MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DIVISION OF COMMUNITY HEALTH

DRUG/DEVICE/PROTOCOL (DDP) COMMITTEE

February 03, 2016 – 10:00 A.M.

MEMBERS PRESENT

Bryan Bledsoe, DO, Chairman, MWA
Tressa Naik, MD, Henderson Fire Dept
August Corrales, JTM
Brandon Hunter, MWA
Jim Kindel, Boulder City Fire Dept.
Troy Tuke, Clark County Fire Department
Frank Simone, NLVFD
Mike Barnum, MD, Vice Chairman, AMR
Eric Dievendorf, AMR
Chief Scott Vivier, Henderson Fire Dept
David Slattery, M.D., LVF&R (via phone)
Derek Cox, LVF&R
Devon Eisma, Mercy Air
Ryan Bezemer, Community Ambulance

MEMBERS ABSENT

K. Alexander Malone, MD, NLVFD
Jarrod Johnson, DO, MFR
Chief Rick Resnick, MFR

SNHD STAFF PRESENT

Christian Young, MD, EMSTS Medical Director
Laura Palmer, EMSTS Supervisor
John Hammond, EMSTS Manager
Judy Tabat, Recording Secretary

PUBLIC ATTENDANCE

Stephen Johnson, MWA
Tony Greenway, AMR
Eric Anderson, MD, MW
Syd Selitzky, Henderson Fire
Sarah McCrea, LVF&R
Brandie Green, CSN
Jim McAllister, LVMS
Dale Carrison, DO, CCFD
Nancy Cassell, CSN
Henry Kokoszka, HFD
M. Monica Manig, HFD
Mark Calabrese, CCFD

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The Drug/Device/Protocol Committee convened in Red Rock Conference Room at The Southern Nevada Health District on Wednesday, February 03, 2016. Chairman Bryan Bledsoe, D.O. called the meeting to order at 10:02 a.m. The Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law. Chairman Bledsoe noted that a quorum was present.

I. PUBLIC COMMENT

Public comment is a period devoted to comments by the general public on items listed on the Agenda. All comments are limited to five (5) minutes. Chairman Bledsoe asked if anyone wished to address the Committee pertaining to items listed on the Agenda. Seeing no one, he closed the Public Comment portion of the meeting.

II. CONSENT AGENDA

Chairman Bledsoe stated the Consent Agenda consisted of matters to be considered by the Drug/Device/Protocol Committee 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.

Minutes Drug/Device/Protocol Committee Meeting, October 07, 2015

Chairman Bledsoe asked for a motion to approve the consent agenda which included the minutes of the October 07, 2015 Drug/Device/Protocol Committee meeting. *Motion made by Member Corrales, seconded by Member Naik and carried unanimously.*

III. REPORT/DISCUSSION/POSSIBLE ACTION

Discussion on the New American Heart Association (AHA) Guidelines

Chairman Bledsoe reported that with the new AHA standards he developed a matrix summarizing the changes and the levels of evidence to discuss. He referred to the handout and added that there are 3 items for discussion and stated he will go through them item by item and then open it up for discussion:

The 1st 2015 AHA recommendation listed is referring to induced therapeutic hypothermia (ITH) in the prehospital setting. AHA's statement reads: "We recommend against the routine prehospital cooling of patients after ROSC with rapid infusion of cold intravenous fluids".
Chairman Bledsoe stated that they knew the literature was not supportive however the new AHA standards made a clear recommendation that prehospital induced hypothermia is not beneficial.

The 2nd recommendation listed is in regard to Cardiac Arrest in Pregnancy. The American College of Obstetricians and Gynecologists, American College of Emergency Physicians and AHA have published a document that is somewhat exclusive of the ACLS standards. It is the management of cardiac arrest in the pregnant patient. There is good literature supporting the idea of what's calling "Manual Lateral Uterine Displacement" and that is during the course of CPR somebody puts pressure either toward or against them taking the gravid uterus off the inferior vena cava.

The 3rd recommendation listed is in regard to pain management. In January of this year, a position paper was jointly published between the National Association of EMS Physicians (NAEMSP), the American College of Emergency Physicians (ACEP) and other interested entities that are guiding the community to a more comprehensive approach to pain management in the prehospital setting. Like pain management in the emergency department (ED), it doesn't always have to be managed with opiates and opiates may not always be the best choice. ACEP and NAEMSP took a pretty strong position on using sub-dissociative Ketamine dosages in the prehospital setting. He added that he has heard quite a few complaints about patients coming in by EMS obtunded from big doses of Morphine and felt that this protocol needs to be reviewed. Chairman Bledsoe opened up the discussion to the Committee.

Dr. Naik stated that this Committee has had the discussion on removing ITH in past and she felt that with this recommendation from AHA, it is time to act. She added that if a patient needs to have ITH, it needs to be done at the hospital and felt that is the most appropriate place where it can be a targeted controlled temperature decrease.

Mr. Hammond questioned if they would continue using the induced hypothermia centers as receiving facilities for those patients or would they discontinue that as well. He added that the ITH receiving facility criteria was based on continuing the care that was developed in the field and he believed that every hospital emergency department (ED) has the capability of chilled saline. Dr. Naik answered in the affirmative.

Dr. Bledsoe commented that there is a new concept of resuscitation centers developing for STEMI care. He added that they may be getting to the point where the science will come to them and say not every hospital in Las Vegas should get every cardiac arrest. They should treat cardiac arrests like strokes or STEMI's and should only go to those facilities that can promptly get them into the lab or can put them on ECMO (extracorporeal membrane oxygenation).

Mr. Cox questioned if the problem was just large volumes of fluid after return of spontaneous circulation (ROSC) or is the issue inducing hypothermia in the prehospital setting.

Dr. Naik stated that part of the problem is utilizing large volumes of cold saline which is causing vasospasm and ischemia which is more detrimental. She stated that they can use external ways to cool down the patient if you want to do that with ROSC.

Mr. Cox questioned that if the issue is large volumes of cold saline, why don't they make a correction to the protocol that dictates a smaller volume with some external cooling if inducing therapeutic hypothermia is efficacious.

Dr. Anderson responded by stating that a 15 minute transport time isn't going to have any effect on the patient. He did want the Committee to consider that if they remove the prehospital destination for hypothermia he could foresee somebody wanting to do hypothermia on a patient and not being able to because the receiving facility doesn't have the capability to continue ITH. Dr. Naik stated that she thought most hospitals have the ability to cool down patients. Dr. Anderson stated that there are (2) that do not.

Dr. Slattery stated that he would caution the Committee for making vast changes without seeing protocol changes and looking at the actual data in terms of performance across the entire spectrum of cardiac arrest. He added that it would be a mistake removing targeted temperature management from prehospital providers. This is different from using large volumes of ice saline which is the specific language of restriction from the AHA. It does not say we shouldn't be doing targeted temperature management in the field, it says we shouldn't be doing it routinely with large volumes of ice saline. The 2nd issue is the removal of destination criteria for therapeutic hypothermia. He stated he would caution this Committee to not remove that destination criteria and in fact strengthening what those criteria are for post resuscitation care of patient.

After considerable discussion the Committee felt they were not prepared to make a final decision and recommended sending this discussion to a workshop setting.

Motion made by Member Naik to send this discussion to workshop. Seconded by Member Bledsoe and carried unanimously.

Dr. Bledsoe stated that the 2nd topic was in regards to creating a new protocol for cardiac arrest in the pregnant patient.

Dr. Young questioned if the thought was to make this a separate algorithm protocol versus including this as an adjunct in the current arrest protocols.

Mr. Simone supported the recommendation of an adjunct, adding it to the pearls component. He felt adding a new protocol would be confusing.

Dr. Bledsoe asked the Committee if they wanted to refer this to a workshop since it is not ready to be voted on yet. Mr. Hammond suggested moving this to a workshop for review.

Dr. Bledsoe moved the discussion to Item 3, pain management.

Dr. Carrison stated that looking at the guidelines from the EMS standpoint he questioned if this means every unit is going to have Morphine, Fentanyl or Hydromorphone because each one of these has a cost and protocol. He added that there is a horrible narcotics problem in this community with regard to prescription medications. The bottom line is what do we want to do as EMS transporting agencies and what are we going to recommend that they carry so we have a rational pain management protocol so that we can follow those.

Dr. Bledsoe felt that one of the problems is not everybody is carrying the same thing now. When they did the protocol last year, there were various shortages of drugs at any given time.

Dr. Slattery stated that ideally it would be nice for everyone to be on the same analgesic pain medication but that pigeon holes this system when national shortages come out with that medication. One of the advantages of having diverse options for pain control is they don't have to bring it back to Committee if he's having problems getting Fentanyl, he can transition to Dilaudid or Morphine if needed. His suggestion would be not to remove it but to keep it as an option and they can make it a second line medication like they did with their anti-emetic medications.

Dr. Bledsoe questioned who circulated a document that wants this Committee to look at Ketamine.

Dr. Slattery stated he requested that the discussion to expand the use of Ketamine for pain management be put on the MAB agenda to be referred to this Committee because of the formality of the process. They carry Fentanyl for pain control right now but they also have Ketamine with them for an induction agent or treatment for agitated delirium. He stated that the crews are reporting that the Fentanyl is inadequate for isolated fractures so the analgesic dose of Ketamine would be an effective pain medicine.

Dr. Young responded to the anecdotal reports of patients coming in obtunded from the dose of Morphine that the medics are giving. He stated that with the short transport times he questioned how people are coming in obtunded especially when you hear Fentanyl is not adequate for isolated fractures. He felt that our system has more pain medication that patients have pain and they have to be used correctly.

Dr. Naik stated that there is a dosing regimen for Morphine and Versed in the protocols and felt the problem is they are going weight based and that is where they are giving up to 8 to 10 mg of morphine.

Dr. Carrison stated that all the literature is showing that Ketamine is a terrific adjunct to morphine. The key is what dosage you should use in what situations. Dr. Anderson felt that 0.15mg/kg Ketamine is a good dose.

Dr. Bledsoe summarized the discussion stating that the workgroup will need to review not just the ITH but all the AHA standards for changes that need to be made in the protocols. The workgroup also needs to look at whether a new protocol needs to be developed for the pregnancy cardiac arrest patient, and to revisit pain management. He asked if that summarizes the Committee thoughts. The Committee agreed.

Chairman Bledsoe made a motion to form a Workshop to evaluate the SNHD protocols for potential changes with a particular emphasis on:

1. *AHA changes that pertain to EMS*
2. *The necessity or lack thereof of a cardiac arrest protocol for pregnant patients with an emphasis on manual lateral uterine displacement*
3. *Review the use of pain medications in the SNHD system with tickler emphasis on evaluating the possibility of adding Ketamine in a sub-dissociative dose for analgesia.*

Seconded by Member Tuke and carried unanimously.

IV. INFORMATIONAL ITEMS/ DISCUSSION ONLY

None

V. PUBLIC COMMENT

Public comment is a period devoted to comments by the general public, if any, and discussions of those comments, about matters relevant to the Committee's jurisdiction will be held. No action may be taken upon a matter raised under this item of this Agenda until the matter itself has been specifically include on an agenda as an item upon which may be taken pursuant to NRS 241.020. All comments are limited to five (5) minutes. Chairman Bledsoe asked if anyone wished to address the Committee. Seeing no one, he closed the Public Comment portion of the meeting.

VI. ADJOURNMENT

There being no further business to come before the Committee, Chairman Bledsoe called for a motion to adjourn; *Motion made by Member Tuke, seconded by Member Naik and carried unanimously to adjourn at 11:00 am.*