PRC Meeting

Wednesday, March 12, 2025
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		
Announcements		
Old Business	Labetalol for Hypertension	Dr. Stone et al.
New Business	Critically Unstable Patient – Pediatric Pediatric Destination Decision Tree (PDTree) - move from Research to standard protocol	Dr. Anders Dr. Anders
Journal Club		
Discussion(s)	Metoprolol for A-fib	Dr. Chizmar
Adjournment		
Next Meeting	May 14, 2025 9:30am-12:00pm	

Protocol Review Committee Meeting Minutes

March 12, 2025

Attendance:

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

MIEMSS Staff: Mustafa Sidik, Donna Geisel, Dr. Douglas Floccare, Melissa Meyers, Scott Legore,

Guests: Kristy Mayne, Eric Cohn, JoElyn Lerp, Tina Kintop, Kathy Jo Marvel, Mike Cole, Will Tipton, Logan Quinn, Peter Dugan, Dr. Kyle Fratta, Dr. Stephanie Kemp, Dr. Jeff Nusbaum, Michael Reynolds, Anthony Scott, Jonathan Siegel, Dr. Jonathan Wendell, Dr. Jeff Short, Dr. Ryan McFague, Terrell Buckson

Excused:

Alternates:

Absent: Christian Griffin

Meeting called to order at 9:33 a.m. by Dr. Chizmar.

Minutes: A motion was made by Marianne Warehime and seconded by Dr. Levy to accept the minutes as written. The motion passed with no objections, abstentions or discussion.

New Business:

Critically Unstable Patient – Pediatric – Dr. Anders: The current Critically Unstable Patient Protocol applies only to adult patients. Dr. Anders presented a proposal for a Critically Unstable Patient – Pediatric Protocol that mirrors the adult protocol but with slight adjustments to make it more relevant for pediatric patients with less concern for acute coronary syndromes and more concern for respiratory emergencies. These adjustments include adding abnormalities in the Pediatric Assessment Triangle to the Indications as well as references to some specific treatments.

Discussion topics included:

- Modifications of the verbiage, especially with regard to the directions to “cease all efforts at patient movement until treatments in this protocol are complete”. Suggested alternate wording included “defer movement of the patient in favor of completing all treatments in this protocol” to allow for extenuating circumstances.
- A question regarding the need to reference the BLS treatments in the ALS section raised a larger question of formatting and repetition for the entire protocols. Suggested changes included renaming the BLS treatments to emphasis that BLS care should be provided by both BLS and ALS clinicians.

- Modification of patient age references to include the patients less than 18 years old for medical but less than 15 years old for trauma patients.
- Consolidation of the proposed pediatric protocol with the existing adult protocol rather than having two separate protocols.

Dr. Anders advised that she is willing to try to consolidate the two protocols as well as incorporate suggestions from the committee into the proposal. Dr. Levy expressed interest in helping with the revisions. Dr. Anders welcomed help from anyone else who is interested. She will bring a modified proposal back to the committee at a later date.

Pediatric Destination Decision Tree (PDTree) – Dr. Anders: Dr. Anders presented results from the Pediatric Decision Tree (PDTree) Research Protocol and proposed that it be moved from the Research Protocol section into the Standard Protocols.

The research protocol was tested in three jurisdictions, Baltimore City, Prince George's County, and Queen Anne's County. The results showed an increase in the proportion of transports by-passing the nearest facility. The specific destinations for these patients also changed. The number of patients transported to Specialty Centers decreased while the number transported to Comprehensive Centers increased.

Identification of resource levels for pediatric hospitals is needed prior to the protocol becoming standard. Dr. Anders is currently working on creating a Maryland Facility Recognition Program that would designate hospitals as either Pediatric Ready, a Pediatric Resource Hospital, or a Comprehensive Pediatric Hospital and anticipates the designations to be in place in time for the 2026 Protocol Rollout.

Discussion included:

- Identification of possible middle tier hospitals
- Use of on-line medical direction, pediatric base stations, and alert tracking
- Benefits of a decision support tool to reduce the need for dual consults

Dr. Levy made a motion to move forward with the proposal. The motion was seconded by Dr. Chiccone with a third by Dr. Stone.

Further discussion points included:

- Out-of-state transports and possible designation for facilities in neighboring states
- Designation of freestanding facilities as Pediatric Ready
- Incorporation of the decision-making tool into the protocol app to reduce the need for memorization

With no further discussion, the motion passed with no objections or abstentions.

Old Business:

Labetalol for Hypertension – Dr. Stone and Will Tipton: This proposal is a modification of a proposal that was tabled in 2024. A work group was formed during the November 2024 PRC meeting and since then has been working to address the concerns expressed by the PRC during previous meetings. Dr. Stone and Will Tipton presented an update on the work group's progress including feedback and advise from neurologists. The presentation centered on blood pressure criteria and other indications including

stroke symptoms, signs of hypertension mediated end organ damage (HMOD) and acute aortic syndrome were discussed as well as labetalol dosing.

Discussion topics included:

- Possible difficulty of incorporating this protocol into the Stroke Protocol
- Concerns of potential over-treatment of HMOD
- Possible confusion with the Hypertensive Disorders of Pregnancy Protocol and treatment of pregnant patients
- Other concerns included head injuries, cocaine use, and A-fib with RVR

Dr. Stone thanked the members of the work group, Dr. Sward, Tristan Eberle, and Dr. Fratta. Their goal is to present a full proposal at the May PRC meeting.

Discussion:

Medication Shortages / Metoprolol for A-fib – Dr. Chizmar: One of the two suppliers is planning to discontinue production of Advantage diltiazem at the end of this year. Vial-based diltiazem has a short shelf life when unrefrigerated. Dr. Chizmar is looking at alternative medications in case diltiazem becomes unavailable. He asked whether any jurisdictions besides Region IV may be facing a shortage of diltiazem. Metoprolol may be a good alternative medication. Dr. Chizmar proposed removing verapamil from the formulary in favor of metoprolol as a shortage medication to back-up diltiazem. Using esmolol instead of metoprolol as it is already in the formulary was suggested. Metoprolol was favored over esmolol in discussion as it is more comparable to diltiazem and esmolol is very short-lived so would need to be administered as an infusion rather than a bolus. Amiodarone was also discussed as it is already in the algorithm. However, amiodarone is on back order and both Baltimore and Prince George's Counties are having difficulty obtaining it.

Dr. Chizmar noted that we may need to add a lidocaine back into the formulary as a back-up to amiodarone. With no objections, he will also draft a pharmacology page for metoprolol.

Good-of-the-Order:

Dr. Levy is drafting a tourniquet conversion and down staging protocol for the May meeting. The protocol would address tourniquets applied unnecessarily prior to EMS arrival and the "high and tight" applications by law enforcement.

Dr. Stone asked whether b-lines were being taught for ultrasound pulmonary assessments. Dr. White advised that they are being used in field assessment by EMS and are very useful for distinguishing CHF versus COPD, COVID, and other lung conditions. Use of ultrasound for obtaining vascular access was also discussed and is not currently in the protocol.

The work of the outside reviewers who are proofreading the new protocols was acknowledged.

Adjournment: A motion was made by Rachel Cockerham, seconded by Marianne Warehime, to adjourn the meeting. The motion passed with no objections and the meet adjourned at 11:31 a.m.