



MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DIVISION OF COMMUNITY HEALTH

DRUG/DEVICE/PROTOCOL (DDP) COMMITTEE

February 4, 2026 – 9:00 A.M.

MEMBERS PRESENT

Kelly Morgan, MD, Chair
Jessica Leduc, DO, HFD
Stephen DuMontier, DO, NLVFD
Capt. James Whitworth, BCFD
Chief Kim Moore, HFD
Chief Daylon Woolbright, CCFD
Kady Dabash-Meininger, MW
Samuel Scheller, GEMS

Mike Barnum, MD, AMR
Michael Holtz, MD, CCFD
Chief John Lansing, NLVFD
Chief Ryan Thornton, MFR
Derek Cox, LVFR
Michael Whitehead, AMR
Jim McAllister, LVMS
John Osborn, CA

MEMBERS ABSENT

Jeff Davidson, MD, MW
Nate Jenson, DO, MFR
Brandon Miles, Mercy Air

Chief Stephen Neel, MVFD
Sydni Senecal, OptimuMedicine
Troy Biro, Guardian Flight

SNHD STAFF PRESENT

John Hammond, EMSTS Manager
Laura Palmer, EMSTS Supervisor
Stacy Johnson, EMSTS Regional Trauma Coordinator
Kristen Anderson, EMSTS Program/Project Coordinator
Devin Atwood, EMSTS Senior Admin. Assistant

Christian Young, MD, EMSTS Medical Director
Dustin Johnson, EMSTS Field Representative
Roni Mauro, EMSTS Field Representative
Rae Pettie, Recording Secretary

PUBLIC ATTENDANCE

Sandra Horning, MD
Chris Thorpe
Mason Georgi
Heriberto Lule
Erik Grismanauskas
Dylan Helmer
Chance Hayes
Rebecca Carmody
Mario Perkins
Jason Perlmutter
Debra Dailey
Matthew Dryden
Sun Kang
Jim McAllister
Khadeejah Jenkins

Kat Fivelstad, MD
Trevik Jenkins
Kane Jacobs
Esther Mills
Cian Figueras
Dylan Schurle
Emily Keener
Ketan Patel
Chris Dobson
Daniel Llamas
Jonathan Wiercinski
Ryan Young
Chris Stachyra
Aly Marshall
Joseph Booker

PUBLIC ATTENDANCE (Cont)

Adam Olesen
Christopher Barker
Lonnie Arnold
Angel Morgan
Spencer Lewis
Liam Grady
Hayden Villani
Joshua LoMonaco
Christopher Mockler
Scott Rye
Thomas Vince

David Obert
Nicholas Ellis
Alicia Alpuerto
Ashley Tolar
Maya Holmes
Joseph Booker
Sarita Lundin
Jallen Keele
Michael Schafer
Michael Gannon

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, February 4, 2026. Chair Kelly Morgan, MD, called the meeting to order at 9:08 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. 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 (702) 907-7151 and entering access code 168 574 242#. 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.

Ryan Tyler made a request to the Board to revise the meeting structure to be held monthly, and to extend the meeting times.

IV. ADOPTION OF THE FEBRUARY 4, 2026 AGENDA

A motion was made by Dr. Morgan, seconded by Chief Lansing, and carried unanimously to adopt the February 4, 2026 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: December 3, 2025 Drug/Device/Protocol Committee Meeting

A motion was made by Chief Lansing, seconded by Dr. Morgan, and carried unanimously to approve the December 3, 2025 minutes as written.

VI. REPORT / DISCUSSION / ACTION

A. Discussion of Potential Formatting Changes to the Clark County Emergency Medical Care Protocols

Ms. Palmer stated the discussion of formatting changes came from the last DDP meeting when we expanded the Pediatric Behavioral Emergencies protocol, which resulted in a 3-page protocol as opposed to the customary 2-page protocol. The committee agreed that a lot of the information we include is repetitive and educational. They discussed removing some of the education because that should already be in place. They also discussed removing the history, signs and symptoms, and differentials boxes from each of the protocols.

Mr. Scheller related that the old format was more streamlined and included very limited information in terms of education. He agreed it has become cumbersome to sift through. He recalled the initial discussion was to keep each protocol to two pages with the protocol on page one, and the pearls on page two. Dr. Holtz stated he spoke with a few providers who appreciate the added information to utilize as a reference. He noted that most people will be looking at the protocols on a device rather than printing it out, so the length of the protocol shouldn't be an issue. If the protocol requires additional pages, we should allow that practice to continue. Mr. Cox stated that almost all the protocols should include QI metrics, which may result in an additional page. He noted that some of the providers look at the differentials, not necessarily while on a call, but afterward. He asked whether there was an appetite to create a separate manual to encompass the educational material which may be cross-referenced to a specific protocol. Dr. Holtz suggested they allow a protocol to be expanded to three pages if needed to include pertinent information/ease in readability for the provider, rather than trying to squeeze everything into two pages. Dr. Morgan noted there's a significant difference between a protocol and reference material associated with that protocol. She asked if it makes sense to keep the protocol algorithm to one page and include links to the related reference material, i.e. the pearls and/or additional education. The protocol and QI metrics are what the providers will be held accountable for knowing, and that may be kept as a single page. Dr. Holtz remarked that moving the QI metrics to the first page will only further clutter the first page. Ms. Palmer noted the OEMSTS tests licensure applicants on the protocol and the pearls, not the information listed under the history, signs and symptoms, or differential boxes. Ms. Palmer asked if the agenda item should be forwarded to the Education Committee for further discussion. Dr. Barnum noted that their opinion is important to determine the value of the education contained in each protocol. Dr. Morgan suggested that each agency send out a brief 3-question survey, so we have feedback from the providers. The committee agreed to table the agenda item.

B. Discussion of Droperidol as a Mandatory Medication in Formulary

Dr. Holtz stated that Droperidol was added to the Pediatric Behavioral Emergencies protocol. In speaking with our pediatric colleagues, including Dr. Horning, Droperidol is the best medication for sedation in pediatric patients. It's also a very good medication for adult sedation, which is why we include it in the Adult Behavioral Emergencies protocol. He suggested we change the designation of Droperidol in the Paramedic Drug Inventory from an alternate medication to a mandatory medication. Chief Lansing asked if we know how often Droperidol is used, and the typical cost. It was determined that it's currently solely carried on the critical care units. Dr. Morgan reported that North Las Vegas FD utilized it 180 times in December for sedation (20% of the time) and nausea/vomiting (80% of the time), which is fairly frequent. Mr. Scheller stated that Life-Assist sells a box of 25 for \$695, which is \$27.80/vial as per contract pricing.

A motion was made by Dr. Holtz, seconded by Mr. Scheller, and carried unanimously to amend the Paramedic Drug Inventory to remove Droperidol from the "Alternate Drugs" list and make it a mandatory medication.

C. Discussion of the OB-Uncomplicated Childbirth/Labor Protocol - Tabled

D. Discussion of the Use of Amiodarone and Lidocaine in Protocol and Formulary

Mr. Root continued the discussion started at the last meeting to replace Amiodarone with Lidocaine during cardiac arrest for V-fib and V-tach codes. Although the AHA has not taken a stance on which is better, they have stated Amiodarone and Lidocaine have very equal outcomes. Mr. Root remarked that Amiodarone contains a dangerous additive, Polysorbate 80, which is usually related to hypotension, bradycardia, and low cardiac output. Some studies show that when codes are shockable, Amiodarone is causing a hypotensive state which makes it harder for: 1) all of the other drugs to work; 2) other therapies to respond to it; and 3) post-cardiac arrest ROSC care. It's harder because sometimes we load the patient with a high dose of Amiodarone,

and Polysorbate 80 has a long half-life just like Amiodarone itself. Amiodarone is also highly lipophilic, so there's been discussion on whether the IO absorption is reliable. Mr. Root related that Lidocaine doesn't carry these risks. It was utilized as a good antiarrhythmic and has a very high success of terminating ventricular arrhythmias. It is also hemodynamically stable. Mr. Root stated there are enough studies Henderson FD reviewed prior to their proposal that have said it's quicker to terminate the ventricular arrhythmia, but it's also more likely to result in a good ROSC outcome, and some natures of being neurologically protective. Additionally, the cost is also significantly cheaper than Amiodarone. Mr. Root believes Lidocaine is going to be the superior antiarrhythmic. If implemented, the committee will just need to agree on the appropriate dosing. He stated Henderson FD's proposal is to add Lidocaine as an option for shockable cardiac arrest, or to replace Amiodarone for Lidocaine as an antiarrhythmic of choice.

Dr. Barnum asked the committee for discussion on completely abandoning Amiodarone as an antiarrhythmic. Dr. Holtz stated the majority of evidence for treatment in cardiac arrest shows the most effective measures are good chest compressions and defibrillation when appropriate. Many of the medications have not been shown to increase patient-centered outcomes. The antiarrhythmics are still in the guidelines. He stated that after researching the guidelines of the AHA, ERC (European Resuscitation Council), and ANZCOR (Australian and New Zealand Committee on Resuscitation), they all state you can utilize either Amiodarone or Lidocaine. There is no good data that shows that one is better than the other. His understanding is that there has been a shortage of Amiodarone recently, and if we choose it as the drug of choice, we should keep Lidocaine as an option solely for cardiac arrest. Dr. Holtz noted that Lidocaine is not a recommended antiarrhythmic for V-tach with a pulse in any of those guidelines. Dr. Barnum stated he is also in favor of keeping Lidocaine as an option, especially with the re-emergence of Lidocaine in terms of efficacy and safety profile. Dr. Morgan agreed but suggested they look into issues related to its efficacy for V-tach. Dr. Holtz stated the 2025 AHA Guidelines for V-tach or wide complex tachycardia with a pulse, state that Lidocaine's kinetic properties are less effective for V-tach at tolerated rates than Amiodarone, Procainamide, or Sotalol, and it's unclear if Lidocaine is more efficacious than a placebo. In consideration of this information, he would not recommend adding it to the tachydysrhythmia protocols. It should only go into the cardiac arrest protocols where it is in the current guidelines.

After some discussion on the appropriate dosing, the committee agreed to add Lidocaine 1.0 mg/kg IV/IO; may repeat at 5-10 minutes x 1 at 0.5 mg/kg, if refractory, for both the adult and pediatric cardiac arrest protocols, as well as adding it as an alternate to the Amiodarone dosing. Mr. Cox asked whether the AHA Guidelines still address whether the therapeutic levels need to be maintained following ROSC. Dr. Holtz stated that our current box states, "Amiodarone 300 mg IV/IO; may repeat one dose of 150 mg if refractory after 5th shock." Mr. Root suggested they remove the 3rd and 5th shock requirements from the adult and pediatric cardiac protocols. That requirement handcuffs the providers to where the antiarrhythmics aren't getting administered until the 16 to 18-minute mark, and they just don't have any effect at that point. It has the highest effect if it's given within the 8 to 13-minute mark. If they're in a shockable arrhythmia, the sooner we can provide these therapies, the better their chance of survival. He added that AHA Guidelines state 5-10 minutes, without mentioning the 3rd or 5th shock; it just states "early." We can put it in the providers' hands to use the education that teaches them to recognize that the timing of these medications is 5-10 minutes. Dr. Holtz agreed with the removal of criteria related to number of shocks.

A motion was made by Mr. Root, seconded by Chief Lansing and carried unanimously to make the following revisions to both the adult and pediatric Cardiac Arrest (Non-Traumatic) protocols:

- 1) Add Lidocaine 1.0 mg/kg IV/IO; may repeat x 1 at 0.5 mg/kg if refractory;*
- 2) Remove all references to the number of shocks and add, "may repeat if refractory."*

Mr. Root stated that it's common practice to use an i-gel supraglottic airway device for an unresponsive cardiac arrest. He suggested they add a pearl that states the provider should first assess the airway for foreign body obstruction, especially in pediatric patients.

A motion was made by Dr. Holtz, seconded by Mr. Root and carried unanimously to add "Consider foreign body airway obstruction" to the box at the top right corner of the pediatric Cardiac Arrest (Non-Traumatic) protocol.

E. Discussion of the Use of Ketamine in Refractory Status Seizure – Tabled

F. Discussion of the Chest Pain/ACS and STEMI Protocols

Dr. Holtz stated the stated the Non-Traumatic Chest Pain and Suspected Acute Coronary Syndrome was combined with the Non-Traumatic STEMI protocol to align with the most recent ACS Guidelines. There was a box added to the protocol to address the contraindications to Nitroglycerin, which includes a revision to the pearls on page two. The oxygen therapy was also revised to SpO₂ > 90% as opposed to ≥ 94%. Ms. Palmer asked for directions on how to address the disparity in the General Adult Assessment protocol, which states SpO₂ ≥ 94%. The committee agreed to discuss this issue at their next meeting.

Dr. Morgan proposed they reverse the order of the Nitroglycerin and Pain Management boxes, so the pain is managed prior to the administration of Nitroglycerin. She also recommended adding “consider” to the Nitroglycerin box since it is not always appropriate. In addition, she recommended adding verbiage to address holding the administration of Aspirin in suspected aortic dissection, like the language for Nitroglycerin in the pearls. The committee agreed to move “Fentanyl preferred” in the Pain Management box to the pearls.

A motion was made by Dr. Holtz, seconded by Mr. Scheller and carried unanimously to accept the draft Chest Pain (Non-Traumatic) and Suspected Acute Coronary Syndrome/STEMI protocol with the following revisions:

- 1) Reverse the order of the Nitroglycerin and Pain Management boxes;
- 2) Add “consider” to the Nitroglycerin box;
- 3) Remove “(Fentanyl preferred)” from the Pain Management box and add it to the pearls;
- 4) Add a pearl to hold the administration of Aspirin for suspected aortic dissection; and
- 5) Remove the STEMI (Suspected) protocol from the protocol manual.

G. Discussion of the Pediatric Respiratory Distress Protocol

Dr. Holtz stated he branched the current pediatric Respiratory Distress protocol into three separate protocols to address wheezing/ bronchospasm, stridor/croup/upper airway, and foreign body airway obstruction separately. He stated that a telemetry icon needs to be added to the “consider cricothyroidotomy” box in the foreign body airway protocol. Dr. Morgan noted that End Tidal CO₂ monitoring should be added to the QI metrics for all respiratory distress protocols. The committee agreed to allow AEMTs to administer Ipratropium. Dr. Horning suggested they add 1 mg/ml in parentheses after Epinephrine 1:1000 because it’s referenced both ways on the packaging.

A motion was made by Dr. Holtz, seconded by Dr. DuMontier and carried unanimously to accept the above-referenced draft pediatric respiratory protocols with the following revisions:

- 1) Remove “Consider SLAT technique” from page one of the Foreign Body Airway Obstruction protocol;
- 2) Add “(1 mg/ml)” after the Epinephrine 1:1000 reference on the Wheezing/Bronchospasm protocol;
- 3) Add “(1 mg/ml)” after the Nebulized Epinephrine 1:1000 reference on the Stridor/Croup/Upper Airway protocol;
- 4) Add telemetry icon to the “Consider Cricothyroidotomy” box on the Stridor/Croup/Upper Airway and Foreign Body Airway Obstruction protocols; and
- 5) Add End Tidal CO₂ monitoring to the list of QI Metrics on all three protocols.

H. Discussion of Adult Respiratory Distress Protocol

Dr. Holtz stated he branched the current adult Respiratory Distress protocol into two separate draft protocols so foreign body airway obstruction can be addressed on its own. He noted he would like to revise the Albuterol dose from 5-10 mg to 2.5-10 mg; and the Ipratropium dose from 1.0-1.5 mg to 0.5-1.5 mg. Ms. Palmer added that the SpO₂ oxygen saturation needs to be changed from >92% to >94%. Dr. Holtz noted Epinephrine should be considered for patients with respiratory distress WITH known history of asthma, AND evidence of extremis (severe fatigue, silent chest, cyanosis, altered mental status). It should not be used routinely for COPD.

A motion was made by Dr. Holtz, seconded by Chief Lansing and carried unanimously to accept the draft adult Respiratory Distress and Foreign Body Airway Obstruction protocols with the following revisions:

- 1) Remove “Consider SLAT technique” from page one;
- 2) Change the Albuterol dose from 5-10 mg to 2.5-10 mg;
- 3) Add “(1 mg/ml)” after the Epinephrine 1:1000 reference on the Respiratory Distress protocol;

- 4) Change the Ipratropium dose from 1.0-1.5 mg to 0.5-1.5 mg; and
- 5) Change the SpO2 oxygen saturation from >92% to >94%.

I. Discussion of Pediatric Behavioral Emergencies Protocol

Dr. Holtz stated the ED/EMS Regional Leadership Committee discussed the addition of Droperidol to the newly approved pediatric Behavioral Emergencies Protocol. After a discussion with Dr. Horning, it was agreed it would be more beneficial for the paramedics to have a set dose instead of a range. Dr. Holtz proposed they revise the Droperidol dose to 0.2 mg/kg IV/IM, with a max dose of 5 mg.

A motion was made by Dr. Holtz, seconded by Dr. DuMontier and carried unanimously to revise the Droperidol dose in the pediatric Behavioral Emergencies protocol to 0.2 mg/kg IV/IM, with a max dose of 5 mg.

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. 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.

IX. ADJOURNMENT

There being no further business to come before the Committee, the meeting was adjourned at 10:35 a.m.