0455. To provide public comment over the telephone, please press *3 during the comment period and wait to be called on. To provide public comment over Webex, 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. Morgan asked if anyone wished to address the Board concerning items listed on the agenda. Seeing no one she closed the public comment portion of the meeting.

IV. ADOPTION OF THE June 5, 2024 AGENDA

A motion was made by Chief Simone, seconded by Chief Neel, and carried unanimously to adopt the June 5, 1024 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 per Committee Member request before action. Any exceptions to the Consent Agenda must be stated prior to approval.

Approve Minutes April 3, 2024 Drug/Device/Protocol Committee Meeting ***(for possible action)***

A motion was made by Mr. McAllister, seconded by Chief Simone, and carried unanimously to approve the Consent Agenda.

VI. REPORT / DISCUSSION / ACTION

A. Discussion and Approval of the Recommendation to Revise the Pediatric Allergic Reaction Protocol

Mr. Ford stated he received several recommendations/suggestions at the March meeting. He noted the current version starts off with pediatric assessment, then goes down to evidence of airway involvement or breathing difficulties. He feels the verbiage should be revised to add a branch that states "evidence of anaphylaxis?" He stated Dr. Horning is in agreement with that verbiage. Other feedback he received was to revise the pearls to include that not all anaphylaxis results in skin changes, plus cardiovascular, respiratory or GI issues, and there are additional pearls he feels should be considered for adoption. He noted that 15% of anaphylaxis patients won't have urticaria. Mr. Cox suggested that in the pearls under Severity they consider revising the verbiage to "partial obstruction" as opposed to "upper airway obstruction" because if they're obstructed, they may need to go down a different pathway. Dr. Morgan stated we also need to ensure we're aligned with the national guidelines. Dr. Horning commented that early intervention is key, and epinephrine should be considered if the child has a history of anaphylaxis with exposure to the same allergen. Mr. Ford suggested they add that to the pearls under "Special Considerations" as an educational point. He suggested they also remove "Provide oxygen and airway support as needed" as that should be common sense as part of the general patient assessment.

A motion was made by Mr. Ford and seconded by Mr. Cox to approve the following revisions to the draft Pediatric Allergic Reaction protocol:

1) *Remove "Evidence of airway involvement/breathing difficulties?" at the top of the protocol, and replace it with "Evidence of anaphylaxis;"*
2) *Add "Consider push-dose epinephrine 0.1 mcg/kg IV/IO, max dose of 5 mcg. Titrate to SBP >70mmHg + 2x age;*
3) *Replace the "Severity" section in the pearls with "Anaphylaxis, a moderate or severe immune reaction with acute onset of skin changes, urticaria, erythema, flushing and/or angioedema plus cardiovascular, plus/minus respiratory or GI issues, or hypotension, bronchospasms or angioedema with exposure to known allergens; and*
4) *Under "Special Considerations" delete "Provide oxygen and airway support as needed" and replace with "If patient has a history of anaphylaxis with exposure to the same allergen, consider early administration of epinephrine despite no hard signs of anaphylaxis present yet" under "Special Considerations."*

After some discussion, Mr. Ford rescinded his motion and agreed to table this agenda item to allow Mr. Ford to bring back a reformatted version of the protocol for review at the next meeting.

B. Discussion and Approval of the Recommendation to Revise the Pulmonary Edema/CHF Protocol

Mr. Ford stated they removed phenylephrine and replaced it with push dose epinephrine for cardiogenic shock in the Shock protocol, but they were unable to make the same adjustment to the Pulmonary Edema/CHF protocol because it wasn't listed for discussion at the April meeting.

A motion was made by Mr. Ford, seconded by Chief Simone, and carried unanimously to replace phenylephrine with push-dose epinephrine for cardiogenic shock in the Pulmonary Edema/CHF protocol.

C. Discussion and Recommendation to Approve Adding Tranexamic Acid (TXA) to the Formulary and the General Adult Trauma Protocol

Chief Neel referred the committee to the draft General Adult Trauma Assessment protocol. He noted the addition, "Consider Tranexamic Acid 2g in 50 ml NS over 10 min for SBP <90 or HR >110" under Hemorrhage Control. He also added two pearls. Dr. Young asked where Chief Neel arrived at the 2g dose. Chief Neel replied there is a new study that has not yet been published that states it's better to give 2g than to give 1g and another gram later at the hospital. Dr. Young stated he is not in agreement with giving 2g simply because it's easier than having to rely on the hospital to give the second dose. There's not necessarily any harm in giving 2g but giving 1g is definitely the best way to go forward. He noted that most of the protocols he has reviewed give a 1g dose. Dr. Young also noted that patients with hypotension and signs of hypoperfusion and shock frequently have a HR>110 because of pain or distress, so that's another reason he wouldn't give a 2g dose. Chief Neel agreed and stated the verbiage should also be changed to "SBP <90 *and* HR>110." Dr. Young stated there may be more buy-in with the 1g dose as people are still getting used to giving TXA, so if we start with a conservative dose first and see how it goes, we can potentially evolve into giving a 2g dose. He noted that some EMS systems have implemented a wrist band that states the patient has received TXA. That way you're sure there's going to be follow-through by the receiving facilities. Dr. Morgan stated the time(s) the medication was given should also be reported.

Dr. Morgan stated they need to ensure TXA is only for intracavitary chest and abdominal hemorrhaging. She questioned why the tourniquet isn't included in the protocol for external signs of hemorrhage. The crews should also communicate what time a tourniquet was applied. Dr. Young asked if they want to add another box that states "Control active extremity hemorrhage?" They can make an arrow to "apply hemorrhage control/tourniquet" and then "blunt or penetrating trauma with suspected blood loss, along with vital signs," prior to giving TXA. He noted the draft protocol is written similar to the General Adult Assessment protocol in that it redirects you to the appropriate protocol, so we can probably just re-route them to the Hemorrhage Control protocol. He suggested they also include verbiage that states TXA must be given within one hour of injury and is contraindicated after three hours.

A motion was made by Chief Neel make the following revisions:

1) *Move the verbiage related to hemorrhage control from the General Trauma Assessment protocol to the Hemorrhage Control;*
2) *Add a box titled "torso control" and change the verbiage to "consider TXA 1g over 10 min, or SBP <90 or a HR> 110;*

3) *Add to the pearls, "TXA should be given within one hour of injury, and should not be given if the injury has occurred >3 hours; and*
4) *Add to the pearls, "Do not delay transport to administer TXA."*

After some discussion, Chief Neel agreed to make the necessary changes to the draft protocol(s) to bring back to the next meeting for review and discussion.

VII. INFORMATIONAL ITEMS/ DISCUSSION ONLY

None

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. Morgan asked if anyone wished to address the Board regarding items listed on the agenda. Seeing no one, she 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 10:07 a.m.