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

MEMBERS PRESENT

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

MEMBERS ABSENT

Ken Riddle, Deputy Chief
Allen Marino, M.D.

CCHD STAFF PRESENT

Jane Shunney
Jean Folk
Kelly Quinn
Mary Ellen Britt
Jennifer Carter

PUBLIC ATTENDANCE

Geoff Archer (Las Vegas Fire)
J. L. Netski (AMR
David Watson, M. D. (Sunrise)
Simonne Beck (UMC)
Pam Turner (Valley)
Mary Levy (UMC)
Nancy Harland (Sunrise)
Nancy Cassell (CCSN)
Bede Parry (AMR)
Helen Vos (Mtn. View)
Kathy Sneed (St. Rose Siena)
Joe Calise (Summerlin)
James Tate, M.D. (Silver State Disaster Medical Assistance Team)
Derek M. Cox (AMR)
Graig D. Newell (Silver State Disaster Medical Assistance Team)

CALL TO ORDER-NOTICE OF POSTING OF AGENDA

The EMS Medical Advisory Board convened on Wednesday, June 6, 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 6:10 p.m. and the Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law.

I. CONSENT AGENDA

A. Board approval of the Medical Advisory Board Meeting minutes of May 2, 2001.

B. LMA – This is being sent to the Airway committee then to the Drug and Equipment committees and will be reviewed in August. This is a possible future intervention for airway events management.

Motion to approve A and B, seconded, and carried.

II. REPORT/DISCUSSION/POSSIBLE ACTION:

A. Education Committee Update:

Regarding Etomidate in the educational program, a meeting was held two weeks ago to discuss the education component, which is on the internet web page. All agencies decided the education component should be completed by August 1st. Paramedics need to complete the education component, take the test and send it to the Clark County Health District. Ninety percent of the employees must complete the educational component of the Etomidate protocol, before the drug can be placed on the unit.

The Education Committee wants this concept to be endorsed and this is how all the drug and equipment protocols should be.

Dr. Laauwe said, to refresh everybody's memory on temporary limited license, once the paramedic starts training and is issued a temporary license, they have twelve months to complete their internship training. If an individual gets sick, injured, pregnant, whatever, and they cannot continue on with their training, the regulations state they cannot stop and start again. Once it's issued, it's issued for twelve months. If it's not completed in twelve months, that's it, they have to start all over again. The lawyer says the temporary license can not be extended. So the only way is to finish it in the twelve month period or to not issue the temporary license. Example, a person is pregnant but she has finished her training and testing. She has not been issued her temporary license until she's ready to proceed and then she'll have her twelve months. If the person is injured, there isn't a way to get around that. Legislature doesn't meet for two more years so the options are to change the regulations or do it through the Health District.

Randy Howell said the EMS regulations call for nine months. The State law allows up to a year. He suggested changing the regulations to be in line with the State. He said Henderson Fire had to go through a variance in an effort to get an additional three-month extension to allow one of their guys to be able to use that full year that the State allows.

Dr. Kwalick said our regulations do have the nine-month stipulation however the Board will grant a variance. He did agree that why come for a variance if indeed the State law says twelve months.

Randy Howell made a motion that the Board of Health change the regulations to allow for a one year temporary authorization to function as a paramedic from a nine month temporary authorization. It was seconded and approved.

B. Divert Task Force Update:

Dr. Davidson said the Divert Task Force met a couple of weeks ago to view some definitions and go over suggestions made by Board members on ambulances or EMS personnel's understanding of the diagram showing the three circular regions. This was used so that regions could be developed. They weren't inclusive boundaries and this has somehow come up as a sense of confusion in the EMS system. For example, an ambulance group that is feeling a heavy burden in region C and wants to move towards region B, but doesn't feel they can do that. That's not at all what the system is meant to be. The regions were a radius' that we used to develop regions based on the number of calls occurring in areas. Open meant Open. EMS can go in between regions. We did try to make everyone understand that usually the closest facility was what most patients would request based on their doctors, etc. If that facility was closed then you could suggest the next closest facility or the patient could pick the next closest facility. Obviously, this is allowing that the patient is in a stable condition and the EMS is not going lights and sirens. Dr. Davidson said he was trying to clarify some of the concern that MAB members had asked about whether there can be inter lap between regions and if so could some specific language be developed for that. The group met and didn't feel that there needed to be any language change. It was very clear to the committee members, specifically EMS field staff.

Michael Walsh said it was a five mile radius. It was strictly to try and identify how we might divide up the valley. It was done at the pre-hospital task force and really wasn't designed for any other purpose.

Dr. Davidson said an example is region B, with Sunrise and Desert Springs, who are feeling very heavy burdens at times and one hospital is closing and the other one is being forced open, so to speak. The question was could some of the EMS go to regions A and C. The answer is yes. They can go anywhere they want. There is no specific mandate that an ambulance has to stay in region B because they picked up a patient within region B. It's most likely they will transport within that region based on patient's pick up location and patient's hospital and physician request. For example, Sunrise shows closure, Desert Springs shows very delayed, drop off times, between

sixty and ninety minutes, it may be in the best interest to go into region C or A or off to Lake Mead.

Dr. Fischer said if the answer is so clearly used, then why not put it into the procedure where people outside this room can see it as simply as we can.

Dr. Davidson suggested that some time be given because it's a fairly new system. It's only been operational for two months. It's been reiterated over and over again so that people understand that when a facility is closed, you can go anywhere else basically, for safety or patient request.

Dr. Homansky said it's a procedure for emergency department closure and has nothing to do with destination. It is not a destination policy and it's not a destination protocol. Nothing changes in how the destination of a patient is determined.

Dr. Fischer asked everyone to look at the procedure one, two and three. He said it does not show how they should operate in the field and it stops short of saying anything about inter-regional cooperation. He felt some of it should be in there.

Randy Howell said maybe the recommendation should be to re-institute a transport destination protocol or incorporate the language that was in that transport destination protocol. First choice is patient request, second choice is family or physician request and third choice is closest appropriate. Maybe that would solve some of the issues that Dr. Fischer is talking about when he asked where is the specific language that says how patients are dispersed.

Dr. Fischer said you have to have the procedure and protocol mixed where as if you just put a number four I think it would serve better purpose.

Steve Kramer said he thought the idea was that we were trying to get across was that we wouldn't dictate how the crews transport. The crews would just know which hospitals were on closed status and give the patient the choice to go to anyone of the other facilities no matter what region they were in and that's why we cut everything out as far as transportation destinations is concerned.

Joe Calise said the question, from the ED standpoint, is will we see more patients or will patients be sent to different areas. He asked if we're worried about how the system is working. It's open 95% of the time now which was the goal. He wondered if certain hospitals were getting too many patients. He said the issue seems to be can those hospitals handle that volume. He thought that's what some of the hospitals brought to the picture when they say hospital A and B in region 1 both need to be closed and they're not allowed. In the old system they were because they were just closed. Most of the hospitals, if they appear busy to the community, teach medics a better way of looking at the screen we're working off. They would see that hospital A is closed, hospital B is waiting to be closed, maybe I can go to hospital A in the other division who's wide open.

Dr. Davidson said the destination protocol would be located and reviewed and then, if it's approved by the Board, it can be attached. He said the FAB met last Wednesday and representatives from all of the facilities were there and voted unanimously to accept the communications system that Mike Myers presented be accepted on their behalf. There will be a significant improvement at least in being able to visualize from other emergency departments what's truly going on in the field as far as transports, what's coming to you and what the time frames are, which has been a big concern of the ED managers in trying to plan the multiple EMS systems that can transfer all at once. I think the system is working and you see that by the statistics. We haven't even got into it's full force yet because we haven't got the communication systems that we've all agreed we want to see. We're actually in a very good time frame right now because we're not experiencing high volumes like we did last summer. If there's a region that's getting an excessively high volume, do we need to put some provision in the protocol or readjust the region to try and compensate. At some point in the future, if we need to realign regions, we can.

Dr. Fischer asked to have the Divert committee look at the destination protocol and bring it back to the next meeting and see if it can be incorporated into the procedure.

Dr. Slattery said when the QA program was developed for this, there was an algorithm that was distributed to all the agencies that was suppose to be used for education of their providers about the new protocol. Part of that is a very simple algorithm. It could be put in verbal form rather then in a graphical form.

Dr. Davidson said when he first started as the Divert chairman, there was a four and five page procedure and policy. Dr. Slattery will present drop time information because it's been requested by some of the ED managers.

Dr. Slattery presented AMR numbers which represented a little over 70% of the EMS community. He said what we're focusing on is drop time which is from the time they arrive at the hospital to going back in service. Just to compare drop times from May, 2001 to May, 1999, the total number of transports in 1999 were 5,437. Their total drop time at that time was 26 minutes and 42 seconds average and for May, 2001, there was 4,000 runs and the average drop time was 31minutes and 35 seconds. He said he wasn't sure what the numbers meant but there was a request to present some sort of data on what's going on. He said compared to 1999, even compared to last year at this time, there was 5,545 transports in May, 2000, drop time was about 29 minutes. Without more numbers and more data, it can't be a statistical analysis.

Dr. Davidson said this is AMR's data and Southwest's data has to correlate in also.

Dr. Slattery said it's going to take at least six months to get enough information to make some meaningful evaluation.

Dr. Davidson said for the period of May, most everyone stayed open (above 90%). So there isn't even a facility that's closing. The old data, the different divert categories, there were facilities that were just closed all month. It represents a great

change in that facilities are obviously making headway staying open and accommodating patient flow.

Dr. Fischer said the mood represents the calm before the storm.

Dr. Reisch asked for a better explanation.

Dr. Slattery said this is actually something that was put together by Matt Netsky at AMR. At the top, H-1 through H-11, are the hospital numbers that the EMS system use. Across the top is their priority code, 1-2-3 (level of severity). What you really want to concentrate on is the grand totals at the end. These are just averages of all their calls for that month in 2001. So if you look at the bottom right corner, the total number of runs for all categories was 4,002 and the average drop time, the time it took to arrive at the hospital and then get back in service, was 31 minutes 35 seconds for that period of time.

C. Divert and Helicopter Traffic

Michael Walsh said at the last FAB meeting, one of the members brought up the question of when a hospital is closed, is it closed to air ambulance as well as ground ambulance? There was some discussion but it was agreed by the participating members that it meant closed to all types of ambulance both air and ground.

Dr. Davidson said this excludes the trauma center. For the other facilities that take air ambulances, we wanted to clarify if that specific emergency department is closed then they would not be accepting air traffic either for that one hour of closure period.

Dr. Fildes said for clarification that would also include burns and pediatric ED.

D. Priority Dispatch Committee Update

Dr. Han advised that the committee met and finalized some of the words in Version 11 for use by the EMS. Basically all of the Version 11 protocols will be kept as it is with the following additions: Card #9 is about cardiac respiratory arrest and under obvious death, we will check off everything except submersion. We'll also add in quotations "must be physically verified by person reporting". Card #9 also has a section of expected death and we'll check off DNR only as the ones that will be marked off. Card #24 is the pregnancy, child birth, and miscarriage. Under the section high risk, we will check off premature birth, multiple birth and we'll add these three things: #1 – eclampsia/pre-ecalmpsia, #2 – will be fever, #3 – no prenatal care/age greater than 40. Card #33 was narrowed down to three sections. In quotations again, #1 – "transport only no lights and sirens", #2 – "transport only for evaluation", #3 – "will be specialty transport". Those will all be additions to this protocol. It was finalized from all of the agencies present, Fire, AMR, Southwest. Dr. Han said he understood that this protocol, Version 11, is being taught to the new dispatchers.

A motion to accept these changes and amendments to the EMT protocols was made, seconded and approved.

Randy Howell explained the EMSystem which is on the internet under EMSystem.com. He said they have allowed us to set up a system in a test mode that's being used everyday right now to track the regional divert. It meets some of the needs that the Metropolitan Medical Response Team is looking for in tracking different types of items and it also allows us to track the open and closed status of the hospitals. In the Fall, they're looking at a communication component that will actually send information to hospitals of a unit in route, their ETA and the possible problem that the patient is having.

Dr. Davidson said hopefully it will replace the somewhat archaic monitor that we're all using right now. I think it's going to be a great component of the new open/closed system especially it will facilitate the EMS transport people in knowing which EDs are extremely busy, which ones can take great volumes and which ones can just take a little bit of volume.

E. MAB Board Restructure

Dr. Kwalick said the size of the Board continues to grow and it may be time to consider other alternatives. We meet monthly, maybe we should be going to bi-monthly, maybe we should reorganize into other groups that would be meeting on the inter-monthly sessions and allow committees to meet in between the bi-monthly meetings of the bigger group. Since we're not meeting in July, we have room for thought for a couple of months. We'll get back again in August and have it as an agenda item to discuss in detail. Get your pros and cons, suggestions, etc. and maybe look towards changing the way we do business.

Dr. Slattery gave a Power Point presentation on the possibility of breaking into three groups, Medical Advisory Board, Facility Advisory Board and a new group, Operations Board. He explained the functions of each Board and distributed a handout of his presentation for the Board to review.

III. INFORMATIONAL ITEMS/DISCUSSION ONLY

A. Facilities Advisory Board May 14, 2001 Meeting

Michael Walsh said funding the paramedic training for the Chronic Public Inebriate was discussed and the FAB approved paying $13,000 to be divided amongst the hospitals based on their ER volume.

B. ED Nurse Managers Meeting

Virginia DeLeon reported on the June 1st meeting at UMC. Spring Mountain Treatment Center gave a presentation regarding their new 84-bed adolescent residential care facility. They're going to serve patients, ages 12 to 18. They have a day treatment program that is open now and on the June 18th, they should open their residential beds. The Gold Spike fire was discussed. There were a lot of problems with communication and coordination, such as what patients were going to what hospitals. UMC initially got a call that they were going to get 40.

Steve Kramer asked if she knew who made that call?

Virginia DeLeon said fire transportation.

Dr. Davidson said the center of the hospitals around the fire, which were expecting the bulk of the patients, mobilized their disaster teams very effectively. He did agree the communication initially was a little rough on numbers. He said when there is initially fire and a lot of smoke you don't know what to expect Steve Kramer told him there was a lot of havoc and then it started to settle down so they could figure out the volumes.

Virginia DeLeon said there was a problem with the coordination as well. UMC's concern was that they were getting a number of patients with smoke inhalation, when they should be getting the burns. There was a concern about that coordination. She said they recommend critiquing and it was their understanding that there will not be one.

Steve Kramer said that's up to City fire whether they want to critique it

Dr. Davidson said the ED Nurse Managers had brought this to his attention on several occasions. He felt that all disasters were worth critiquing. The information would be brought back to the Board at least for the learning so that we're never caught off guard. With all our mini disasters at least we'll be well prepared in the event that we do get another MGM fire with large numbers of casualties.

Steve Kramer said they had just gone through a tabletop exercise with the Office of Emergency Management at the Government Center. They discussed how they wanted notifications to go out to the hospitals. There were members there from administration from each hospital or the agencies and they said that the point of contact should be the ED and it would go up from there. The Emergency Department would notify administration on up and then filter it down. He said that was what was done. He said we followed just the way we had our tabletop exercise two weeks ago.

Pam Turner said she thought the hospitals responded very appropriately. The problem is combining the two. It's again a communication issue. She agreed that the recommendation was anytime there is any kind of a mass casualty where this type system is being activated, we should learn from it. We still critique it because as a facility we need to know. As a community, I think we should be critiquing. She said after several different phone calls, they could not get a clear picture of what needed to be done in their facility. The call did not go to the charge nurse, it went to a unit secretary. So I think that needs to be made clear to whoever is making these phone calls. She said Alice Conroy at Sunrise asked if she was getting 40 patients or was that the total number. Ms. Turner didn't think that the EMSystem would take care of this problem altogether.

Dr. Davidson asked for a critique of the event. It would be good to bring some information on how a critiquing committee would evolve.

Kelly Quinn said the new DNR protocol that will become effective July 1st. There are three components, one is for the ability to honor a charted order in a facility, two is the pediatric issue, and three is the bracelet issue. The pediatric and bracelet issue need to have regulations written for them so the soonest those could become effective would be October or November. However the charted order portion needs to be implemented right away. Dr. Kwalick signed this protocol today with an effective date of July 1. The main change is the addition of the do not resuscitate order definition and policy roman numeral II has been added. The paramedic can honor an order noted by the physician in the medical record. If they're going to a facility, nursing home, whatever, you have that order in your hand. The rest of it is housekeeping issues throughout.

Dr. Kwalick said he signed it and it's in effect just to protect the paramedics on the street. It can be ratified in August.

Dr. Davidson commented on a yellow flyer that was passed out on the weapons of mass destruction equipment. Please note time, dates, and participation.

Jane Shunney said all of this equipment has been purchased specifically for the hospital emergency rooms and the training has been scheduled for next week. She said to call Richard Brenner and let him know that you're attending. You will have to go through the training in order to get the equipment for your hospital ED.

IV. PUBLIC APPEARANCE/CITIZEN PARTICIPATION

Dr. Tate, Disaster Medical Assistance Team (D-Mat) announced that the Silver State Response Team, which is the Nevada D-MAT Team, has now been approved as a National D-MAT Team.

Dr. Davidson said Dr. Tate and Nancy Newell, R.N. went through a lot of work and initially it didn't seem like they had much momentum or support but they built it on their own. This was approved by the State as the Silver State D-MAT and it can only help this state in the long run. It's a wonderful thing. He said he just wanted to make their presence known to MAB. If there is any support or help needed in the future, he asked that they let MAB know.

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 7:12 p.m.