PRC Meeting

Wednesday, September 14, 2022
9:30 AM to 12:00 PM
****The Committee does not anticipate a need for a closed session during this meeting****
****VIRTUAL / IN-PERSON HYBRID****

Meeting called by:	Dr. Timothy Chizmar
Type of meeting:	Protocol Review Committee

PRC Agenda Items

Call to order		Dr. Chizmar
Approval of minutes	July 2022 minutes	
Announcements		Dr. Chizmar
Old Business	Push Dose TXA for Wilderness EMS	Dr. Millin
New Business	Diltiazem Maintenance Infusion for Interfacility Transport	Lisa Rosenberg, RN, NRP
	Clarification of Guidelines for Interfacility Transport of Palliative Care and Hospice Patients	William Rosenberg
	PEMAC Recommendations for Changes in Respiratory Rates for Pediatric Rescue Breathing and HPCPR	Dr. Anders
	PEMAC Recommendations for Changes in Pediatric Cardiac Arrest Protocol and Procedures	Dr. Anders
	Incorporation of the New National Guidelines into the Trauma Decision Tree	Dr. Chizmar and Meg Stein
	General Patient Care – Communications	Dr. Stone and Tim Burns
Journal Club		
Discussion(s)	PEMAC Trauma Decision Tree and the New National Guidelines	Dr. Anders

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	Use of TXA in Obstetric Bleeding	Dr. Stone
Adjournment		Dr. Chizmar
Next Meeting	November 9, 2022 9:30am-12:00pm	

Protocol Review Committee Meeting Minutes

September 14, 2022

Attendance:

Committee Members in Attendance (In-person/Virtual): Kathleen Grote, Dr. Jennifer Anders, Tyler Stroh, Dr. Steven White, David Chisholm, Marianne Warehime, James Gannon, Dr. Kevin Pearl, Dr. Thomas Chiccone, Dr. Roger Stone, Dr. Matthew Levy, Dr. Janelle Martin, Dr. Jennifer Guyther, Dr. Timothy Chizmar (Chair), Meg Stein (Protocol Administrator)

Guests: Dr. Eric Garfinkel, Cyndy Wright-Johnson, Scott Gordon, Ben Kaufman, William Rosenberg, Dr. Michael Millin, Jeanie Hannas, Jon Schardt, Dr. Jon Krohmer, Bryan Pardoe, Dr. Jonathan Wendell, Dr. Ruben Troncoso, Pete Fiackos

Excused: Mary Alice Vanhoy, Mary Beachley, Gary Rains

Alternates: Tim Burns

Absent: Melissa Fox, Rachel Itzoe, Mark Buchholtz, Dr. Jeffrey Fillmore

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Meeting called to order at 9:34 by Dr. Chizmar.

Minutes: A motion was made by Kathleen Grote and seconded by Marianne Warehime to approve the July 2022 minutes with noted corrections in the committee members' titles. The motion passed without objection.

Announcements:

Old Business:

Push Dose TXA for Wilderness EMS – Presented by Dr. Millin: Dr. Millin review the modification to his original proposal that had been discussed extensively in the May and July meetings. In the modified proposal 1 gram of TXA will be diluted in 30 ml of an approved diluent and administered as a very slow IVP over 8-10 minutes.

Dr. Chizmar opened the floor for discussion. With no further discussion, a motion was made by Dr. Pearl and seconded by Marianne Warehime to move the proposal forward. With no objections, the motion passed.

IV Nitro Pilot: Dr. Chizmar asked that the Committee reconsider the dosing parameters for the IV Nitro Pilot approved at the July 2022 meeting as there had been some inconsistency in the dosing in the previous discussion. The proposal suggests 160 mmHg as the minimum starting SBP and with administration titrated to an SBP of 140 mmHg or a 20% reduction in SBP.

Discussion revolved around whether calculating a 20% reduction in SBP is too cumbersome as well as whether eliminating the 20% reduction and simply titrating SBP to 140 mmHg might lead to very large drops in SBP for extremely hypertensive patients. It was noted that titration to a 20% reduction would be consistent with the current protocol for sublingual nitro. Dr. Garfinkel raised concerns over lowering SBP more than 20%, which an absolute number target SBP could do. Dr. Levy was in favor of a 20% reduction with an absolute floor SBP such as 140 mmHg. Consideration of titration parameters for infusion pumps

was also discussed. Discussion concluded with Dr. Chizmar advising he would take these comments back to the sponsors and ask them to amend the proposal.

New Business:

Diltiazem Maintenance Infusion for Interfacility Transport – Presented by William Rosenberg: William Rosenberg presented Lisa Rosenberg's proposal as she was unable to attend the meeting. Currently an RN is required for interfacility transports of patients on diltiazem drips. This proposal would allow Paramedics and CRTs to transport adult patients on continuous IV diltiazem infusions provided that the infusion was started by hospital staff prior to transport and the dose does not exceed 15 mg/hr. It was noted that diltiazem is already in the formulary for ALS clinicians.

Dr. Chizmar opened the floor for discussion.

Initial discussion concerned the frequency of need for such transports and the possibility of unintended consequences for high acuity patients. William Rosenberg pointed out that patients in a-fib with RVR are frequently transported from rural or free-standing facilities. He also noted that interfacility transport oversite would still have to approve the transport level and would screen out the high acuity patients that should have SCT transport.

Further discussion concerned the underlying problem of the lack of uniform training and credentialing of SCT Paramedics within the state. Concern was raised over the difference in training level for maintaining a drip between SCT and "regular" Paramedics and CRTs. It was suggested that wording be added to the proposed procedures requiring service orientation and credentialing by an SCT service.

A motion to forward the proposal as amended was made by Tyler Stroh and seconded by Dr. Pearl. With no objections or abstentions, the motion was approved.

Clarification of Guidelines for Interfacility Transport of Palliative Care and Hospice Patients – Presented by William Rosenberg: William Rosenberg presented a proposal that would allow ALS or BLS transport for adult patients being transported to palliative care or hospice who have interventions that would normally require an SCT clinician. For ALS clinicians this would include patients with chest tubes, on ventilators, and on fixed rate vasopressor infusions. BLS clinicians would be allowed to transport patients with any medication running through a Computerized Ambulatory Delivery Device (CADD) pump.

Dr. Chizmar opened the floor for discussion and asked for clarification regarding the list of fixed rate ALS medications versus any CADD pump medication for BLS clinicians. William Rosenberg advised that CADD pump medications are already allowed for BLS clinicians since clinicians are unable to make any changes to the CADD pump settings. A medication list was provided for the ALS clinicians to avoid being overly ambiguous. It was suggested that, since these are MOLST B hospice and palliative care patients, there is no need to limit the specific fixed rate intravenous medications that may be transported by the ALS clinicians. The ALS Level of Care section of the proposal was modified from "Fixed Rate Vasopressors" to read "Intravenous infusion not on a CADD pump".

Further discussion raised the question of whether pediatric patients should be included in the protocol. Dr. Anders advised that she would take the questions to PEMAC for possible inclusion in the 2024 Protocols.

Dr. Chizmar then asked about what happens if the patient dies en route. William Rosenberg advised that that it is not uncommon on BLS transports but is not typical of ALS transports. Dr. Chizmar suggested a

line be added to the protocol stating that in the event of patient death during transport, continue to the destination and contact the patient's hospice agency for the next steps.

Tyler Stroh made and motion, seconded by Dr. Stone, to move forward with the proposal as amended. The motion passed with no objections or abstentions.

PEMAC Recommendations for Changes in Respiratory Rates for Pediatric Rescue Breathing and HPCPR – Presented by Dr. Anders: AHA and APP updated the ventilation rates for infants and children in 2020. Dr. Anders explained that this proposal would bring the Protocols in line with the AHA guidelines by changing respiratory rates for pediatric rescue breathing and HPCPR to 1 breath every 3 seconds or 20 bpm throughout the Protocols.

Dr. Chizmar opened the floor for discussion.

No concerns were raised regarding the proposed changes to pediatric respiratory rates. Inconsistencies in adult respiratory rates for rescue breathing versus HPCPR were noted and Dr. Chizmar advised he would discuss these with Dr. Seaman.

Whether to combine the newly born algorithm with the pediatric protocol or to provide a link to the newly born algorithm was discussed. Both Dr. Anders and Cyndy Wright-Johnson felt that combining the algorithms was not practical but agreed that redirecting clinicians to the newly born algorithm via a link or footnote was appropriate.

A motion was made by Dr. Stone and seconded by Marianne Warehime to move forward with the proposal. The motion passed with no objections or abstentions.

PEMAC Recommendations for Changes in Pediatric Cardiac Arrest Protocol and Procedures – Presented by Dr. Anders: Dr. Anders presented a proposal to reorganize the Pediatric Cardiac Arrest Protocols and Procedures to prioritize staying on scene, HPCPR, and IV/IO access with rapid epinephrine administration.

The proposal includes changing epi dosing from weight based to age based in an attempt to shorten time to administration. Dr. Anders asked for the Committee's thoughts on this. Dr. Guyther was concerned that this dosing might not match dosing on Broslow tapes and other dosing charts.

Due to the extent of the proposed changes, Dr. Chizmar proposed that further discussion be tabled until the November meeting so that it can be shown in the graphic protocol format.

Incorporation of the New National Guidelines into the Trauma Decision Tree – Presented by Dr. Chizmar: Dr. Chizmar presented a proposal for incorporating components of the new National Guideline into the Trauma Decision Tree. The proposal includes recommendations from PEMAC regarding the guidelines for children.

Discussion revolved around specifics of some of the proposed Category Charlie and Delta changes including clarification of seatbelt sign, need for extrication, falls down stairs, low level falls with altered mental status, and burns. Dr. Stone discussed the need for a general review of the TDT, aviation use, and the need for consults.

Dr. Chizmar asked that further discussion of this proposal be tabled until the November meeting to give everyone time to think about it.

General Patient Care – Communications – Presented by Tim Burns and Dr. Stone: This protocol proposed to clarify the differences between medical consultations and hospital notifications and to modify when a hospital notification is required versus a medical consultation. A hospital notification is described as a brief communication to warn the ED of an incoming patient. A notification is usually directed at the ED nursing staff and is required for all priority 1 and 2 patients. A medical Consultation is a communication between an EMS clinician and an authorized physician with the purpose of obtaining advice from the physician regarding patient care.

Dr. Chizmar reviewed the specific changes to the protocol and then open the floor for discussion.

Dr. Stone pointed out that with this proposal there is no absolute need for medical consultations for all priority 1 and unstable priority 2 patients.

Dr. White made a motion, seconded by Dr. Anders, to move forward with the proposal. The motion passed with no further discussion, objections or abstentions.

Journal Club:

Discussions:
Use of TXA in Obstetric Bleeding: Dr. Stone briefly discussed a recent event in which TXA was used to treat post-partum hemorrhage resulting in a good outcome. The case involved massive bleeding and hypotension. He suggested that post-partum hemorrhage should be another indication for EMS use of TXA. It was agreed that this is worth brining forward as a protocol proposal. Dr. Chizmar agreed and advised he will have a proposal ready for the November meeting.

Good of the Order: Dr. Chizmar noted that a new Protocol Submission packet was included in the mailing for this meeting. The new packet will also be posted on the MIEMSS website.

The meeting was adjourned by acclimation at 12:48.