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

November 6, 2024 – 9:00 A.M.

MEMBERS PRESENT

Kelly Morgan, MD, Chair
Jessica Leduc, DO, HFD
Chief Kim Moore, HFD
Sean Collins, CCFD (Alt)
Stacy Pokorny, MWA (Alt)
Chief Shawn Tobler, MFR
Jim McAllister, LVMS
Nate Jenson, DO, MFR
Sydni Senecal, OptimuMedicine
Mike Barnum, MD, AMR
Michael Holtz, MD, CCFD
Aric Seal, NLVFD (Alt)
Todd Ford, HFD (Alt)
John Osborn, CA
Derek Cox, LVFR
Capt. James Whitworth, BCFD
Michael Whitehead, AMR

MEMBERS ABSENT

Alicia Farrow, Mercy Air
Troy Biro, Guardian Flight
Chief Stephen Neel, MVFD

SNHD STAFF PRESENT

John Hammond, EMSTS Manager
Christian Young, MD, EMSTS Medical Director
Stacy Johnson, EMSTS Regional Trauma Coordinator
Roni Mauro, EMSTS Field Representative
Rae Pettie, Recording Secretary
Laura Palmer, EMSTS Supervisor
Edward Wynder, Associate General Counsel
Cassius Lockett, PhD, Deputy District Health Officer
Nicole Charlton, EMSTS Program/Project Coordinator

PUBLIC ATTENDANCE

Kate Jessop
Kady Dabash-Meininger
Braiden Green
Sean Collins
Maya Holmes
Aaron Goldstein
Shannon Ruiz, PharmD
David Obert, DO
Dan Shinn
William Vance
Rebecca Carmody
Erik Grismanauskas
Mark Calabrese
Eric Dievendorf
Christopher Dobson

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 November 6, 2024. Chairman Kelly Morgan, MD, called the meeting to order at 9:06 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. Laura Palmer, EMSTS Supervisor, 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 NOVEMBER 6, 2024 AGENDA

A motion was made by Mr. Cox, seconded by Mr. McAllister, and carried unanimously to adopt the November 6, 2024 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 October 2, 2024 Drug/Device/Protocol Committee Meeting ***(for possible action)***

A motion was made by Mr. McAllister, seconded by Dr. Barnum, and carried unanimously to approve the October 2, 2024 Consent Agenda as written.

VI. REPORT / DISCUSSION / ACTION

A. Discussion and Recommendation to Approve Adding Buprenorphine to the Formulary and Adult Overdose/ Poisoning Protocol

Dr. Morgan continued her discussion of addressing the nationwide opiate problem by asking the DDP to approve her proposal for the addition of Buprenorphine (BUP) to the formulary and Adult Overdose/Poisoning protocol. She referred the committee to the draft Opioid Withdrawal and Adult Overdose protocols for review. She stated the draft protocol is based on the Hennepin County protocols and CA Bridge to Treatment, now a national bridge, who has done a lot of work over the past few years working on the opiate problem and linking people to care. In that process they generated evidence-based national protocols for guidance. The draft Adult Overdose/Poisoning protocol algorithm includes a reference to the Opioid Withdrawal protocol if the patient exhibits signs of opioid withdrawal after the administration of Naloxone. The handout also included the protocol and formulary utilized by Hennepin County in the 911 system for over a year. Dr. Morgan stated that they reported great results with no precipitated withdrawal or bad outcomes in approximately 180 administrations. The protocol for patient refusal of transport after administration was also included in the handout, along with the protocol utilized in Multnomah, Portland.

Mr. Cox thanked Dr. Morgan on LVFR's behalf for the work she put into putting the information together, including the QI metrics. He added that LVFR supports the inclusion of BUP into the EMS system. Dr. Holtz asked if they researched past calls to see how many patients would qualify, or potentially qualify for BUP. Dr. Morgan stated she can show the number of overdose calls that are run in the county; at least the ones that came through the FAO; the numbers have doubled what they were last year. Dr. Holtz asked if those were specifically for opiate withdrawals. She related that it's hard to specify because it comes down to what the primary impressions are when you actually sort the data to pull out only overdose calls because it's not always

listed as "overdose." For example, calls may come in as unconscious, unresponsive, or cardiac arrest. If you sort it based just on Narcan administration you're not getting great examples. She stated the numbers are in the several hundred. Dr. Holtz noted that those would be related to overdose. He is curious to see the calls that are specific to opioid withdrawal. Dr. Morgan stated it's never been an ICD-10 code that we have in the system, so a number of those calls come in as abdominal pain or nausea/vomiting. The primary impression when the provider is charting comes in as "opioid overdose" and then we precipitate withdrawal with Narcan, after which the patient gets combative and jumps off the gurney. She reiterated that it's hard to track because the primary impressions have not been accurately noted for them to sort and gather the pertinent data appropriately. Dr. Holtz stated he is all for a reduction in general, and in EMS; however, he has some concerns with bringing this protocol to the entire system. He feels that it's a very complicated process, and the COWS (Clinical Opioid Withdrawal Scale) is not easy to do quickly, which may prolong scene times. In speaking with other systems that utilize it, they've all said they're not using it as much as they thought they would, and all of the paramedics just don't do it because of the length and complexity of the protocol. He suggested they start with a pilot study to see if there's a benefit to utilizing BUP. He added that we may not have the appropriate resources that other EMS systems have, such as Portland's MOUD facility. Dr. Morgan stated that part of that comes with transport to an alternate destination, which hasn't been fully flushed out in our system. But with the broad education of all ER providers and anybody who has a DEA license, the goal is to get them to a facility where they can get linked up with a substance abuse navigator in order to move forward with the patient hand-off. If you save one life--that's worth something. A lot of these patients are seen over and over again. A lot of times, if you can give a medication that is protective for a 24-hour period from repeat overdose, I think that as a public health agency and somebody delivering patient safety across a broad net of people, we almost have a moral obligation to provide this service. And whether or not they're able to get directly hooked to care probably should not dictate how we treat people in the street in acute crisis.

Dr. Leduc agreed that this is how we are moving forward in emergency medicine, at least in the Valley Health System. Although we may continue to see repeat offenders, right now we're doing nothing for these individuals. The app looks pretty easy. If you scan the QR code it comes up pretty quickly and goes right to MDCalc. It's something that people are going to learn and will get easier to utilize. She stated we shouldn't let something like that hold us back from doing something this good, and that can be followed up in the EDs here because we're all trained on this. Receiving the training to renew their DEA license is mandatory, so it's not going to be a foreign entity after you come to the ED after having treated this patient in the field. Dr. Barnum stated that there will most likely be practitioners in the system who won't jump at the chance to give BUP because it's complicated, especially the COWS. However, he thinks in the future we'll get something that's combed down from that. He doesn't think they'll hurt anybody with BUP because the practitioners that are interested in weighing in on this are looking for the appropriate patients, and they want to use it, so this is a great opportunity to do quite a bit of good for those patients. He expressed concern with moving forward because it's such a huge problem.

Dr. Holtz stated he's torn because he supports harm reduction, and if we say the patient is protected for 24 hours after giving BUP, the patients need follow-up to get into an opioid treatment program and be placed on a long-term treatment plan. It shouldn't be "Okay, see you, good luck trying to find a treatment center." He stated that overall, BUP is a great thing for a lot of patients with opioid abuse disorder. However, he expressed concern on whether BUP is the best option for the system. Dr. Holtz related that he rarely orders BUP for patients in opiate withdrawal in the ED because of the lack of follow-up care.

Ms. Jessop introduced herself as a Family Nurse Practitioner, Emergency Nurse Practitioner, and a certified Addiction Nurse Practitioner. She just completed a year of post-master certificate with Johns Hopkins and rotated with the substance abuse disorder team at their hospital in Baltimore. She worked for 13 years in the ER here, and about 8-9 years in the addiction realm, as well as outpatient. She's been writing for Suboxone (BUP) products on an out-patient basis. And the past year she has been at the Clark County Detention Center piloting their medication assisted treatment program for opioid abuse disorder. She wanted to let the committee know her background as to why she is sitting at the table.

Ms. Jessop stated that when you look at the COWS, it looks scary. When she first looked at it, she felt the same way the committee did at first glance. But in reality, for EMS purposes, a COWS greater than "8" would qualify. A pulse over 100 is two points. If the patient is unable to sit still and is fidgeting, that's 5 points. So, it isn't something that has to be overly complicated, unless you want your practitioners to go point by point. There are systems that once they hit their threshold, which for our system will be "8," they conclude with further assessment. In Hennepin County, if they can't sit still, they would qualify. Ms. Jessop related that the COWS

appears more time-consuming than it is. It's must a matter of gaining familiarity with the process. As far as out-patient follow-up, she completely agrees that there can be barriers. However, she feels that communication is improving. She noted that the Southern Nevada Opiate Advisory Council meets quarterly and is a fantastic resource for out-patient resources. There is also an addiction fellowship in town that's been operating for a few years. There has been an increase in out-patient providers requesting these services. There are also a number of rehabilitation facilities that could be alternate destinations in our system, as well as psychiatric hospitals. A lot of that partners with peer navigation. Ms. Jessop noted the hospital EDs don't have addiction on call because now the hospitals have delineation of privileges to allow it as an actual acknowledged specialty, despite having an addiction fellowship. She stated that if that's one the barriers, she would encourage them to reach out to people in the hospital that have a say, because that's something she knows the addiction fellowship has tried pushing through, and she believes that will go a long way. If we have people to whom we can refer these patients to in the ED, then this just got that much easier for the EMS system as well. Having peer navigators in the ED being able to help guide where these patients would fit best is another necessary piece to the puzzle. So having those two pieces in place would really facilitate the process. Since we have follow-up facilities so she doesn't think it's a barrier than should prevent them from moving forward. We just need to essentially find them and create a list. However, even with patients that aren't able to get into long-term treatment, she has seen other systems being able to provide BUP through EMS; sometimes it's their introduction to the medication. Many patients start feeling better and start to research BUP and come to their office to receive further treatment. Ms. Jessop stated that the results are not something that you see on your rig but there are ripple effects. Although you may run repeated calls on that same patient, if you've already treated the patient for an overdose, then giving them BUP helps protect that repeated call within that approximate 24-hour period.

Dr. Morgan noted that we don't necessarily have to have every single piece lined up in order to start the race. You need to know what the destination is, and what your end goal is, and sometimes you just need to start. In EMS we have the ability to work to continue to push the system in making the out-patient follow-up easier to access and schedule appointments. We need to validate the need for substance abuse navigators to take the load off case managers, social workers, and resources we currently don't have 24/7 to help people get connected. Dr. Morgan related she has spent a lot of time in the last year and a half trying to work on ED readiness for opiate use, but at some point, hospital administration just gets in the way, and she feels EMS can drive the change that's needed for public safety and for this massive public health initiative. Her worry is that we're looking so far down the line that it's preventing us from even starting. She feels sometimes you just need to start, and things will continue to fall into place because of the momentum you put behind it. As we get more and more patients on BUP, there will be an increased need for peer navigators. We're adding more and more resources to this, but if we wait for everything to be magically in place, we're going to be waiting a long time, and people are going to continue to die. She noted there used to be an X waiver where there was a specific number where you had to report the number of patients per month, but they realized it became a barrier, so it was subsequently removed.

Ms. Jessop stated these resources are already being deployed. NLVFD has a CRT overdose response team that follows overdoses. There's a lot of overlap there, but a lot of these resources are already starting to be deployed. If we wait until all of that is set up, we're going to be years behind what could've already been occurring. At the end of the day, if our main concern is that not enough EMS providers will implement it, if we don't have the education, the protocols in place, and the availability to learn and do this, then no one ever will. Primary care providers could have been prescribing this medication for years. It was first suggested for opioid use disorder in the 60's. Part of the reason people weren't adopting it more broadly was because of these barriers, much like the X waiver. Ms. Jessop stated that we're already using BUP in other arenas with good outcomes in multiple EMS systems, so it's not unprecedented. She offered her contact information and stated she works with multiple clinics. She reiterated that the fellowship is a great resource if you have questions about a medication, about a protocol, or to find what resources are available for the holidays. There are people who want to be involved to help this subset of patients, but unless the protocol is approved, we won't know about them.

Dr. Morgan stated the clinics out there literally don't know how to get patients; that link between the ED and the clinics is a point of failure in our system. She stated there are ongoing efforts to add those links to care through substance abuse peer navigators, whether it's through telehealth or in-person in the ED. But the clinics want the patients. We have the patients. We just need to help connect the dots better.

Mr. Seal inquired about price and availability, whether there is an opioid derivative, and the possibility of shortages. In addition, if they're not getting secondary treatment, are we getting recalls for patients wanting the medication we're giving? Ms. Jessop stated that BUP is a partial agonist that has a ceiling effect. The full

agonists such as morphine, heroin, and methadone are what people can use to get high, overdose, and stop breathing. Although BUP is a partial agonist, it's not something people can easily overdose on. They can take handfuls of it and get sleepy or groggy, but they're not going to stop breathing. Since COVID, every single medication on the market has had shortages, but it's simply switching to another pharmacy, which is usually done through out-patient practice. She stated she hasn't experienced any issues with stocking BUP. Dr. Morgan noted that BUP is a lot cheaper than glucagon, at around $2.30/dose. Dr. Barnum stated that to his knowledge there hasn't been a shortage of BUP in the past, which is good for us from a system standpoint. If we do encounter a shortage, we would simply revert to symptomatic care, and while that may not be ideal, that's what we would need to do. He added that in terms of recall patients, he thinks that will be people who several days later have relapsed onto their opiates and are back in the same situation. So, when we see these patients recalling us, it'll be less within the 24-hour period for an additional dose of medication. It'll be more likely to be secondary to their own medications. Dr. Morgan stated there are programs around the country that utilize community paramedics for the most part to bridge dose people until their out-patient follow-up appointment. Although we're not at that point within our system, it 100% exists in other systems. She believes with more education being done in the ED the practitioners will be more likely to prescribe. She noted that Nevada passed a new law that pharmacists can prescribe this medication utilizing their license through the Nevada State Board of Pharmacy.

Dr. Holtz stated there may be clinics out there that want these patients, but they don't have outreach that he's aware of. Ms. Jessop replied that it's not like there's one singular office to send everyone. That's why she mentioned the fellowship. They have contacts within the community, and their fellows rotate through different clinical sites. They know a lot of resources in the community. She believes the peer navigators are going to be the lifeline to connect these patients to continued care. Chief Moore asked if the list of peer navigators is only tied to HCA, because that may make a difference on whether their insurance will pay. Ms. Jessop responded that the insurance plan is the peer navigator. Dr. Holtz stated the idea is that you transport to the hospital you usually transport to, and it's the hospital's job to get a peer navigator. Dr. Leduc noted that that will be much easier in relieving the EMS system. The ED should be doing that part anyway.

Chief Tobler asked how difficult it is for a person to get into a treatment center. Ms. Jessop replied that it completely depends on the center. There are some who have grant funding, and there are many that are self-pay or insurance, or some combination thereof. She noted that a lot of primary care offices do maintenance, even induction. Agencies in town like Crossroads, Vegas Stronger and WestCare are places where they can get triaged to a higher level of care. At her clinic, even if there isn't one they're contracted with, they at least see the patient for the first visit, get them stabilized, and then get over to a clinic that accepts their insurance. Dr. Morgan added that HBI has resources; they do MAT. She stated a lot of the clinics that are contracting in the un-housed population are also being pushed in or providing MAT services as well. So, it's available even for patients who don't have other resources; and Medicaid covers BUP, as well as one-a-month injections. Chief Tobler stated that from a rural perspective, he's not sure what resources they would be able to offer people in their community that are in this situation. Would they need to direct them into the valley metropolitan area? He agrees it would be helpful for him as a provider to give this information to the patients to seek follow-up care. Ms. Jessop stated that Mesquite has local resources. There are a few clinics up there, and also Mesa View Regional Hospital. There are also tele-health options for patients to continue with their treatment with BUP. There are some entities who operate solely online. Dr. Morgan stated she will personally put together a list of resources.

Dr. Holtz stated that these patients should still be transported. It's not a "treat and release" on scene. That needs to be made exceedingly clear, as the draft protocol does not. Dr. Morgan stated she can "reassess and transport as necessary" to the protocol. Dr. Holtz responded that in this case it's necessary because a lot of people are going to assume we're initiating treatment and that the patient can follow up on his own. He recommended they change the Midazolam and Droperidol doses. His thought is to remove Midazolam in general and make Droperidol the required drug for our system. It's a much better option for safe patient sedation than Versed, which we have.

Chief Collins asked if there is any other metric than the COWS as it's a lot to try to memorize and utilize on scene. Dr. Morgan related that COWS is the most widely known and accepted metric. She stated she would stick to the easiest boxes on the list and once you have 3-4 of those, you're going to be pretty close to hitting the threshold of "8" for the most part. She thinks people are going to get more used to it, and using MDCalc is fairly easy. The QR code for the COWS brings you directly to the calculator so it doesn't require a lot of thinking. Mr. Cox agreed that they can build something for the COWS similar to what they provide for the RACE scores.

Mr. Ford asked whether we have buy-in from the EDs and EMS providers. Do they have their resources set up for social work and follow up? Dr. Morgan replied, yes, to some degree. She thinks a lot of the struggle is that

things have been grant funded, and then you run into hospital administration because they've been working on opiate grants for the last two years now and she's had funding for a peer navigator that is stuck in hospital administration over contract issues instead of just getting it out there. So, this is where bringing in navigation lines on tele-health is just easier than doing it any other way. A lot of times social workers and case managers just don't have the time and resources. They have Monday-Friday jobs from 9:00 to 4:00 which is not when we see a lot of these patients. Adding in resources such as a warm line is similar to calling poison control, and it's enough to put on an iPad or tablet to where the nurse dials the number, hands the iPad to the patient, and the patient and navigator do a quick tele-health based on the 42 CFR. She noted there are certain limitations as to what can be included on a healthcare record. She thinks it can be as simple as putting in a "peer navigation order" in the same way you put in an overdose order. Using the tele-health method is pretty much the way to spread the resources and allow more people access to the services and not be burdened by the cost and reimbursement of having a physical person in the ER 24/7. That's been a barrier in getting that resource out there. She feels as more and more education is being taught in every residency program, it's going to gain steam. The bottom line is that we don't send patients away with high blood pressure without refilling the medication they've been off for a month and tell them they just have to walk around with a BP of 240/130. She feels if they can re-frame how people think about it, we can continue to move people in the right direction. Ms. Jessop related that when she first started in the ED it was a very different landscape. In the last few years there has been more and more momentum towards doing something to address the issue of this relapsing disease process. As we educate more and more of our residents, fellows, and nurses, it will become more widely accepted. More abstinence-based facilities are moving towards medication-assisted treatment.

Dr. Jenson asked what kind of outreach can be done by the provider, what resources are in place to know when there's a good patient hand-off. Dr. Leduc noted that the medical directors should accept the responsibility to take that information back to their respective hospital(s). You can't renew your DEA license without taking an 8-hour course. We can choose to educate our community and make this successful, or we can just keep going as we are, just prescribing Narcan. Dr. Morgan noted the National Bridge has put out great resources for physician, PA, and nursing education. All of it is free of charge. Ms. Jessop related that if we're keeping them alive, then we're winning. If we can keep them alive and at least introduce them to treatment, sometimes it's just that glimmer of hope and being treated like a human. If some of that stigma is reduced, she believes we'll see a lot of success. We just need to redefine what success looks like. Sometimes success is just keeping that person alive for that day and giving them education on what the next steps can be in giving them that opportunity.

Mr. Hammond asked if anyone has any use or experience with the 988 Crisis Response System as it relates to mental health, substance abuse, and crisis intervention. He suggested that could be used for those individuals that refuse to go. We can set them up with a navigator there, or even at the hospitals where a physician may know that this is an available resource for patients that have no other resources.

Dr. Morgan read through the proposed changes to the draft protocol related to the QR code and changing the Midazolam and Droperidol doses. Mr. Ford asked whether "obtain consent" will be added to the protocol. He noted the Hennepin County protocol cites a long list under that title, which includes advising the patient that BUP can cause actual withdrawals, and that if they do want to get into a program to make sure they're qualified. After some discussion, it was agreed to use the verbiage "patient agrees to treatment."

Dr. Holtz suggested the routes for Zofran and Tylenol be changed to PO/IM/IV, and then not PR for nausea, just for nausea or vomiting, and then the same for Tylenol, which should be PO/IV for pain. Ms. Palmer stated that for consistency she will mirror that language from other protocols where we give nausea medications.

A motion was made by Dr. Barnum, seconded by Chief Moore, and passed unanimously to accept the draft Opioid Withdrawal protocol with the following revisions:

1) *Add a QR Code next to the COWS*
2) *Change "obtain consent" to "patient agrees to treatment"*
3) *Mirror the language from other protocols related to nausea medications for Zofran and Tylenol*
4) *Change the Midazolam dose to 2.5 mg*
5) *Change the droperidol dose to 2.5 mg IM or 1.25 mg IV/IO*
6) *Add "reassess and transport to the most appropriate facility"*

B. Discussion and Recommendation to Approve the Addition of a Restraints Protocol

Dr. Holtz referred the committee to the draft Patient Restraint protocol and asked for their feedback. He noted that patient restraint is probably one of the more dangerous things we do in terms of interventions on patients because improper restraints can be fatal. He noted that a key consideration cautions providers not to use gauze or kerlix. Although frequently used, there is a very consistent recommendation to NOT use them because they are very likely to cause restrictions on circulation or vascular compromise. He related that most of the wording is in alignment with best practices, such as to avoid any prone positioning or any restriction of breathing, or chest wall motion.

Dr. Morgan stated that a lot of times these calls don't initially go out as an ALS level call, and the protocol refers to cardiac and $ETCO_2$ monitoring. She asked if that would change the response models for what's allowed on these patients. A lot of times the psychiatric or behavioral emergency calls are sometimes being downgraded to an ILS, or potentially a BLS level call. Dr. Holtz agreed we should add the wording "if possible."

Mr. McAllister questioned the verbiage related to placement of the gurney straps under Key Procedural Considerations. He related that almost all gurneys have some type of a chest or an over-the-shoulder cross, primarily to secure them to the gurney in case of bumps, or a collision en route. He noted that the wording "may not be placed" is pretty strong language, even with the added parenthetical.

Mr. Ford inquired whether spit hoods should be added to the protocol. He stated that according to Google AI, spit hoods are considered a restraint. Dr. Holtz noted that best practices would be not to use spit hoods at all. The committee discussed the legal ramifications of adding a patient restraint protocol, and that it may be better to address everything in education. Also discussed was the use of 2-point and 4-point restraints.

The committee agreed to table the agenda item to allow Dr. Holtz to make further revisions to the draft protocol for discussion at the December meeting.

C. Discussion and Approval of the Recommendation to Revise the Obstetrical Emergency Protocol

Dr. Morgan stated she brought this forward because we currently have nothing for blood pressure for pre-eclampsia patients. This is 100% NOT in line with ACOG (The American College of Obstetricians and Gynecologists) related to increasing maternal morbidity and mortality. She suggested we include an anti-hypertensive in the Obstetrical Emergency protocol. The committee agreed to table this agenda item for a future meeting.

D. Discussion and Recommendation to Approve the Use of Acetaminophen at the AEMT Level

Dr. Morgan stated that when we initially brought acetaminophen into the system, it was to make it an AEMT level medication. She has not seen or heard any bad outcomes from doing this, and it will allow us, especially some of the falls and isolated extremity traumas that don't require an ALS level of care, to treat for pain, which is greatly under-treated by our prehospital providers. This will give us an option to treat pain without an ALS unit. Ms. Palmer asked whether this would force the agencies to carry two different forms. Dr. Morgan stated if you're running a BLS level call, then having PO Tylenol is probably appropriate.

A motion was made by Chief Moore, seconded by Mr. Seal, and passed unanimously to allow AEMTs to administer acetaminophen IV.

VII. 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.

VIII. ADJOURNMENT

There being no further business to come before the Committee, the meeting was adjourned at 10:57 a.m.