MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DIVISION OF COMMUNITY HEALTH

DRUG/DEVICE/PROTOCOL (DDP) COMMITTEE

September 3, 2025 – 9:00 A.M.

MEMBERS PRESENT

Kelly Morgan, MD, Chair
Jessica Leduc, DO, HFD
Chief Stephen Neel, MVFD
Chief Kim Moore, HFD
Capt. James Whitworth, BCFD
Sean Collins, CCFD (Alt)
Stacy Pokorny, MWA
John Osborn, CA
Kady Dabash-Meininger, MW
Samuel Scheller, GEMS
Mike Barnum, MD, AMR
Michael Holtz, MD, CCFD
Chief Frank Simone, NLVFD
Chief Shawn Tobler, MFR
Stephen DuMontier, DO, NLVFD
Nate Jenson, DO, MFR
Jim McAllister, LVMS
Brandon Miles, Mercy Air (Alt)
Sydni Senecal, OptimuMedicine
Derek Cox, LVFR

MEMBERS ABSENT

Troy Biro, Guardian Flight
Nate Jenson, DO, MFR
Michael Whitehead, AMR

SNHD STAFF PRESENT

John Hammond, EMSTS Manager
Laura Palmer, EMSTS Supervisor
Stacy Johnson, EMSTS Regional Trauma Coordinator
Kristen Anderson, EMSTS Senior Admin. Assistant
Rae Pettie, Recording Secretary
Christian Young, MD, EMSTS Medical Director
Dustin Johnson, EMSTS Field Representative
Roni Mauro, EMSTS Field Representative
Nicole Charlton, EMSTS Program/Project Coordinator

PUBLIC ATTENDANCE

Sandra Horning, MD
John Gonzalez
Mark Calabrese
Jason Perlmutter
Daniel Llamas
Brett Olbur
Spencer Lewis
Ashley Tolar
Scott Rye
Michael Denton
Luis Sanchez
Kat Fivelstad, MD
Matthew Dryden
Chris Thorpe
Erik Grismanauskas
Chris Dobson
Rebecca Carmody
Timothy Gundersen
Taylor Lee
Todd Ford
Dawn Brown

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 September 3, 2025. Chairman Kelly Morgan, MD, called the meeting to order at

9:07 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. Dr. Kelly Morgan 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 295 373 181. To provide public comment over the telephone, please press *5 during the comment period and wait to be called on. To provide public comment over Teams 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 SEPTEMBER 3, 2025 AGENDA

A motion was made by Mr. McAllister, seconded by Dr. Holtz, and carried unanimously to adopt the September 3, 2025 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 by Committee Member request before action. Any exceptions to the Consent Agenda must be stated prior to approval.

Approve Minutes June 4, 2025 Drug/Device/Protocol Committee Meeting ***(for possible action)***

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

VI. REPORT / DISCUSSION / ACTION

A. Discussion and Recommendation to Revise the Childbirth/Labor Protocol

The committee reviewed the draft revisions made to the Childbirth/Labor Protocol. Dr. Holtz noted the revised protocol includes evidence-based information and QI metrics.

A motion was made by Dr. Holtz, seconded by Chief Simone, and carried unanimously to approve the draft Childbirth/Labor protocol as written.

B. Discussion and Recommendation to Revise the Obstetric Emergencies Protocol

Dr. Holtz stated the Obstetric Emergencies protocol was split into two separate protocols so eclampsia/preeclampsia could be addressed separately. The new protocols will be titled "OB-Obstetric Emergencies" and "OB-Preeclampsia/Eclampsia." He stated a suggestion was made by one of LVFR's personnel to include an additional pearl to the OB-Obstetric Emergencies protocol:

"EMS clinicians should prioritize maternal stabilization, safe delivery if imminent, and rapid transport when indicated. Presentation of a single arm or leg through the vagina is in indication for immediate transport to the hospital. Notify the intended receiving facility as early as possible to allow preparation of the receiving team. For complicated deliveries (breech, prolapsed cord, shoulder dystocia), initiate appropriate prehospital interventions per protocol. If unable to resolve the complication or if delivery does not progress after indicated maneuvers, maintain maternal and fetal support and expedite transport while continuing interventions en route."

Dr. Holtz stated the pearl provides guidance on how the OB-Obstetric Emergencies protocol should be handled. He related that initially there was some concern about whether the EMS providers should be doing some of the interventions on scene, or whether they should just transport immediately. The pearl lays out more clearly that they should be doing all the interventions indicated per protocol except for situations such as single limb

presentation which would be an indication for immediate transport because there is no possibility for successful intervention on scene. Dr. Morgan shared that the L&D team, Neonatal team, and hospital leadership were all participants in the process. Dr. Barnum asked whether the receiving facilities, specifically charge nurses, are being provided with information on what to expect. Dr. Holtz suggested the discussion be added to the agenda for the next ED/EMS Regional Leadership meeting. Hospital liaison Daniel Llamas reported there have been a few delays and miscommunications between the hospitals and the pre-hospital alert. He personally ensured that following today's meeting the CNCs, charge nurses, ER directors, ER medical directors, and C-Suite will be made aware of what's going to be in place. Mr. Olbur reiterated that the key is communication. Telemetry should not be called in via telephone. The call needs to be placed via telemetry radio or the FAO so it can be recorded. He stressed there needs to be clear communication with the adult E.D. so the pediatric team can be notified. Ms. Palmer confirmed the telemetry icon has been added to all three protocols.

A motion was made by Dr. Morgan, seconded by Chief Neel, and carried unanimously to approve the draft OB-Obstetric Emergencies protocol with the additional revisions:

1) Add "Administer Oxygen to all patients" above the "Vascular Access" box at the top;
2) Under "Postpartum Hemorrhage," add "Consider Tranexamic Acid (TXA) 1g IV/IO over 10 minutes (only if given <3 hours after delivery);"
3) Add a pearl that reads, "EMS clinicians should prioritize maternal stabilization, safe delivery if imminent, and rapid transport when indicated. Presentation of a single arm or leg through the vagina is in indication for immediate transport to the hospital. Notify the intended receiving facility as early as possible to allow preparation of the receiving team. For complicated deliveries (breech, prolapsed cord, shoulder dystocia), initiate appropriate prehospital interventions per protocol. If unable to resolve the complication or if delivery does not progress after indicated maneuvers, maintain maternal and fetal support and expedite transport while continuing interventions en route;" and
4) Add QI metrics as listed on the OB-Uncomplicated Childbirth/Labor protocol.

Dr. Holtz asked the committee to review the draft OB-Preeclampsia/Eclampsia protocol. He related that the Magnesium dosing for sepsis differs across the country. The committee previously agreed to 4mg IV/IO in 50cc NS over 20 mins for severe features of preeclampsia, and for active seizure 6g IV/IO in 50cc NS over 5 mins, OR 5g IM (4g in each buttock). Mr. Scheller noted the Health District's minimum requirement for Magnesium is 5g, so that is what they are required to carry. There's also concern in how it's packaged; it comes in 5g in 10ml through multiple vendors. After some discussion the committee agreed to revise the dosing.

A motion was made by Dr. Holtz, seconded by Chief Neel, and carried unanimously to approve the draft OB-Preeclampsia/Eclampsia protocol with the following revisions:

1) Change Magnesium dosing to 5g IV/IO in 50cc NS over 5 minutes OR 8g IM (4g in each buttock); and
2) Add QI metrics as listed on the OB-Uncomplicated Childbirth/Labor protocol.

C. Discussion and Recommendation to Revise the Neonatal Resuscitation Protocol

Dr. Kat Fivelstad, assistant Medical Director for Las Vegas Fire & Rescue, reported there was a sub-committee of responding EMS professionals within LVFR who had questions/concerns about not being given enough guidance to handle the very early neonatal resuscitation. They sought answers to questions such as when to initiate interactions or comfort care measures. Following the group discussion, they drafted a protocol which still utilizes the traditional CPR 3:1 ratio for chest compressions, including the emphasized use of positive pressure ventilations. It was suggested that Neonatal Advanced Life Support training may be an accessible resource for EMS providers. The education component will likely include the time parameters where you stimulate and warm for 30 seconds prior to moving on to the next steps.

Dr. Fivelstad reported that the sub-committee also discussed ventilation management. Dr. Jenson, neonatologist, recommended they include more verbiage about positive pressure ventilation rather than just straight BVM as some agencies may have a T-Piece or other ventilatory device(s) and they don't want to pigeon-hole them by requiring one comparable device over another. She noted the second page includes a lot of special considerations as the crews are asking for guidance. They also wanted to ensure there was a reference to pre-ductal readings for SPO2 and some of the expected pulse oximetry levels so that crews aren't expecting to see 98-99% oxygen saturations on their neonatal patients.

Mr. Calabrese asked for clarification on the 7th pearl on the back page that states "….confirm that the Emergency Department is the intended destination." Dr. Fivelstad stated they included all the local emergency departments because there have been some discrepancies regarding where to take the patients. After consulting with all the pediatric facilities they agreed they want the patient to go to the main emergency department, and they will bring their neonatal and resuscitation teams there.

A motion was made by Mr. Cox, seconded by Chief Simone, and carried unanimously to accept the draft Neonatal Resuscitation protocol as written.

VII. BOARD REPORTS

No report.

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.

1. Dr. Morgan asked the committee for any recommendations for future discussions. It was suggested they review pediatric psychiatric emergencies and heat-related emergencies at the next regularly scheduled meeting. Chief Neel and Dr. Horning both agreed to furnish Ms. Palmer with all related handouts two weeks prior to the next scheduled meeting.
2. Chief Simone introduced Dr. Stephen DuMontier as the new Medical Director at North Las Vegas Fire Department.
3. Brett Olbur thanked Henderson Fire Department for supplying them with a cooling pod. He related that a very hypothermic patient arrived at the E.D. when one of HFD's units was there. The crew recognized the dire situation and recommended they deploy one of their cooling pods. The patient was cooled passively in the E.D. and did very, very well. He stated the cooling pod is an outstanding system.
4. Dr. Morgan asked Drs. Horning and Fivelstad to think of any pertinent issues related to pediatric care that they would like to be addressed/discussed in future meetings.

IX. ADJOURNMENT

There being no further business to come before the Committee, the meeting was adjourned at 10:22 a.m.