



## MINUTES

### EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

#### DIVISION OF COMMUNITY HEALTH

#### DRUG/DEVICE/PROTOCOL (DDP) COMMITTEE

May 03, 2017 – 10:00 A.M.

#### MEMBERS PRESENT

Mike Barnum, MD, Vice Chairman, AMR  
Jason Driggars, AMR  
Derek Cox, Las Vegas Fire & Rescue  
Chief Troy Tuke, Clark County F.D.  
Melanie Ondik, Community Ambulance  
Eric Anderson, MD, MedicWest  
Shane Splinter, Henderson F.D.

Jim Kindel, Boulder City F.D.  
Frank Simone, North Las Vegas F.D.  
Steve Carter, AMR  
David Slattery, MD, Las Vegas Fire & Rescue  
Steve Johnson, MedicWest  
TJ Smith, Henderson F.D.

#### MEMBERS ABSENT

Tressa Naik, MD, Henderson FD  
Chris Calcagni, JTM  
Jarrod Johnson, DO, Mesquite Fire & Rescue  
K. Alexander Malone, MD, NLV F.D.

Chief Kim Moore, Henderson F.D.  
Jeff Davidson, MD, MedicWest  
Rick Resnick, Mesquite Fire & Rescue

#### SNHD STAFF PRESENT

Christian Young, M.D., EMSTS Medical Director (phone)  
Laura Palmer, EMSTS Supervisor  
Michelle Stanton, Recording Secretary

John Hammond, EMSTS Manager  
Scott Wagner, EMS Field Rep

#### PUBLIC ATTENDANCE

Mark Calabrese, CCFD  
Douglas Hayes, CSN  
Charles Wosh, CSN  
Nick Pavelka, LVFR  
Kim Dokken, St Rose  
Daniel Youssef, LVFR  
Sadie Helm, LVFR  
Kevin Reonos-Flores, CSN  
Daniel Perez, CSN  
Victor Nowak, CSN  
Nate Hannig, CSN  
Scott Selco, Md, PhD

Jim McAllister, LVMS  
Vicki Walker, VHS  
Jonathan Christensen, LVFR  
Anthony Butler, LVFR  
Mario Rleda, LVFR  
Kennedy Alexander, MFR  
Michael Schafer, MedicWest  
Mirasa Loyd, MedicWest  
Eric Major, CSN  
Tony Greenway, VHS  
Chais Low, CSN

## **CALL TO ORDER - NOTICE OF POSTING OF AGENDA**

The Drug/Device/Protocol Committee convened in the Red Rock Conference Room at the Southern Nevada Health District on Wednesday, May 03, 2017. Vice Chairman Mike Barnum, MD, called the meeting to order at 10:02 a.m. The Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law. Vice Chairman Barnum 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. Vice Chairman Barnum asked if anyone wished to address the Committee pertaining to items listed on the Agenda.

Vice Chairman Barnum asked if anyone wished to address the committee. Seeing no one, he closed the Public Comment portion of the meeting.

### **II. CONSENT AGENDA**

Vice Chairman Barnum 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 Board member request. Any exceptions to the Consent Agenda must be stated prior to approval.

Approve Minutes for the Drug/Device/Protocol Committee Meeting: March 01, 2017

Vice Chairman Barnum asked for a motion to approve the March 01, 2017 minutes of the Drug/Device/Protocol Committee meeting. A motion was made by Member Tuke, seconded by Member Ondik and carried unanimously to approve the minutes as written.

### **III. REPORT/DISCUSSION/POSSIBLE ACTION**

#### **A. Discussion of Nomination for Chair and Vice-Chair**

Ms Palmer advised the committee that Dr. Mike Barnum has been automatically nominated as Chairperson because he currently serves in the position of Vice Chair. Vice Chair Barnum asked if there were any other nominations for Chairperson. Hearing none he asked for a motion to approve his appointment as Chairperson of the Drug/Device/Protocol Committee. A motion was made by Member Tuke, seconded by Member Slattery and carried unanimously to appoint Dr. Mike Barnum as Chair to the DDP Committee, effective immediately.

Dr. Barnum asked the committee for nominations for Vice Chair. Mr. Kindel nominated Chief Tuke however there was some concern from the committee with this nominee not being a physician. Ms Palmer stated that the bylaws do not specify the need for this position to be filled by a physician. If committee members are not comfortable with a non-physician filling this role this item can be referred to the Medical Advisory Board for a final decision. It was decided to send this topic to the Medical Advisory Board.

#### **B. Review/Discuss Proposed Changes to the Drug/Device/Protocol Bylaws**

Ms Palmer reported to the committee that an addition to the Drug/Device/Protocol bylaws should be made in order to keep all committee bylaws consistent. Addition to be made as follows: Article 3, Subsection 3. Alternates - "Each standing member may designate an alternate member(s) to serve in their place should they be temporarily unable to perform the required duties. All requests must be made in writing to the OEMSTS." Ms Palmer reminded the committee that designation of alternates is voluntary, should be filled with an individual who can make decisions on their behalf, and will help the committee meet quorum.

A motion was made by Member Simone, seconded by Member Tuke and carried unanimously to approve the change to the DDP Bylaws.

C. Review/Discuss Schedule for Periodic Review of Protocol Manual

Dr. Young advised the committee that monthly he would be sending approximately five protocols to all members for review and member input. This would make the task of rewriting the protocol manual less cumbersome than trying to update the manual all at one time. He also asked the members to review the protocols in advance and to come prepared with suggests or email ideas before the next scheduled meeting. By doing so, this will assist in time management during meetings.

D. Review/Discuss First Group of Protocols for 2017

1. Abdominal / Flank Pain, Nausea & Vomiting

Dr. Young referred to the pearls which states “In patients  $\geq 35$  years old consider cardiac origin and perform a 12-Lead ECG.” He suggested replacing the word “and” with a period then say “Perform a 12-lead ECG.” This should eliminate any confusion about whether or not a 12-Lead ECG should be performed because according to protocol it must be done. Dr. Slattery suggests a box be added to the ACS protocol along with the individual protocols stating who should be receiving an EKG and also to add “within 5 minutes of patient contact” to “Perform a 12-lead ECG.” Mr. Smith suggests a 12-Lead ECG protocol be developed with a hyperlink said protocol added to each current protocol that has a 12-Lead associated with it. Dr. Slattery agreed to put together a draft protocol for review at the next scheduled DDP meeting.

2. Acute Coronary Syndrome (Suspected)

Dr. Young suggests separating the left column of the protocol into its own STEMI protocol and to also add EKG criteria to make it clear when a STEMI should be called. He also suggests combining the ACS and Chest Pain Protocols into one protocol. Dr. Slattery suggests eliminating the Chest Pain Protocol and instead replacing it with a STEMI protocol. Member Calabrese suggests moving telemetry from the bottom of the algorithm to immediately following “STEMI”. He suggested also adding “consider second IV pathway” at the bottom of the protocol. Dr. Barnum suggests moving the erectile dysfunction medications from the history to the pearls and making a note to avoid nitroglycerin. Dr. Young agreed to put together a draft protocol for review at the next scheduled DDP meeting. Dr. Barnum asked the committee to review the draft and discuss off line so that the next discussion will go more rapidly.

3. Allergic Reaction

Dr. Slattery stated that there is some confusion among medics with regard to IV epinephrine and suggests using push dose epinephrine instead. Dr. Slattery also stated that dopamine is extremely expensive, rarely used, and that pressors would be a good alternative. Dr. Barnum asked if the committee thinks push dose should be a replacement for infusions in general; several committee members agreed. Dr. Slattery stated that he will query all agencies to find out how often dopamine is used in field, what the cost is, and options for push dose pressors and report back at the next meeting.

4. Altered Mental Status / Syncope

Member Cox reported that some providers are confused because you have patients with altered mental status that may or may not have syncope and if the altered mental status is due to alcohol consumption they are unsure if a 12-Lead is necessary. Dr. Slattery stated that an intoxicated person with syncope should always receive a monitor and 12-Lead ECG.

5. Behavioral Emergency

Member Cox noted that 5.0 mg is mentioned in the protocol and that for housekeeping purposes the .0 should be dropped from all protocols. He stated that the peer review committee asked if there has been any discussion about using no-opioid, non-narcotic based analgesics for pain. Dr. Barnum mentioned the use of Ketorolac as it is therapeutically equivalent to other NSAIDS. He said that good feedback to the peer review would be that with the relatively short transport times in our area an alternative would be to give PO medications to belly pain patients.

E. Review/Discuss STEMI Receiving Criteria

Dr. Young gave some background on the concept of STEMI receiving criteria. The regional STEMI plan according to the Mission: Lifeline accelerator initiative is for hospitals and EMS to work together for the advance activation of cath labs. Nationally there are 11 other systems participating in this initiative with Southern Nevada being in the top three or four in overall time from door to balloon. This plan includes such things as code STEMI, STEMI criteria, and EKGs. STEMI center designation can be obtained from multiple agencies and is extremely expensive but many of the hospitals are applying for this designation. Some of the criteria for obtaining STEMI care accreditation are the ability to receive EKGs, the ability for the ED doctor to activate the cath lab, activating from the prehospital setting, along with an open book test.

Dr. Young reported that in 2013 Senate Bill 167 was presented to the Nevada Legislature which in part states, “designation of hospital STEMI receiving center; the state health division is to maintain a list of hospitals so designated.” Also, what is considered a STEMI center, “Any hospital that is accredited by the Society of Cardiovascular Patient Care in conjunction with the initiative developed by AHA known as the Mission: Lifeline Initiative.” The State Health Division has a list of these centers on the website.

Dr. Young suggested that some criteria to consider putting into a protocol could be; do you have an ED physician who has the authority to activate the cath lab, a one call activation system, a no STEMI diversion policy, formalized back up protocol for simultaneous STEMI activation when the lab comes down, and have you defined roles and responsibilities for all STEMI team members?

Dr. Barnum asked if facilities who do not achieve official designation would have to be inspected to see if they have met all criteria in order to receive STEMI patients. Mr. Hammond replied it would be up to the State to decide if and how that would be addressed. He also reminded the committee that it would be approximately a six month process to put the protocols out to the facilities and for the facilities to have staff fully trained.

Dr. Slattery suggested that a workgroup be formed which would include community stakeholders to decide on the STEMI destination criteria.

Dr. Barnum asked for a vote to refer to the Medical Advisory Board that DDP is in support of forming workgroups that will include hospital partners to create STEMI destination criteria. All were in favor, none were opposed.

F. Review/Discuss Rapid Arterial Occlusion Evaluation (RACE)Tool

Mr. Smith advised the room that he has updated the draft protocol to include Valley Hospital as a NIR capable stroke center and in the QI metrics was added if the Cincinnati prehospital stroke scale is positive then complete the RACE in less than five minutes. The draft protocol is in alignment with Mission: Lifeline’s algorithm and also AHA’s recommendations. On the draft protocol the symptom onset time has been increased from five to eight hours because when dealing with LVO the window of treatment for mechanical thrombectomy is much greater than that of TPA alone and these patients should be delivered straight to a NIR capable facility. Also added is radio contact with receiving facility for suspected LVO.

Dr. Young stated there are actually three different topics to be addressed here. First, should the facilities be categorized similar to the trauma centers e.g. level 1, level 2 etc. Second, is this the scale all agencies will use or can other scales also be used? Third, if there is a positive scale are other facilities bypassed to transport the patient to one of the LVO facilities?

Dr. Selco advised the committee that there may be an unfunded, vacant position for a Coordinator of Vascular Health through the State that could assist the committee in accomplishing some of its goals. Dr. Selco pointed out that as the draft is written it state to first perform the Cincinnati Scale leading into the RACE Scale and that simplification of the protocol would assist the EMS personnel in transporting patients in a timely manner.

Mr. Smith offered to draft a couple of different protocols for review by the committee. One, a scaled down version to emphasize completing the RACE, getting off scene, performing 12-lead and all the things to be done in route to the hospital. Once the draft is completed he will send it to Ms. Palmer for distribution to committee members.

*A motion was made by Member Tuke, seconded by Member Carter and carried unanimously to replace the Cincinnati Stroke Scale with the RACE Scale*

*A motion was made by Member Slattery, seconded by Member Tuke and carried unanimously to approve the stroke protocol after Mr. Smith has made the aforementioned updates to include clarification of NIR capable stroke centers.*

#### **IV. INFORMATIONAL ITEMS/ DISCUSSION ONLY**

Chairman Barnum asked if anyone wished to address the Committee. Seeing no one, he closed the Information Items/Discussion portion of the meeting.

#### **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 Barnum asked if anyone wished to address the Committee.

#### **VI. ADJOURNMENT**

There being no further business to come before the Committee, Chairman Barnum called for a motion to adjourn. *A motion was made by John Hammond, seconded by Chief Troy Tuke and carried unanimously to adjourn at 11:24 am.*