MINUTES
EMERGENCY MEDICAL SERVICES
MEDICAL ADVISORY BOARD MEETING
MAY 2, 2001 – 6:00 P.M.

MEMBERS PRESENT

Allen Marino, M.D.
David E. Slattery, M.D.
Donald Reisch, M.D.
Jeff Davidson, M.D., Chairman
Karen Laauwe, M.D.
Michael Walsh
Paul Fischer, M.D.
Philis Beifuss, R.N.
Richard Henderson, M.D.
Steve Kramer
David Daitch, D.O.
Donald Kwalick, M.D.
E. P. Homansky, M.D.
Jeff Greenlee, D.O.
Kenneth Riddle, Deputy Chief
Nicholas Han, M.D.
Pete Carlo
Randy Howell, Division Chief
Steve Hanson, Deputy Chief
Virginia DeLeon

MEMBERS ABSENT

Brian Lungo, M.D.
Dennis Lemon, D.O.
John J. Fildes, M.D.

CCHD STAFF PRESENT

Jane Shunney
Mary Ellen Britt
Jennifer Carter – Recording Secretary
LaRue Scull
Jean Folk
Kelly Quinn

PUBLIC ATTENDANCE

Alice Conroy (Sunrise Hospital)
Aspen Scharff (Southwest Ambulance)
Bede Parry (AMR)
Brian Rogers (Southwest Ambulance)
Patti Glavin (Boulder City Hospital)
Sue Hoppler (Desert Springs Hospital)
E. A. Wetzel (AMR)
Frank Daddabbo (CCSN)
Henry Clinton (LVFD)
Joelle Babula (Review Journal)
Linda Courtney (Clark County)
Jon Kingma (Boulder City Fire)
Kathy Palm (UMC)
Richard Hardman (CCFD)
Dale Carrison (UMC)
Don Hales (AMR)
Todd Jaynes (MFR)
Sandy Young (LVFD)
Michael Denton (AMR)
Joe Calise (Summerlin)
Mike Griffiths (Airlife)
J. L. Netski (AMR)

CALL TO ORDER-NOTICE OF POSTING OF AGENDA

The EMS Medical Advisory Board convened on Wednesday, May 2, 2001 in the Clemens Room at the Otto H. Ravenholt, M.D. Public Health Center. Chairman Jeff Davidson, M.D. called the meeting to order at 6:00 p.m. and the Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law. Dr. Davidson noted that a quorum was present.

I. CONSENT AGENDA

A motion for Board approval of the following item on the Consent Agenda was made, seconded, and unanimously carried.

Minutes Medical Advisory Board Meeting May 2, 2001.

II. REPORT/DISCUSSION/POSSIBLE ACTION:

A. Priority Dispatch Update Review of New Protocols

Dr Han stated the March 24th meeting, a discussion regarding Version 11 of the Medical Dispatch protocols that the old version has been in use for about 10 years. Consensus at the meeting, represented by the Las Vegas Fire and Rescue, Henderson Fire Department and the North Las Vegas Fire Department, was that the protocols be made more convenient and efficient. There are additions that need to be voted on at the next meeting. Dr. Han went over the five main ones.

The first addition was a change to card #9, "Local medical control must define and authorize". Check off marks; cold and stiff and warm environment, decapitation, decomposition, explosive gun shot wounds, incineration, severe injuries obviously incompatible with life. There was also a move to include "a person responding must physically verify the body". The proposed addition was to put this statement in the bottom blocks.

Randy Howell asked if it would go after submersion?

Dr. Han answered it would be the empty box where there is space to add on a new definition and that's because sometimes a third person party calling in could not verify the obvious death. We'd like the person responding to physically verify that the body is obviously dead.

Randy Howell said wouldn't you state the level of the responding person that's confirming this?

Dr. Han said if they call in saying this is an obvious death, it needs to be defined and these are the descriptions or definitions of these obvious deaths.

Chief Riddle clarified second and third party calls. The first party is the patient themselves that call; the second party is someone who is with the patient; and the third party would be someone driving down the street, sees somebody laying on the sidewalk and places the call. They're not physically with the person. What I'm hearing is that we want to include "the obvious death is verified by a second party" because obviously the first party can't, as that's the patient.

Regarding card 9, Chief Riddle said in the old system, we actually allowed what was called ALPHA response which means no lights, no sirens; and this new system for obvious death, they call a B level response an EMT level response with lights and sirens. It's tough sometimes when you send an ambulance with no lights and sirens because somebody's dead but, based on the dispatch information, it's obvious that their dead, but I'm not sure there's not an emotional support thing, like go code B with lights and siren. So that would be a change from the old system. The other thing is that they added an OMEGA response, which we have not used in our system. An OMEGA response is basically a referral.

Tim Gardner said I've gone through a lot of Medical Priority Dispatch (MPD) at Henderson. I am certified in MPD and we've gone through data collection to tailor our response based on the category. MPD does not allow you to change categories. What they do want you to do is tailor your response to the category itself. Everyone has used the chart in the back that says a BRAVO response might be a cold or a hot unit. All that is, is a basic structure and it was an example. They didn't intend for everyone to be using it. All we have is ALS units, so based on our data on patients that are transported or based on the determinative level, we would either respond to a unit code 1, where there'd be a rescuing engine, or both units code 1 or both units code 3. We're in the process of doing that we're just waiting for MAB approval. We're doing that associated with our dispatch and our CAD terminal. I think Chief Riddle mentioned, the OMEGA response has to do with their CAD and changing the response of what they've been doing for so long. It would be hard to say that a BRAVO response is now a different response because everyone's used to a BRAVO response being a code 3.

Dr Han said looking at this page, ECHO, DELTA, BRAVO (EDB) OMEGA response, there are certain cards, previously in version 10, which were crossed out. We're proposing to keep the levels EDB and OMEGA as is and respond appropriately.

Chief Riddle said version 10, from our dispatch center, stated an obvious death was a BRAVO response, which is red lights and sirens. But through the MAB, 2 or 3 years ago, it was changed to an ALPHA response and that's what is currently done in the community. He pointed out that this Board changed version 10.2 and the new version still makes it a lights and sirens response. He expressed his concern that this is a minimum level of response. In Henderson, if they send everything ALS then they can still send everything ALS just because it says an EMT level. But in Las Vegas and Clark County, we have private ambulance and a mix of BLS and ALS. With our franchise, the billing level is actually determined on the level of response provided.

Dr. Davidson asked if a lower level response is always sent, if it's approved, or any higher level?

Chief Riddle answered it's okay to overkill but it's not recommended to under kill.

Dr. Davidson said if we approve a lower level, which currently is BRAVO, and change it to an ALPHA then it can always be ALPHA or anything higher, BRAVO or up to DELTA.

Chief Riddle agreed with Tim. He thought the most legally defensible position is to stay with determinates that are recommended by the National Academy.

Dr. Han said there's no problem with keeping it the way it is and not changing it from BRAVO to ALPHA.

Chief Riddle said what I heard Tim saying is that we changed it to going with no lights or sirens. It was very uncomfortable for us to do that and now we're going back.

Tim Gardner said actually, on the BRAVO category, we might have units going code 1. The BRAVO category is not telling us to go code 3. All it's telling us is, based on this category this is what's going on with the patient. For an obvious death we're probably not going to send a unit code 3. We'll send an ALS unit but it will be going code 1 because it's verifiable that the patient is dead. All we're using is the ALPHA through ECHO calls. On the same card, on an ECHO response, we may be sending our police officers with AED's as a first unit responder because we identified in the first 5 seconds of the call, that this patient needs help. If they are a cardiac arrest, all our units have AED's and they can get there probably a lot quicker than our regular apparatus. On an OMEGA call, we haven't decided yet as a company or as a department but we have pursued options, especially on a poisoning or overdose call 23. A lot of agencies are referring that to poison control and staying on the line until it's verified that they no longer need help or poison control says wait a second we need to send a rescue now code 3. It's still an OMEGA response, based on the determinates, but now poison control is helping the dispatch center out and they are getting some sort of professional advice.

Chief Riddle said he went through the training several years ago, but in the back where they give you the matrix for A, B, C, & D – B is a hot call with BLS. Now you're telling me it can go either way.

Tim Gardner said they're coming out with fire cards now and this is such a hot topic across the nation. People thought this was the bible in the back, which is a hot response, and it's not. It's an example. With the Fire Cards coming out, they're actually getting rid of that algorithm because of all the confusion it caused. MPD or the National Academy of Emergency Medical Dispatchers can care less what we respond to the call. What they do care about is the structure, the determinate levels and the key questions that the dispatchers ask to get that information out to the crews.

Dr. Henderson said I think that it points out the difference. For instance; for us a BRAVO call on page 8 is responded to differently than a BRAVO call on page 10.

Tim Gardner said it's based on our call statistics. If we feel the patient hasn't been transported based on the stats that we've gathered, we're going to send a unit, an ALS engine to assess the patient. If we know that this is a traumatic injury, and we always transport this patient, we're going to send an ALS rescue to the call. So BRAVO calls for us are handled very differently and it could be different units going to it. It could be two units, or one unit based on the data that we've collected. That's really how Medical Priority Dispatch recommends you set it up. I know it's been set up this way because of our CADS (Computer Aided Dispatch). An ECHO response is anything that normally doesn't go as a first responder. You can send a battalion chief, if they have the ability to an echo response. If you have someone that is drowning or someone that's choking, anybody with basic first aide would go to that call as opposed to other echo responses.

Russ Cameron asked if the dispatcher gives a recommendation to the crew on how to respond as far as code?

Tim Gardner said that's what we're looking into. They would recommend, for example, rescue 93 handled a call code 3 just as a BRAVO 33 or BRAVO 29 and then they would respond to that because of the differences that we set up in our BRAVO and ALPHA categories. Some DELTA responses we're sending 3 engines 2 rescues and a battalion chief.

Dr. Henderson said right now all the representatives from all levels of the agencies are going over each call and each level deciding what they think the appropriate response should be.

Chief Riddle said our approach, when they implemented this in 1990, was to get the blessing of the MAB because we felt the response and the level of response is a medical decision. I know each city determines what they are willing to pay for, that's why it was brought here for approval.

Dr. Han said each city responds slightly differently. Henderson responds differently with different crew versus Las Vegas or North Las Vegas. I think this protocol, where it says ECHO, DELTA, BRAVO, I think that would be the dispatcher's prerogative. As far as we're concerned, for the MAB meeting, is to just recognize that those are the levels and would be the minimum requirement for that kind of response or situation. If it's an obvious death it would be B and from that, dispatch can control. So we're not voting on this but just discussing that we're going to keep these protocols as is…E, B, D, and OMEGA.

Dr. Han said there are four more cards to be discussed before the vote next month. **Card 12** – Seizures – 4th question is; is she or he an epileptic or ever had a seizure history? This question does not lead to any kind of response. So is this an unnecessary, time-consuming question for the dispatcher or phone answering personnel. We will be voting on whether to leave this question in or out.

Chief Riddle said we actually use a computerized version of this, not a card version, and, depending on the answers, that actually determines the response. Logistically, if you delete a question, how is the response affected.

Dr. Han said it only helps the physicians if it is a repeat seizure or new onset of seizures, whether it is a new onset seizure or a chronic seizure person calling in, and whether that's going to affect how we dispatch equipment.

Dr. Reisch said it seems to be frequently useful information. The party giving the information may not be there when they get there and the patient is still postictal so you may not get that information in a timely fashion. I'd like to see it stay on.

Dr. Han said another issue is whether we are going to change this protocol or if it would be convenient to leave it in there and just follow their recommendations.

Tim Gardner said he placed a call to MPD on that question and they are looking into it. He said he thought it a deterrent that doesn't take you anywhere. Our system has come up and said that any first time seizure needs to be transported to the hospital. However, if you follow the algorithm, if they've had a first time seizure, they seize and now they're conscious and breathing. It's an ALPHA response. Any first time seizure for the most part is considered a cardiac arrest above age 35 until proven otherwise. That's how it comes across in the cards. He said he didn't understand why it doesn't point you to some sort of level of response, if you're asking a question. It may be a bug in the system.

Don Hales asked if they knew if their software gives you a choice whether to ask some of the questions, all of the questions or none of the questions?

Chief Riddle said it reflects in the QA reports whether they didn't ask a question, so yes, you can bypass it.

Dr. Han said **Card 24** is pregnancy. If you look at the center of the page there's a high-risk complication. This is another area where we need to vote on and fill in the definition of what high-risk means.

Chief Riddle said on version 10.2, this Board added a 4th category; any pregnancy related hemorrhage is a D level response under the old system.

Dr. Han said the first box says premature birth, which is obviously high-risk. Multiple birth is high risk and we're thinking of adding on seizure or eclampsia. The word eclampsia is not really a good word to include here because no one knows what it means. I was thinking hypertension with a description of blood pressure 140/90 greater than what is a normal tension pressure.

Chief Riddle said I think if someone calls in and says they are having a seizure, dispatchers will go to the seizure card. I don't know if the seizure card shunts them to pregnancy.

Dr. Marino said it actually becomes a C level call under seizures.

Dr. Homansky said maybe you could cover eclampsia with the term swelling. We're looking for high-risk pregnancies.

Dr. Henderson said why does it matter. Dispatch just wants to get a rig there quickly.

Dr. Davidson said the only thing I could think of is age. And I don't know if you'd want to put that one in. Pregnancy and age becomes a high risk if it's above a certain age, some people say 40.

Chief Riddle said there are some key entry questions, and age is one of those that is always there.

Phyliss Beilfuss said the question asked is if she has any high-risk complications. This will help the dispatcher if she comes out with a complication that they can relate.

Dr. Davidson asked if there was anything specific anyone wanted to see under high risk other than what's currently there; pre-mature birth and multiple birth? If there are no suggestions as to what we want to include, it will stand as is with substance abuse included.

Dr Han discussed **Card 28**, stroke also refers to version 10 versus the new version and how the response was before. In the old version the determinate B was left out.

Chief Riddle said it was eliminated by the Board.

Dr. Han: Is this something that we want to keep out? Going back to the 2 cards before, where we're going to keep it as it is and as a B determinate. The known status was upgraded to a C.

Chief Riddle said the only non red-light siren was normal breathing, age less than 35, in the old system. This Board, when this medication for strokes was a big deal, eliminated the B level response to set paramedic level response.

Dr. Han said now the new protocol here, B is back again. Do we keep it as a B or continue eliminating the B level and bump it up to a C?

Chief Riddle said the only thing I want to add is a 3rd party caller is not actually with the patient.

Dr. Davidson said that might be something that's easier for the EMS people to answer than MAB. I don't think there's a uniform practice on how strokes are being handled and trying to meet certain kinds of standards of recommendations, so I can't tell you it's still not urgent to get a potential stroke in within 3 hours to get the CT completed. I'm not saying time isn't urgent. Every facility might have different limitations from their scanners and things like that.

Tim Gardner advised that on all the cards, if it's an unknown status 3rd party call, it means they can't ask the questions or they can't get the answers for the questions, or someone says I had a stroke and you've got to go to this call. But they don't know whether the patient is breathing or any thing else. And that's consistent through all the cards for 3rd party unknown status. It's always a BRAVO category. We've looked at it and said it's got to be some ALS unit going code 3 to that call until they can verify by someone what is going on. If you got rid of this, it would change all the other cards with the BRAVO category as a 3rd party unknown status.

Chief Riddle said my recommendation is to stay with the protocol, because there's a lot of research that goes into this.

Dr. Han said the final and last card is **Card #33** – Inter Facility Transfers. This is a brand new card and this was the bulk of our discussion at the meeting. Acuity level 1, 2, 3, on the left bottom corner is what we need to fill out on the educational part of the card. Acuity level 1, 2, 3 is going to be an A response which means it's low priority. All we have to do is just fill in the definition and a few examples of it. What I'm thinking about is; if a clinic calls in to the dispatch saying ambulance please come because I need to get an x-ray or I need to put in a foley catheter or very simple things that do not require a higher level of care. If the committee could tell me what other suggested procedures need to be under that category it would be appreciated. I have foley, simple x-ray, a line placement, or simple blood draw.

Dr. Henderson said we don't really have a committee that would be able to review this particularly before the meeting to actually put some real thought into it rather than put us on the spur of the moment right now.

Dr. Han said it really is not much to think about. We've thought it over and it is a very simple thing that requires only a response.

Dr. Henderson said rather then give diagnosis, I'd rather see a defining thing if you want to say QD1 is the least, non-monitored, no IV access, etc. That would define, like a QM1 vs a Q2B IV access required, monitor required. I'm trying to define them more by what their work is going to be.

Dr. Han said If it requires a monitor or IV line then it would be a higher response. It would be a DELTA, BRAVO, a CHARLIE response versus ALPHA response. And all they are asking is acuity level 1, 2, 3 under ALPHA response, which is the minimum requirement. So this would be a very simple card that every body's having trouble with.

Dr. Henderson said why would you need to have acuity 1, 2, and 3? Why couldn't you just shove them all together? Why can't they just all be ALPHA?

Chief Riddle said I think that's what Dr. Han is trying to say. This allows the local medical community to define what you want to define as a 1, 2, and 3 and you list what those are.

Dr. Henderson said just have one set of acuity, non-acute.

Dr. Han said that's my opinion too but we're just kind of going along with this version with this printout card that already states acuity 1, 2, 3 and what are we going to do about it is the question.

Chief Riddle said can we recognize acuity 1 and don't recognize 2 and 3, is that a possibility.

Dr. Han said we could do that. This is really up in the air.

Chief Riddle asked Dr. Han if he knew why they give the 3 options? Is it a scheduling issue for prioritizing who gets transported first?

Tim Gardner said they do set it up to where you can send a BLS unit to take the patient or a paramedic unit to take the patient. They do say you don't have to have all those responses. You can have almost 26 different responses under A alone. But it's all based on what is easy for the dispatch to identify with and that can easily be write down.

Dr. Davidson said whatever the dispatch centers want to put in, whether it's the top 3, top 5, or top 10, it's a lot. It's all going to fall under ALPHA, which means non acute.

Dr. Han said suggested that before the next meeting, we'll get the top 5 and just put it in there.

Dr. Davidson said These levels will just all equal non acute and we can give 5 examples.

Chief Riddle said when they are actually doing the call processing they're really only looking at the top part of the card. The bottom part is kind of like an educational, quick reference. The majority of the time, especially on the cards that get used over and over again, this is just more of refresher training when they are on down time.

Dr. Han said the consensus is that this new protocol is very good and should help the whole city.

Randy Howell said underneath each card are all these different codes. Like on card 33 there's a 33 DELTA 1, 33 CHARLIE 1, 2 ,3, all the way down. I think there's 265 or 270 categories. We have looked at each one, line by line. What I would like to do is present that to the MAB for review and make sure that there is a feeling of support. That would be my recommendation.

Chief Riddle said all our people get is 33C. Why it's 33C 1,2,3 or 4 is that the medics can have a pocket guide so to speak and they can go okay 33C is this with that and it gives them a little more information.

Randy Howell said but it also gives you the ability to break it down into those 270 different categories. One type of DELTA call might need more resources than another type of DELTA call. That's what I would like to bring before the MAB. I would like to have it out in a packet so that it can be reviewed ahead of time, so that when we come to the June MAB meeting people have been able to review it and maybe digest it and be able to vote upon it. If that's what our local medical community wants us to do.

Chief Riddle said my concern is, and again I haven't been involved in this for probably the last four or five years, it's a lot more complicated than it used to be. And I'm not sure that everyone on the Board totally understands the process and how you actually go through it. I don't know if there's a mini overview video that says here's how the call comes in, you ask these questions and you go to this card, and what the whole process is. The goal is to process the call in 60 seconds or less. Some agencies have a little stricter processing standard.

Dr. Davidson said most of us probably don't understand how this functions. We kind of get the jest of it but the question would be; 1: Do you want to have a committee meeting prior to next month and review any other comments and anyone can participate; and 2: get the information out to us to review in our packets so that we can have it for vote next month. I really see this Board as supporting what this academy of dispatchers has already researched and knows the most effective method right now. That's probably why it's updated every couple of years.

Dr. Henderson said to review that in a meaningful way takes a couple of hours. I don't think anybody's going to want to do that, so I think what we should do is give a direction that we're comfortable with the local agencies making their own call or some kind of generalization. Because there is no way that we're going to spend a couple of hours reviewing these things.

Chief Riddle said one thing we did in the past, when we first brought this in the 90's, was we actually brought a dispatch computer in and put it up on the board and just had people practice calls to show you how it went. I don't know if that's something you want to do or not.

Dr. Greenlee said I'd rather know what the problems are identified with these because that would limit it down to scope of just a few things to discuss. Then discuss the problems and correct them as it would apply to our system.

Dr. Davidson said this group has already met for three hours and I know that because Dr. Han called me and reviewed the information they had been going through. If the system works, we're here to approve that. If there's new protocols or new cards in place that will improve the current system we want to support that.

Dr. Henderson said let's say one of the agencies decided that they were going to send an EMT crew to a cardiac arrest, we as the Board would probably not like that. I think what Randy is looking for us to do is to say that we agree with him rather than what his agency has settled on but I don't see how we can do that, there are just too many categories.

Randy Howell said we've had multiple meetings for three or four hours at a time going over each one, hashing out the decision, does that require an engine company, a transport capable unit.

Dr. Davidson said I think this Board is comfortable with your decision on that, if this is the standard from the Dispatcher's Academys book.

Dr. Henderson said the book doesn't specify the right word.

Dr. Davidson said yes I know but they're going to individually determine that and I think they are better to determine their level and their area.

Dr. Henderson said then we're saying, as a Board, that we're comfortable deferring their response level decisions to the individual agencies.

Chief Riddle said if you had a new city outside of Las Vegas, that was in Clark County, how could you impose on that city to pay and provide paramedic level service if the people in that city didn't want paramedic level service. I think we're asking the Board to approve the screening process to determine what level of service that we're going to send. But if the community doesn't have

paramedics, how can this Board mandate paramedics. I remember when Henderson had no paramedics and their city decided they wanted paramedics. I'm trying to say it's a medical decision versus a resource decision.

Dr. Henderson said I think what we should do is next month have something on our agenda where we say that we're for the process that the level of response would be up to the agencies.

Dr. Han said it is too complicated and as of now there's different response from different cities.

Dr. Davidson said I think the fact that your committee met with all the proper chiefs from all the different departments, it was taking all the working people together at that time. What we really want to hear is the summary and I think that's the best thing that way we can endorse the summary. I don't think this Board rehashing what that group has already worked on is going to make much sense. So you'll present that next month.

Dr. Han stated the Priority Dispatch Committee will meet on the same day prior to the MAB meeting.

Dr. Davidson thanked Dr. Han and his committee. I'm sure the Board appreciates all the time that you have put in reviewing the new dispatch cards.

B. Education Committee Update

Draft District Procedure for EMT-Basic/Intermediate/Paramedic Recertification

Dr. Laauwe said in the pink draft, District Procedure for EMT-Basic Recertification, Intermediate Recertification and Paramedic Recertification, there are just changes in wording on all of them. They took out on the second page, as an example, the letter E. Initially it said maximum of 8 hours annually of earned pre-approved self-education. They had interactive computer programs. So it was limiting the amount of computer activity that was being done by the paramedics and the basics in learning and getting their CME's. So they made it a separate category, interactive computer programs will be pre-approved on a case-by-case basis by the Health District EMS office. This will actually give the paramedics and the basics more CME availability, able to use computer programs. They will be pre-approved by the Health District, to include skills and interactive types of things with testing at the end and they'll be able to monitor this more closely. So with all of these changes in here, a lot of it is just wording, if everyone agrees this is okay, that's one section of this draft. The other part is just the actual re-certification proficiency record. There's 5 different ones, the agencies would like them to all be put together as one. So, instead of having separate pages, it comes

together as one page listing Basic, Intermediate, Paramedic skills with their sign off sheets, adding practice skills for paramedics and spinal immobilization for adults and peds, seated and lying down So it's going to be all on one page either both sides or whatever just so it's easier for the agencies. All of the agencies agreed. So I would like to bring this draft as a motion that we endorse this for the recertification for EMTS, Basic, Intermediate and Paramedics. Randy Howell said the last thing you mentioned was the sign in sheet. Dr. Laauwe said it's going to be put together as one sheet with the three levels on it. It will also have on it whether it's reciprocity, reinstatement, challenge or recertification which you can circle so you don't have four different sheets.

Dr. Laauwe motioned to endorse this for the recertification of Basic EMT's and Intermediate and Paramedics. It was seconded and passed.

Discussion of Draft Etomidate Protocol and Educational Program

Dr. Laauwe said the next part is the Etomidate back to committee for the educational component. We decided to table this for any voting tonight because Dr. Watson was suppose to get together with Richard Hardman to do a computer disk program for an education component and this hasn't happened.

It was recommended by the Education Committee that whenever we bring up a protocol and it gets approved, wait until the approval process happens at the MAB. Before it can go out to any agency an education component should be included then brought to the MAB and approved together. That way once both are approved the agencies can project a time frame of how long the education component will take before we can place into practice. Allow 30 days to complete the education component.

Dr. Davidson said every protocol that we ever pass, we have to define a timeline and an education component is mandated with it, then educate, when that's done, the drug is used in practice by the whole system. Mary Ellen stated Etomidate dosages would be discussed as part of the education packet. Dr. Davidson said currently the dosage would stay at .3 mg/kg with no maximum placed. The Education Committee will define it with clinical signs of shock under contraindications and that's how it will stand.

C. Divert Update: Discussion of Emergency Department Open/Closure Model

Dr. Davidson said open/closed started April 25, 2001 at 8:00AM. How is the system progressing?

Steve Kramer said overall from the patients standpoint we are able to take them to the facility of choice as long as it's open versus closed is best standpoint for them. We have had a couple of situations arise where we had multiple units at one facility that we had an extended wait time. We have seen the total amount of

minutes where units wait at a facility increase overall. But as far as from the patient's standpoint as far as getting in the closest facility, it has worked for us from that standpoint.

Dr. Fischer said there seems to be no mention in the Operations protocol with regards to the inter-regional corporation. A situation arose where one region had one unit closed and two applying for closure and another region was sending staff home. There doesn't seem to be under procedure #4 which would address that if 2 or more ED's in the region request closure within the same hour the remaining 2 regions should be explored for their ability to provide emergency services covering the affected region.

Dr. Davidson said okay so your comment would be that for example if region C is in high demand and alternating closure and A doesn't know that they might be minimizing and/or sending nurses home, not understanding that some of the flow could shift that way.

Dr. Henderson said but the flow is not being shifted I think is what he's saying. There is nothing that suggests to the system, hey you've got untapped resources in that direction let's go….

Dr. Davidson stated for example, I'm just going to use A and C if someone lives next to Sienna, Sienna's very busy, I guess there would be multiple questions asked, does someone want to be transported to Mountain View if Mountain View is rather slow, we'll say. Which kind of goes back to …well, it's not truly the old system but I mean if it's a patient request and you want to ship 'em across town

Virginia DeLeon said but there's nothing in the policy, that's the problem. It's understood in this MAB but it's not understood in the EMS system.

Sandy Young asked what's not understood?

Virginia DeLeon said that if a couple hospitals in the same region are saturated, let's say that Saint Rose is, that they can cross regional boundaries and go to either Desert Springs or Sunrise.

Sandy Young said from our agency that was part of their educational packet. It is judged by patient request and at the time if the hospital they choose is closed then what we would give them is the hospitals in that region that are opened or close to that proximity. They have the choice to go any where they want. And we will take them wherever they want. But we are trying to get out of the thing of the system telling us to go…

Dr. Davidson said in other words, the patients are being told for example, Sienna is closed, Saint Rose is very busy but Desert Springs and Sunrise are open and are not experiencing high volumes. You'll probably get in quicker at this time. Which is the same wording I'm quoting from an article that I read on how they use open and closed in Chicago area.

Chief Riddle said trust me, when we presented this to our medics their biggest concern was okay we have less distance to travel but we're going to be in hospitals longer. And we explained, well actually you have more options now because if one is closed in one region and another one is closed in another region you have four other resources you can go to.

Dr. Henderson said but the medic, as an example he did not know that some other hospital was sending home staff.

Dr. Fischer said it just needs to be written in the protocols.

Dr. Davidson asked or do you think it's an education item that we've worked this new system five days Dr. Henderson and hasn't had time to truly infiltrate out.

Dr. Henderson said right now there is not a mechanism, or we're not using the mechanism that's there to know what hospitals might be slow.

Sandy Young said but the protocol is to develop the EMS system. We can't dictate to a hospital you can not send staff home. And the open or closed or the regions was not to determine destination. It was to rotate closure, not to determine destination.

Dr. Henderson said I think the point that was brought up was that you have one part of the valley being saturated and the players in that corner don't know that there's unused resources in another corner. And my gut feeling is that the medics on the street don't know which hospital might have - let's say it was Mountain View who was sending people home. The EMS folks that are going into Desert Springs, I'll bet don't know what Mountain View's status is.

Dr. Davidson said so your concern is basically that we're not using our maximum resources. One facility is filled, another facility is not, maybe we're not using maximum resources. So the question becomes, is it a communication thing, and will the communication system that we're going to try and implement in the future better spread that information.

Joe Calise said we had our nurse managers meeting just shortly after we started and we've communicated with a couple of other people and found some flaws in the system. Some of it is educational but a lot of the crews thought we were still on rotation even when there was no language in our system at all. The other thing we found is that in region A, the north side of town or northwest, we were sending staff home. UMC and Valley were getting slammed. Medics weren't getting that communication because there's no way for it to happen yet. It might make the system we are trying to make happen work better. I don't' think that we have all the bugs out yet. But I do think the DIVERT Committee needs to meet and get some language in that part of the protocol that we talked about but avoided. We just didn't think we needed it. But I think that it's going to work better. I just think that communication has always been the Nurse Managers major issue.

Brian Rogers said going back to which hospital would have a shorter wait time. I would hate to be the one on the other end of the phone when the administrator calls and says you told this person that wanted to go to my hospital that the wait time was shorter at this hospital. They will go crazy. We do know who is busy and who isn't because, the computer screen that we have in the services says; forced open, open, or closed. If it says forced open that means that they're busy, we know it, but they can accept a patient. So we have some understanding of who is real busy versus who's wide open versus who you can't go to. And as far as the medics not understanding it, they understand it but what we're doing now, which is the biggest benefit that we've done for this whole project, is we're allowing people to go to the hospitals that they choose. Customer service to our community has increased 100 times. At least we're not taking people any more from out northwest to southeast. And although that may cause some problems, that's probably the biggest benefit. To the EMS system it's still the same number of beds, same number of patients, same total number of hours waiting. It's not a huge benefit to us, I don't think it's huge benefit to the hospitals, but I think it's a benefit to the customers, who we are all here to serve.

Dr. Davidson said I appreciate that comment. I think that's what we're always forgetting. We are here to serve the community.

Matt Nesky, from AMR, said what I've seen in the past five days is an extension in the overall drop times at the facilities. We're calling it the cyclic closure, if you would. You're seeing the rotation between the district A and B if you would. I've not seen it yet in C. Where one's on, one's off, one's on. It's like an hourly thing. Brian's calling it the forced closure, I'm calling it the cyclic rotation of being open or closed. And it's gone to the point where our drop times have gone from an average which has been extended in the past year and a half to the point of 36 to 40 minutes average drop time. And when you add this on top of a 1000 patients a week it is unbelievable. The EMS transport or franchisees has also lost the ability to utilize this as part of their overall method of doing business. We are penalized for not being able and ready to respond to calls. And we as providers need some relief in the staffing of hospital emergency departments so we can be free to turn patients over to ED staff and leave. We've been doing patient care for the past year and a half for an hour- hour and a half with patients on our gurneys and this new rotation even though it's only been a week, the extensive drop times have been noticeable, very noticeable.

Chief Riddle said we do have some statistical data that Sandy can provide but again it's only five days. It's probably not statistically significant.

Dr. Reich said we really don't need five days worth of drop times. What we need, along with DIVERT status, is drop times for each hospital and do it on a regular basis. I'm sure you have been tracking this for more than a year. So I think you should do it for next month and compare it to what was happening a year ago for the same month and just add that in to our statistics. Now that we have a whole lot more space on the DIVERT status we could probably put drop times in there and just add it as one of the columns.

Chief Riddle said we are tracking by hospital and compared to the past month, so we can provide that.

Dr. Reich said I think that's more important than trying to do any simple statistics now.

Dr. Homansky said the data isn't going to be that beneficial, I agree, for five days, but the thing that bothers me is I think that there is increased tension between the ER staffs and the pre-hospital care providers. And it's understandable. It's a new system and there are times when the ER staffs feel they need to go on DIVERT and can't, or whatever, and I've seen more and more friction between the staffs and the EMS providers. That's a real problem and each ER needs to deal with it, my own ERs too. I've seen it get real nasty. Much nastier in the last few days than I've seen it before.

Dr. Reich said we just did a study with Desert Springs where we're actually seeing more ambulance runs. I think we've doubled our ambulance runs in January of this year as opposed to last year. So that means that we're out there trying to take more ambulances in. But all that does if you're successful at taking ambulances is give you more ambulances. So it really doesn't matter what the drop times are. I think it really matters is how many ambulances are you absorbing every week, month, day, and hour. Because if you're good at it, the only thing that's going to happen is they're going to overload the system until you're no longer good at it. If you're good at turning around the first 100 patients that you see the next 150 that you see are going to drop your statistics down into a well. So these are all interesting statistics but I think it's just, we're way overloaded and no matter how good you get, you're still going to be shot down sooner or later.

Dr. Carrison said I think that shows based on the comments that they have, we should hire more people or we should do something to help this out. This shows a lack of understanding in the EMS community and the hospital community. The hospital community will hire as many people as they can. One if they were available to hire. Extensive recruiting plans with all the hospitals in the community there simply aren't enough nurses. The other part is if we were staffed 100% we had all the nurses we wanted and the hospital is full, there are no critical care beds available we've got 10 ambulances in the hall, what are we going to do? You guys think you can solve it…give us some suggestions. We can't solve it. We don't have the beds enough for the patients. I would love to get you guys in and out. Nothing would make me happier. But when I can't admit patients to the hospital because the hospital's full and we're all in this situation, what are we going to do when I hear that you have to send nurses home? There is a misunderstanding between the hospitals and the EMS system. I understand their problem. Nothing's more frustrating for me as an ER Director to walk into my hospital and see 10 people lined up in the hall. All the transport units are the medics that I know. I'm frustrated and I know how frustrated they are standing there. They feel like nobody's paying attention to them. But I also

know the other side of that coin. The nurses are frustrated - everybody's frustrated. And as Flip said ours has been a bit longer than five days, but there have been some tremendous tensions in the EMS community between the hospitals and EMS providers. I think we're all on the same side.

Chief Riddle said I'd just like to add a comment. We did bring a consultant in that identified some items that could be done in the hospitals and I don't know if we fully pursued those. And the second issue I know we have some hospitals where our guys do wait a little longer but because the nurses are nice and recognize they're there, they don't mind waiting. So I agree with the doc that everybody has a different perspective.

Dr. Davidson said remember the Blue Ribbon Committees specifically broke into hospital ER or ED and EMS. I don't know if this MAB Board has any jurisdiction or guidance over an ED and/or hospital. So I do try to keep this restricted back down to where I think we can make input that's important and valuable.

Sandy Young wanted to do a quick overview from their standpoint. What's surprising from our side is that we actually improved, not significantly, but 20 seconds as opposed to 20-30 seconds difference in travel times and in route times. Part of our problem with hospital averages, we had per hospital drop from 22 minutes before to 4 minutes after. Now again I'm the first one to say that five days really isn't a valid sampling. But if you look at the total averages between all the hospitals we went from an average of 26 minutes and 42 second wait in the first 25 days to 23 minutes and 29 seconds in the last five days of the month. It's surprising to me to hear the ER docs saying that there are complaints, because I don't think we've had an increase in complaints from our medics. And usually they're the first one's to complain. The second thing, just as a point of reference, our longest wait in and ER prior to the 25 days prior was 152 minutes and 41 seconds. After this it's 128 minutes and 1 second. And our shortest wait time prior was 4 and our shortest after in the last 5 days has been 3. So we do recognize that there has been substantial progress made by the ER's. I'm going to tell you that there's work we need to do on the hospital side. One is encouraging our crews to get out of the hospitals and back in service in a timely manner. We do have people that do lolly-gag around and visit. We can get them out quicker and become more available, and that will also help. I really don't think that we're looking at it validly in just 5 days.

Dr. Davidson agreed. I think what we'll do here is we'll have a meeting in June. Because obviously I think as tradition has gone, July has been a by-month that we haven't met. So June would be our month prior to an August meeting. We might have some data over 5 or 6 weeks. Again remembering this whole system is in its infancy. The communication system that Randy Howell presented to the nurse managers and individuals able to attend at the Orleans has not never been implemented. So the system's still not really revved up to full speed. And finally, as Dr. Carrison mentioned, there is a full load. Capacity has been met. So

what we're trying to do is take care of the community as best as possible; make the EMS transport as most efficient as possible; and not overburden or overwhelm one ER or one hospital in the entire system along that path. That's truly the goal.

Sandy Young said the last thing we looked at, because we were worried about overloading one hospital as opposed to another within a system, was the percentage of patient destination before and after, it really didn't change. From the city of Las Vegas' standpoint, I think we increased our transports to Summerlin, which we expected because we're keeping our crews in that area. But, we're not going to St. Rose either, unless a patient requests it. So we have not seen a big shift in the percentage of patients changing from how many went before to Sunrise or UMC or Valley than after.

Brian Rogers said I think if anybody went into this change with a divert mentality thinking that it would solve all were crazy. We still have the same number of people and same number of beds. No matter how you slice it, you're still going to have a wait time. I'll just reiterate, I do understand and I think the hospitals here do too, they may get a little bit more overloaded, but we're working together for a solution. Patients are the only one's benefiting from this. If we think we're going to go to the hospital and get out in 15 minutes, it's not going to happen. So don't expect it. And if they think we're only going to get two patients because they're not on DIVERT, that's not going to happen either. I do think that everybody's working together. And if there are complaints please let one of us know. There hasn't been that many problems that we've heard about from our Medics. So if there are please give us the opportunity to know about them and try to fix them.

Dr. Davidson said we'll have a DIVERT meeting in June. I would hope and expect everyone that has data of the five weeks from the different agencies to please show up, so we can intelligently go through and see what the beginnings of an impact would be, and hopefully we'll have more information on a communication system.

Randy Howell said we've had the communication system in place just shy of a month. AMR started tracking it about three or so weeks ago. I've received positive feedback from the people I've e-mailed. A question arose to consider adding a specialty area for the pediatric facilities because a pediatric facility can be either open, closed, or on a forced rotation, according to the protocol. So that might be good. And maybe even adding UMC trauma center on to that specialty screen. We say they never close, but they can be closed if some situation happened, like some sort of disaster or something.

Dr. Davidson said I guess in a worst-case scenario they would call and request the other available emergency departments, to disperse lower levels of trauma.

Randy Howell said I guess I'm thinking of an internal disaster, if someone has a bomb threat.

Dr. Davidson said it might be better to put something on there that says disaster mode, when the city's alerted there's a disaster in place, or a disaster plan has been implemented. That way the trauma center just becomes a participant of a disaster. So maybe we'll do something like that.

Randy Howell said one recommendation would be to bring this system in front of the next FAB meeting.

Virginia DeLeon said it's not on the Agenda for May 14th but Mike Myers is going to give them a demonstration and coordinate a date with Karla.

III. INFORMATIONAL ITEMS/DISCUSSION ONLY

A. ED Nurse Manager's Meeting

Virginia DeLeon said we met April 27th at Montevista. Mike Myers is going to give a presentation to the FAB on the EMSystem. Discussed closure policy, the QA and everything in detail and these will be discussed at the next DIVERT committee.

B. Hospital Divert Statistics

Dr. Davidson stated that the hospital DIVERT statistics are in the MAB packets to take back to the respective administrators and departments to review.

C. Discussion of Release Date of New Protocols and Informational Supplement

Mary Ellen Britt gave a brief update. On April 20th, the new protocols were distributed. These are the April 2001 protocols which are available on the Clark County Health District EMS website. Included in this mailing was a cover letter from Dr. Slattery and an educational supplement developed by Dr. Slattery.

Packets were mailed out to all ED Medical Directors and EMS services. The letter includes the effective date (May 19) of the new protocols, which were approved by the Board months ago. This is in keeping with the discussion that we had earlier about when a protocol is approved we're going to give at least a 30 day period for the agencies to be able to educate their personnel before the protocol is actually implemented.

IV. PUBLIC APPEARANCE/CITIZEN PARTICIPATION

None

V. ADJOURNMENT

There being no further business, Dr. Davidson called for a motion to adjourn. A motion was made, seconded, and unanimously carried.

The meeting adjourned at 7:20 p.m.