MINUTES
MEDICAL ADVISORY BOARD MEETING
August 1, 2001--6:00 P.M.

MEMBERS PRESENT

Allen Marino, M.D.
David Daitch, D.O.
David E. Slattery, M.D.
Donald Reisch, M.D.
E. P. Homansky, M.D.
Jeff Davidson, M.D., Chairman
Jeff Greenlee, D.O.
Joe Calise, R.N.
Michael Zbiegien, M.D.
Dennis Lemon, D.O.
Michael Walsh
Nicolas Han, M.D.
Pete Carlo
Philis Beilfuss, R.N.
Richard Henderson, M.D.
Russ Cameron
Steve Kramer
Steve Hanson

MEMBERS ABSENT

CCHD STAFF PRESENT

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

PUBLIC ATTENDANCE

Alice Conroy, R.N., Sunrise Hospital
Bede Parry, AMR
Bill Cassell, LVMPD
Brett Nash, BCFD
Brian Rogers, SWA
Davette Shea, UMC
Derek Cox, AMR
Gary Sumption, LVMPD
Henry Clinton, LVFD
J. L. Netski, AMR
Jim Mitchell, LVMPD
Lew Dessormeau, AMR
Mary Levy, UMC
Nancy Cassell, CCSN
Wade Sears, M.D., FFL/SMS
Ed Matteson, CCFD
Tim Gardner, HFD
Bob Valdez, Mercy Air
J. D. McCourt, M.D.
Margaret Williams, Mountain View
Pam Turner, Valley Hospital
Nancy Aldridge, SSRT/DMAT
Mike Petricka, LVMPD
Patti Glavin, R.N., Boulder City Hosp.
Anthony Jennings, D.O., UMC/CCT
Sandy Young, LVFD
Sue Hoppler, Desert Springs Hosp.
Todd Jaynes, Mesquite Fire Dept.
Bret Olber, AMR

CALL TO ORDER-NOTICE OF POSTING OF AGENDA

The EMS Medical Advisory Board convened at 6:00 p.m., on Wednesday, August 1, 2001 in the Clemens Room at the Otto H. Ravenholt, M.D. Public Health Center. Chairman Jeff Davidson, M.D., He stated the Affidavit of Posting, mailing of Agenda, and public notice of the meeting agenda were executed 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 items on the Consent Agenda was made, seconded, and carried unanimously.

A. Minutes Medical Advisory Board Meeting June 6, 2001

II. REPORT/DISCUSSION/POSSIBLE ACTION

A. Combined Drug, Education & Equipment Committee – Dr, David Slattery

Discussion of Revision to Morphine Sulfate Protocol

Dr. Slattery said in June, the Combined Protocol Committee met to look at the protocols on a bi-annual basis. The packet was introduced earlier in the year and included Morphine Sulfate. It has been endorsed by the Combined Committee in the form currently listed. The biggest change is something that is consistent with what's happening nationally in terms of recognizing that we are not treating pain very well in the pre-hospital setting or in the emergency department. Basically, it allows the paramedics to give morphine for these very restricted conditions without a physician order. Indications for severe pain, in greater than age 16 patients does not require a physician order. Burns in patients older than age 16 also does need a physician order. All other uses, including pediatrics, would require a physician order.

Everything else about the protocol is unchanged, with the exception of the range in the pediatric dosing to be .1 mg/kg. At this point I'd like to make a motion that we accept this protocol, seconded….

Dr. Riesch asked what is the maximum amount that we're talking about and is there a cap on the adult side?

Dr. Slattery said it's not identified in the protocol. It's going to be identified in the Education portion. What would you say the cap would be?

Dr. Riesch said it's somewhere between 10 and 20mg.

Dr. Slattery said the committee talked about that and felt that anything passed 20mg is probably pushing the envelope. We didn't put that on the protocol. We don't really have that many restrictions on our protocols. It's going to be part of the Education….

Dr. Marino said normally, I think the dosing range is .1 to .3 mg/kg. What do they carry on the rigs?

Dr. Henderson said 20mg.

Dr. Davidson said if you have a fairly large person, you could potentially get beyond what the rig carried. Isn't that typical dosing, .1 to .3 mg/kg?

Dr. Slattery said we had the range in the protocol before, especially for the pediatric age group, but it was removed. We thought it was too confusing to have the range and we wanted just one dose.

Dr. Davidson said basically the top dose would be 20 mg. by virtue of what's carried on all the rigs.

Dr. Henderson said if they changed how much they carry on the rigs to 30 mg, theoretically a person could get 30mg.

Dr. Reisch said 2mg every 3 minutes would be the maximum. I don't know how many hours that is but there's 20 X an hour transport.

Pete Carlo said the protocol reads, under adult, "every three to five minutes until pain is relieved or respiratory depression occurs".

Dr. Henderson said quite frankly, within those parameters, I wouldn't have a number where I'd say stop. If they've got somebody that's still writhing in pain and they've given 30mg, I wouldn't want them to stop.

Dr. Davidson said I understand the need to get the protocol started, which is definitely what Dr. Slattery identified. The issue of pain control in the field has probably never been approached.

Dr. Slattery said Dr. Henderson's point is a good one. We really don't know, how much to give if someone is in severe pain, especially with severe burns, 20mg of morphine is nothing. I think we under-dose all narcotics generally. We don't do a good job of adequately treating, especially with demerol which luckily we're not using. With the exception of that, I think we have the safety parameters built into the protocol. Whatever the MAB decides, if there is a maximum dose, we can keep that in the educational component of the protocol.

Dr. Reisch said I would like to add no more than 20 mg without doctors' orders to the educational component. Does that seem unreasonable?

Dr. Davidson asked Dr. Zbiegien, if the .1mg/kg is enough for a pediatric patient in severe pain?

Dr. Zbiegien said it's enough to start. If it wasn't enough, they could call back for more.

Dr. Lemon asked why age 16? For adult, could it be a kilogram, say 30kg. I'm not looking for consent, I just wondered why the cut off age was sixteen. Dr. Slattery answered for consistency with the other protocols.

Dr. Davidson said the point that Dr. Lemon makes is that you could have a 16 year old that weighs 80 to 90 pounds, and subsequently, could get a large dose or visa versa. You could also get a 16 year old that weighs 200 pounds. I understand the ultimate goal is to provide some incremental pain relief with the idea that the final destination hopefully is only 10, 15, 20 minutes away maximum.

Dr. Marino asked how much is too much morphine? If they're watching pain for pain control and respiratory depression, how are we going to define that it's going to be so many mg/kg on the adult with everybody different? I think that we have set our limit there. Pain is met or the respiratory is compromised. I don't think we need to put a maximum.

Dr. Henderson asked if it would complicate things too much if we moved the pediatric age to 12? That's when you start getting the ankles on the football field and shoulder dislocations from soccer and football.

Dr. Zbiegien said we're having a problem giving the paramedics whatever they want based on the patients' weight. It's not like they're writhing in pain on their arrival, because we have them pretty snowed.

Dr. Henderson asked for the same reason we want to do it for the adults, we want to do it for the 14 year olds?

Dr. Zbiegien said I think we already do that. When the EMT calls in for the order, we give it.

Dr. Henderson said you're not the only receiving facility and there are often delays in getting hold of a physician.

Dr. Davidson asked if pediatrics require a call?

Dr. Slattery said yes, it does on occasion.

Dr. Henderson said and that's the issue, is that where we make our age cut off?

Dr. Zbiegien said I would agree with Rick, but even more so for the burns. A child that's burned, I think that's the one I'd really want to get the morphine right away.

Dr. Slattery said I think Dr. Lungo was the pediatric specialist that was on part of this discussion. I think our paramedics do a good job and are able to decide when patients need pain medication. It's pretty safe, even at this dosing, for 10 or 12 years of age.

Dr. Zbiegien said I don't know what the discussion was as to where we split the year. My only concern is, how would you then dose it. Would you dose by mg/kg dose, or would you leave it open to the paramedic like on the adult, which is 2-5mg.

Dr. Daitch said actually the 2-5mg is more restrictive than the pediatric dosing. Although you'd get it more quickly, you'd actually be giving smaller doses incrementally by moving the age down.

Dr. Zbiegien asked do you want to leave it at the adult dose?

Dr. Daitch said yes I would, for simplicity. I would recommend that we just change the cut off age and let the 14 year old be dosed like an adult. Our adult dosing here is actually more restrictive than our pediatric.

Dr. Davidson asked if it would be better. I guess it's impossible to make it a weight definition like Dr. Lemon had mentioned because you're putting it up to a subjective analysis of an EMT crew out in the field. I'm just trying to capture all the patients that are age 12 to 16, that vary from 80 to 200 pounds.

Dr. Henderson said I'd like to see us use the cut off for 12 years and leave as is and everything else unchanged.

Dr. Davidson asked if that complicates the other protocols?

Dr. Zbiegien said the only thing I would add, and I think everybody would be comfortable with this, is for the pediatric population to go ahead and give them that first dose based on the adult protocol. But, limit the number of doses they can get until there's a physician contact. He said I'm speaking for UMC as well. I'm not sure how comfortable they are with those kinds of pain medications without a physician order. Obviously, Brian Lungo was involved in setting up this protocol, and he wanted to have a physician order. What did he bring up when you guys were talking about it?

Dr. Slattery said Dr. Lungo felt that they would want to be contacted for all the pediatric patients. He wasn't sure about age 16 versus 14 versus 12. That discussion really didn't come up. We just use 16 as a cut off to be consistent with our other protocols in terms of pediatric medications.

Dr. Davidson said he though if you lower the age to 12, you would probably capture any of the groups of patients with a high, low weight or extreme weight, between a 12 to16 age category. At that point, depending on the weight, I would probably trust the EMS personnel to weight and dose adjust properly.

Dr. Henderson said actually if they start using the adult dosing over 12 years they're usually going to be giving a lower dose then they would if they went by weight.

Dr. Homansky said let's either come to a conclusion or send it back to committee.

Dr. Davidson said the motion on the floor is to change the protocol, to a greater age than 12. Dr. Marino seconded and it was unanimously passed.

Dr. Davidson said there's also a motion on the floor to accept this protocol with the new addendum of morphine sulfate as it stands with the new changes that all ages will be greater than 12.

Dr. Marino said I think that all the ER doctors need to go back to our groups and remind them that this is going to be this way, so that we sign the scripts. I know that medics at Southwest have had trouble sometimes, where they've made telemetry contact with one hospital, got an okay and then got diverted to another hospital and didn't get a signature for a morphine script. We need to make sure we reinforce it for signing these scripts on these standing orders.

Dr. Davidson agreed. He said I know that's been a problem in the field. There are a few people that are signing all of them. Do we want greater than and equal to age 12 or just greater than age 12? I'm going to assume that the motion passed as that, greater than or equal to 12. No further discussion.

There's a motion on the floor to accept the morphine sulfate protocol with the adjustment of age greater than or equal to 12, seconded and unanimously passed.

Alice Conroy asked if the meeting addressed the use for pulmonary edema, and CHF. While we're looking at our practice and relieving pain and patient comfort as was indicated, is there a special reason that CHF has to be a yes too?

Dr. Slattery said it's actually something that's being challenged. It's one of those things that we've been doing for years and refining, that it probably doesn't make that much of a difference. I think the practice is dependent on the physician, that's why there's still a physician order. We didn't specifically look at the CHF, pulmonary edema protocol.

Dr. Davidson said my only comment with that is, there's many times where morphine does as good as it does bad, i.e., you give morphine to someone in moderate to severe CHF and the next thing you know you tip them over to be intubated. Based on the fact that now they have high CO_2/Morphine on board, I like the idea of having a yes physician order for pulmonary edema, CHF. Plus there are other things they can do for pulmonary edema. Does that answer your question Alice? It sounds like the pulmonary edema, CHF is going to stay as a yes, based on the committee's recommendation.

Alice Conroy said I just wasn't sure of the discussion in the committee. While we were looking at morphine and utilization was that something the patient would benefit from in this weight and balance with pulse ox being able to be measured.

Dr. Davidson said they are still able to get the morphine. It sounds like the committee felt, that it would be better to be physician directed for the use of morphine.

Dr. Slattery said that specific question was not addressed at our committee level. It's something we could look at in the next one and look at the evidence for use of it in CHF. Currently, the reason it's a physician order is because of that.

Sandy Young said that thing to where we look at it for the use of CHF and pulmonary edema, does that mean that there's probably about 99% of the uses.

Dr. Slattery said yes, we'll discuss that at the next protocol meeting.

Brian Rogers said with a full blown CHF in the field, you don't have time to call for orders, so we won't give it for the first 15-20 minutes. If, as a physician, you want it done anytime when we get there, it's got to be a standing order, otherwise, I'll be honest, most people, can be at the hospital by the time they draw up the morphine after they get the order. If you want it for CHF, then make it a standing order.

Dr. Slattery said I think it's a great discussion, something we can do at the committee level, because it's actually very controversial. Most of the recent studies have shown that it probably causes more harm by depressing their respiratory status.

Dr. Davidson said at least, at the committee level, they can research it, bring the data in and make a definitive decision based on what we feel this group and this community would most benefit. Most of the MAB members sound like they were going to say aye to the protocol before we stopped them. All in favor of this protocol as it is now presented….

Morphine protocol procedure passes with the age group changed to μ12.

Discussion of Temporary Limited License

Dr. Slattery said when we last met we formed a task force to work on temporary limited license. That's a work in progress, as is the EMT paramedic training procedures.

Discussion of ALS, ILS, BLS Protocols

Dr. Slattery said the only thing that we're going to discuss, and we'd like to vote on it tonight is the Chronic Public Inebriate algorithm. We'd be able to divert a lot of CPI patients from the emergency departments and give them the definitive care that they need at an alcohol treatment center.

We've made some changes to the protocol that you approved. We're going to be implementing the training program, starting next Monday, and we'd like this Board to approve the changes we made to the algorithm and the checklist. We made it a safer protocol to hopefully eliminate any major problems.

You should have two algorithms. One basically has information that has to do with once a patient arrives at either the emergency department or alcohol treatment center. We've omitted all of that on the other protocol in which 911 is activated, and EMS is notified. This committee wanted the assessment to occur before the CPI protocol was initiated and we did that change. Basically we put this into whether the patient meets all the CPI field criteria that are listed. The patient is able to stand with minimal assistance; does patient have normal vital signs and Accu check. Normal vital signs and Accu check will be defined in the education component and it will be consistent with what we used in every other clinical scenario, in terms of normal vital signs. No acute medical complications; no signs of trauma; no suspected head injury; and a Glasgow Coma Scale of μ14, if they fit those criteria, the patient will be transported to the alcohol treatment center.

The only thing we are going to add in the last box, patient to alcohol treatment center, is w*hen possible*. We add the words *when possible* because currently West Care does not have the beds to really support doing this 100% of the time. Once they grow, we can look at making that a routine protocol rather than just *when possible*. And, finally, if they don't fit any of those criteria, or if the answer to any of the questions is no, then the patients are transported to the emergency department.

So at this point I'd like to make a motion for this algorithm to be approved and seconded. Dr. Davidson said any further discussion?

Randy Howell asked where West Care is located? Dr. Davidson said one location is at 4th and Washington and one at MLK and Alta.

Dr. Daitch said this is available to the entire EMS system in Clark County, right? Dr. Slattery said correct. Dr. Davidson said Boulder City too? Dr. Slattery said I don't know the specific answer to that. There's going to be vans deployed, but specifics of that are really up to West Care.

Ultimately, we want to model it after the Phoenix system with "Lark" vans, which will actually come to the scene and take these patients.

Dr. Marino said under discussion items, I think everybody should know that when we put *when possible*, it was because there was some discussion amongst agencies that were concerned that if they were being taxed that they didn't want to be forced into making the extra drive and would still like the opportunity to place these patients in the ERs because they were closer. So that was why *when possible* was added and I just thought that everybody should be clear that the expectations that every inebriate patient is going to West Care shouldn't be our expectation.

Dr. Davidson said correct. I think most were hoping this would alleviate some of the load on the ED's.

Dr. Marino said right, but what I'm saying is it doesn't sound like we're going to be able to get that many appropriate patients there because of time in transport. I felt after we got through with this discussion that we've been misled. They've got 25 beds there but they're generally full. If you're 30 minutes away or 10 minutes away from another hospital, the agencies are expressing that *when possible* means that they're going to the nearest hospital.

Dr. Slattery said we think the important thing is that this is where we start this program. Most cities don't have anything like this. Again, West Care is planning to expand to a medical model. Right now they're a social model. With increased funding and increased beds will come increased bed space, and hopefully we'll make this expand.

Dr. Riesch said if these two West Care facilities are in the center of Las Vegas, does that mean that, because of transport times, if you're out in Henderson, Henderson is still not going to get any help from this? Is that what I'm understanding?

Dr. Marino said that's what was generally discussed. Any of the outlying hospitals weren't going to get much help.

Dr. Slattery said I can't speak for Randy but I can speak for the EMS system, it probably depends on their load. If they have the availability to take the 30 minute drive into town then they'll do it. If they can't and if there is in the future a van that can help unload the EMS system, that's our ultimate goal. It all depends on the EMS load at that time.

Randy Howell said right. We're going to educate our crews and let them know about this but, based on system demand, if it's going to take that unit out of service for an hour to transport them down here, we're going to choose to transport them to the closest hospital so that we can continue to provide coverage to our city.

Dr. Davidson said there's a motion and a second to go ahead and accept this new CPI protocol. No further discussion? Passed.

Jane Shunney said I want to bring up the issue about age. They can take pediatric patients at one of their facilities, and that was one of the questions that the field people asked us, what ages can we take there.

Dr. Davidson asked what was the age group?

Jane Shunney said they can take kids 10, 14, 16 years old and that was considered in one of the drafts of this protocol.

Dr. Slattery said this is an adult protocol. We need to be very conservative when we start this program and I think this should be strictly an adult protocol. We can look at expanding it in the future.

Dr. Davidson said why don't we take this protocol for it's face value of adults. I understand that there is a pediatric population that will possibly, in the future, be able to utilize one of the facilities and possibly develop a similar or quite different protocol. There might be a lot more conservatism with a pediatric population, so to speak. I would be less likely to send a drunk pediatric patient straight to a CPI facility.

Dr. Reisch said are we going to see any statistics on how often this is going to be used?

Dr. Slattery said yes. In fact, I met with the Vice President of West Care today and this was discussed. We're going to develop a consent form so that anyone that's admitted will give their consent to share the data. Specifically, we're going to look at how many of the patients that are transported are then bumped to the ER, or how many of those patients are not and get an idea about volume too. A registered nurse will assess all the patients initially. They'll be doing a more complete assessment there, looking for signs of withdrawal and other things that we might miss in our gross assessment.

Dr. Reisch asked if zones that the patients are coming from could be added?

Dr. Slattery said I think we can get that from the pre-hospital records.

Jane Shunney said on the QI sheet, we have location of pick-up. It's part of the QI tool.

Randy Howell asked is this something that we want to add to the EM system and they can participate by showing their bed availability? We have a specialty hospital slot. Maybe this can be considered a specialty hospital and they can put whether they're open or closed, so that we don't get units going there and then find out they don't have room.

Dr. Slattery said part of that QA form checklist has the question, is there a bed available – yes or no.

Dr. Davidson said do we want to pass this protocol with the initiative that we are going to add this to our communications system. There's a first and second – all in favor then of this CPI algorithm to be approved, say aye. Any opposed? Okay, all in favor.

Randy Howell said we could add West Care to the EM System tomorrow.

Dr. Davidson said okay, consider it done.

Discussion of Continuing Medical Education Software Program Update – Richard Hardman

Richard Hardman said with the history involved with it, I'm kind of hesitant to throw a date out and watch it not be met again. But, we're told that we're supposed to have something by the 1st of September.

I'm going to meet with each of the provider agencies, distributing the lists that we have of the individuals that are on the system enabling them to log on and be able to use the system. What I would like to do though, during the MAB meeting next month, is to demonstrate the program so everybody's able to actually see it.

Dr. Davidson said okay, so it's still in its kind of pre-acceptance mode? We haven't officially put this system in?

Richard Hardman said the concept has been approved, it's just making it operational.

Dr. Davidson said okay, I think that's an excellent idea. We'll probably allot a time frame of 10 minutes or 15 minutes for the next meeting to go ahead and preview it.

B. Airway Committee – David Slattery, M.D.

LMA

Dr. Slattery said we discussed the LMA and looked at all the literature. The Airway Committee was pretty unanimous that they felt that LMA was an important tool. They currently have the Combitube as a rescue airway. It has the ability to protect against aspiration and the committee did not feel they can justify the cost of training with LMA when they already have this rescue device in the field. So they made a decision not to go ahead with the LMA.

Dr. Davidson said on analysis, was the cost quite different between the Combitube and LMA?

Dr. Slattery said the cost isn't much. The very cheapest LMA doesn't cost much more than the Combitube, but the problem is the new training in terms of how we are going to get these people and all the paramedics to learn how to use the LMA, which isn't that difficult. The problem with the LMA is it doesn't protect against aspiration. We already have the rescue airway that does do that, which is the combitube. They've been compared and they're equivalent.

Dr. Homansky said what do the paramedics think about that? Are there any paramedics that have experience with both?

Pete Carlo said I've trained on the LMA. The training is real easy, but outside of the cost factor, you need to buy three sizes of them, 3, 4, and 5, and you still can't use them for a pediatric patient. So I felt, because I was on the Airway Committee and this is one of the things we spoke about, that the combitube suffices as an emergency rescue type airway. For the pediatric patients, we're going to visit the SA (Small Adult) combitube. It's just a smaller device you put in a pediatric patient.

Dr. Homansky said how many combitubes have been used in the last six months in this valley?

Pete Carlo said without looking at the data, I couldn't tell you.

Dr. Davidson asked if anyone had an idea?

Dr. Slattery said about 60 a year.

Dr. Davidson said I would almost guess it's more in trauma situations where the airway is probably distorted.

Dr. Fildes said surprisingly, we see half a dozen a year.

Dr. Davidson said I guess the comments are, there were a few people, including myself, that had looked into the LMA and specifically the FAST TRACH for ER's as a rescue device. I thought the device actually was a great interventional device. That was after speaking with several anesthesiologists.

Pete Carlo said in a chaotic setting where I'm always assuming that a patient has a full stomach, I'd rather not even consider putting something down someone's airway where it potentially might make them vomit. Dr. Fildes said I'd have to agree. Pete Carlo said we also have the added benefit that, according to one of the protocols, we can place the NG tube down into the stomach at the same time. So we have the ability to do both with the Combitube.

Dr. Slattery said we did look at the FAST TRACHs. The intubated LMA is about $1100 per set. That's way too expensive for this system. Actually, that would be the best tool to have. That's what we carry at Saint Rose in our difficult Airway box. We have the ILMAs. Again, those are expensive and when the price drops maybe we can look at it again.

Pediatric Bag Size

Dr. Slattery said the next thing is the pediatric bag size. Just to let everyone know we found that there's a big difference in pediatric ambu-bag sizes in all the EMS agencies. We're going to try to standardize those. Brian Lungo and Mary Ellen Britt are working on that currently.

Needle Cricothyotomy

Dr. Slattery said Tim Gardner, Brian Lungo and John Fildes are also looking at the needle cricothyrotomy equipment. They can try to make a decision as to whether or not we're going to be using this new pediatric age group, which really is the rescue surgical airway for the pediatric patient, but just to try to standardize the right equipment to make it safe. And that's what we are looking at currently.

Dr. Slattery said we're still working on that airway management education project.

C. Ratification of DNR – Jeff Davidson, M.D.

Kelly Quinn said we want to ratify the same one that was presented two months ago. He asked if anyone had any comments or changes.

Dr. Davidson said this is the DNR Protocol that's been updated and to meet much more of the needs of what our population, physicians, and patients are presenting to us.

Kelly Quinn said the main change was on number two. In the case of a facility-to-facility transfer and they have the patient's medical record with an order noted, they can honor that record in the absence of the salmon colored identification card.

Motion to approve the new DNR protocol, seconded and passed.

D. MCI Review – Jane Shunney, R.N.

After the Gold Strike fire, downtown, the Emergency Nurse Managers requested that we critique the event. We met at Valley Hospital and went over it with the fire department, Ken Riddle, and people from the fire alarm office. There was representation from most of the hospital emergency room managers. We decided that we would establish a policy within our community to critique every event within 48 hours of its occurrence. These critiques will be held at the CCHD.

Tim McAndrew, office of Emergency Management at the City Fire Department, offered to help design a critique format. He sent me some forms and we redid them a little bit and used them to critique the Greyhound bus rollover.

Greyhound Bus Incident – LaRue Scull

LaRue Scull said this critique was held here at the Health Department on July 6th. There were 31 agency and hospital representatives in attendance. Some of the volunteers that participated in the Greyhound bus crash were here and they did a heck of a job out there as they had their hands full in the early morning hours of July 3rd.

The critique forms that Jane mentioned were faxed out to both the providers and receiving hospitals. We asked that they be faxed back to us or be brought to the critique.

There were some communication problems out at the sight, based on the fact that the Fire Department uses Fire channel 7 and the private ambulances use channel 10. There were a lot of problems in communicating with one another.

It was decided that perhaps 10 or 12 hand-held radios be purchased for MCI's and be kept on a MCI type of vehicle in the event that we do have another mass casualty incident. These radios could be given out to the providers and to private ambulance people, so they could all talk to one another.

One of the big problems with the incident in Glendale was that it took the in-town units approximately one hour to go from town to Glendale, another 20 minutes or so to load patients up, and an hour to come back into Las Vegas. The hospitals were notified but there was a 2½ hour wait before they started getting patients by ground. They were very concerned as to what was going on as to how many patients they were actually going to get. The original thought was that the bus was full and able to hold 65 people. It turned out there were only 38 people on the bus. There was some confusion among the hospitals about how many patients they were going to receive. Based on the 2 ½ hour time frame, the hospitals felt that they should have been updated more.

Lake Mead received eight patients. They did have good communication from the field. As the ambulances were leaving the Glendale area, Southwest Ambulance and AMR ambulances would call into the hospitals and tell them how many patients they were coming in with and an approximate time of arrival.

Sunrise Hospital received four adults and two pediatric patients. They said the communication was good, with the exception that they felt they should've had better updates than what they received.

Desert Springs received five patients and there was little or no communication from the field prior to the patient's arrival. There were some logistics in trying to notify all the hospitals of patients that were coming in.

Summerlin received three patients. They expected to see more walking-wounded patients, and for whatever reason they received a patient that was in fairly poor condition.

Valley received three patients. One was a critical patient that had multiple fractures and internal injuries, but they were able to manage the patient flow.

UMC received ten patients. Some of them came in by the two helicopter services. Others came in by ground.

Mountain View received two patients.

One of the suggestions that came out of this is that if the critique is going to involve volunteers, perhaps we need to do a critique on a weekend or in the evening so the volunteers could attend.

Southwest Ambulance and AMR did very well in coordinating the patient flow into town. It seems like we always have a problem with communications but I think we're working on a plan to resolve that for future MCI's.

Dr. Davidson said the only comment I have is that I got feedback from the Nurse Mangers, who I think probably took a big initiative in starting these almost instantaneous review processes after these MCI events.

Joe Calise said it helps a lot to address it right away, so we know what went on in the community. We're a growing community and we're going to have more of these incidents so it's important for us to do them as soon as possible.

Jane Shunney said I think it's important that we do a community critique which we haven't done in the past. The Health District committed to provide the place to have it.

Randy Howell said the MCI Plan that we have presently in Clark County, hasn't been looked at since 1997. I don't know if it comes through the office of Emergency Management through Clark County. We have additional hospitals that are not addressed in that plan.

Jane Shunney said Jim O'Brien has talked to us about updating the plan. It's one of those items on our list. It definitely needs to be updated. The MCI Plan comes out of the Health District in cooperation with The Office of Emergency Management. The MCI Plan comes out of the Health District in cooperation with the Office of Emergency Management.

Dr. Slattery said that's approved by this Board though, is that correct?

Jane Shunney said she didn't think it had been approved by the Board. The committee that put it together originally were participants from the Fire Department as well as ambulance companies and the Heath District. It has not been "approved by the MAB because it comes out of the Clark County Office of Emergency Management.

Dr. Davidson said I don't know that it would be approved by us, but possibly presented for information so that everyone could take copies of the actual plan back to their facilities.

Jane Shunney said we will do that.

E. MAB Board Restructure – David Slattery, M.D. & Donald S. Kwalick, M.D.

Dr. Slattery said the last time we met we presented the restructuring of the MAB. If you recall the problems with the current Board is that it's too large. At this time, it does not represent all the agencies that need to be represented. One of the solutions to that problem was to split the Board into a Provider Advisory Board and a separate Medical Advisory Board. The idea is that we're all advisors to Dr. Kwalick, the Chief Health Officer. We should have the questions that are most appropriate coming to us in terms of advisors.

The Provider Advisory Board would look at operation protocols, education training, equipment inventory, communications, and closure issues. The MAB would look at procedural protocols and drug protocols, etc.

This was presented last time for you to take home and look at. At this time, I want to hear any discussion in terms of this being a good idea or if there are any other ideas. The other options are to completely downsize the current Board even more and keep it a single Board, or find another room, because this is getting too big. The other problem is that the meetings seem to be lasting a very long time. A lot of these issues can be more efficiently dealt with, with the appropriate advisors.

Dr. Davidson said subsequently it comes back to the appropriate Operations Board, FAB, or MAB for final approval, correct?

Dr. Slattery said that's correct. The only difference is the structuring of the voting Boards. The sub-committee involvement by both providers and physicians will stay exactly the same. That same sub-committee evaluation of new protocols, new drugs, etc. will stay the same. Just the actual vote will take place at one of these two Boards, depending on what that item is.

Dr. Davidson asked for any comments from the audience or Board? Not that we're going to make a motion this evening, but I probably would present it, I'd say next month. We're going to probably need to make a motion or at least put forth some ideas as to what we're going to do. I don't want this to drag on for six months. I'd like to hear from MAB Board members; people who have sat on the Board for years, Dr. Homansky (previous chairman) or Dr. Greenlee. The Board has functioned tremendously well but could it be improved.

Dr. Greenlee said I actually have an opinion on this. I see the pros and cons of both ways to run the Board. Currently, we have a large board, large audience unwieldy, but the benefits are that it gets us all together at the same time. So if the provider agencies and the medical people have two different opinions on something it's actually expressed in one meeting now, not brought back two weeks or a month later. That's a benefit. The cons again are that it's unwieldy, it's large and the meetings can be long, no question about it.

The benefits of the divided Board would be that medical issues could primarily be dealt with on the medical side and provider issues on that side. Both meetings might presumably be shorter. My question is, if you have some issues that go to both Boards, an issue of a new piece of equipment, and this involves a medical decision also, so it goes to both. If the provider agency is for or against it and the medical Board is the opposite, I know Dr. Kwalick won't make a decision on that. Does it have to keep going back to committee or is there one Board that supersedes another?

Dr. Slattery said that's a good question. I think we have talked about this before. Actually, I spoke with Dr. Kwalick and in that situation and with this structure, he would say that he would make the decision, based on both of the recommendations. I don't think there would be a lot of issues that would fall into that category.

When we looked at it, again, not all the agencies that should be represented here on this Board are currently seated. And we're already kind of pushing the size of this room. So there are options. The option is to find another space to meet and continue to expand as our EMS system expands. By splitting this up into two groups, functioning the same way, but just focusing on their expertise, they should be advising on items appropriately, like should the Emergency Physicians at this table be deciding which backboard to be used or which C-collar, etc. Likewise, should all the EMS providers be the ones making decisions in terms of the drug dosing etc. I don't know the answer to that.

Joe Calise said my question is if you split the group, like Dr. Greenlee said, doctors think in a totally different way than nurses, especially when it comes to budgetary things. With fire rescue and AMR; we're talking about training 400 to 500 new medics into a new protocol. Medically you'd say this is the way to go, no problem. Just like LMA, it seems like it's the right thing. American Heart says it's a good way to go, and it's done. Doctors would say yes, it would make sense. The AMR's, Southwest and Fire has to say hey it's going to cost me $50,000. A new drug is going to cost this much so you might think the drug is good, and it might be, but it might not be practical for our system financially.

Dr. Slattery said nothing would change in terms of the current sub-committee composition and function. Everything you just talked about happens at the sub-committee level. You have physicians, providers and nurses at the sub-committee level debating the different protocols, where this goes in the protocol, etc., and it comes back for a final vote somewhere. This will be done separately, the operational issues and those things would be voted on, directed to the Operations Board or Provider Board and those specific medical issues, like drug protocols would be directed towards the Physician Board. The only difference is where that voting takes place, which Board. All the discussion, development of the protocols etc. will occur as they occur right now. Nothing will be changed from the current practice.

Dr. Reisch said the development may stay the same but the actual implementation or voting of it may turn out differently. If you have – just what we went through here when we did this morphine sulfate thing – things that we're changing or the things that were brought up were brought up because there are a number of different people talking about the same issue and a number of different issues were brought up that I wouldn't of thought of and other people did. I think what will happen in this sort of committee, in this sort of structure, is that the lynch pins will be the MAB chairman and the Provider Advisory Board chairman. The people who are going to be on both committees are going to, like Provider Advisory Board, chairperson on the MAB. That person is going to have to know everything that's going on in the Provider Advisory Board and all the committees that fed that Board to present the entire Provider Board view. The problem is that there is rarely a true consensus and there's a compromise. What we are going to see here, is this one person filtering everything out to one or two points and saying well this is the way it should be from Provider Board view when, in fact, there may have been quite a cacophony of opinions about exactly how it should go. So I'm concerned that these two people are really going to control the information flow back and forth.

Sandy Young said I'm assuming that the other providers are under represented, unfortunately. I thought rural Nevada was covered by the Clark County Fire Department.

Dr. Slattery said not all of rural Nevada.

Sandy Young asked if some providers want to use our protocols, because most have their own medical direction, which not a lot of these, other agencies do. The second thing is benefit of the current composition, there has been times where I've talked to each and every ER Physician on the Board for different issues and I think what you're going to decrease is the interaction between providers and hospitals. And that's one of the benefits of the Board that we have. Providers are comfortable discussing things with the Board members, and it's an educational opportunity for us when we have discussions on the protocols, joint, not separate. I think that we would lose that by separating the Boards.

Dr. Homansky said I don't really have a historical perspective here, but I don't want to just say, I'm not in favor of this because it's a new approach. I have no problem with trying new approaches. I don't want to come across that way, but I think this is a pretty amazing process. This morphine protocol wasn't voted on. We didn't come to a 4 – 3 vote. It was a consensus that finally came out…. and it's rarely an issue that we come down to voting because I'm not even sure who has a vote. So this Board has never been at that level. We talk about something and either we reach consensus or we table it and it comes back the next time and we reach consensus. That's amazingly effective.

This is an opportunity that will be lost just like Sandy is saying. I don't say hello to everybody when you come in, but you see a group of people who are all intimately involved in the system. I think that will be lost. I also don't see this as decreasing the time involved. I think that a majority of people are going to go to both meetings. An FAB representative may not have a lot to say on each issue, but needs to be appraised from both ends. I can't imagine the pre-hospital people not coming to both.

As to this meeting going a long time, it rarely goes pass 7:00. It is amazing what gets done in an hour. The room isn't big enough – just doesn't seem quite to be an overriding issue to change. If we want to change and see if it functions better, I have no problem with that. I think that this set up is too cumbersome – no, I don't believe that.

Pam Turner said, as Sandy was saying, how many people need a position on the Board.

Dr. Slattery said how big is the EMS system going to get? I don't know. That's impossible to predict. Right now I'll tell you, that there is probably about 4 agencies that aren't represented that should, by definition, be on the Board. They have equal right to be here. If more agencies come to town as more hospitals are built, we need another spot for each emergency physician. This is not my idea. Dr. Kwalick is realizing that this thing is continuing to grow. We need to find a solution to deal with that growth. At the same time, keeping the strength of this Board, which is equal representation from all the agencies and from all the emergency departments. Other options are to really cut it down and not give everyone representation. I don't know what the ultimate answer is to the problem, but there's no way of predicting the system's growth. There's at least, that I know of, two more hospitals being built. That's two more spots, in addition to just the provider agencies, private agencies, and volunteer agencies, that operate under our protocols.

Jane Shunney said those who aren't seated at the table are, the air ambulance people, helicopter people, Boulder City Fire Department and, Mesquite Fire Department.

Dr. Davidson said for as long as I've been with the Board, there has definitely been a great continuity. I know for the last 7-8 years, I've seen predominantly the same faces. Now, of course the new faces enter as we bring in the new agencies or the new facilities or there is some turn over amongst the hospitals or agencies. I can see that continuity being disrupted and it's amazing the people I've learned to work with and listen to over the years. A lot of good ideas are flowed from here and I just would hate to see that fragmented. Again, I'm not unwilling to change just to see if it would work. But if it's just because we need a bigger room, we could always run into the same problem then too. We could say in five years the Operations Board is too big for the room it's plugged into, and the MAB is still too big for this room it's plugged into. To split the group for that purpose, I don't know, this group seems to function well at this size even though it's grown from prior which was only about nine people. So I think I know which way I probably would lean if we were voting this month and next month.

Dr. Slattery said does anyone have any other ideas. The one thing I would ask the Board is whether you think it's a problem? Dr. Homansky and Dr. Davidson are both saying that it probably isn't. Maybe we just perceive something that isn't a problem. Is it a problem with the size of the Board?

Dr. Daitch said it doesn't seem that it would be that hard to add a couple of seats to the board right now. Some of the people that aren't sitting on the Board are in the audience anyhow. So the physical plant of the room probably wouldn't be impacted that badly.

Dr. Zbiegien said the individuals we take off this Board and divide the Board into two Boards, the individuals now sitting in this circle, who won't be in the future, will wind up sitting out there. So it's going to be the same. I'd just leave it the same way it is now.

Dr. Slattery said I certainly wanted to hear all these ideas, because I know Dr. Kwalick and the Health Department wants to get an idea how everyone feels. We'll bring it up next month.

Dr. Homansky asked to hear from Mesquite, to hear what they think.

Todd Jaynes said a lot of times the items deal with the Valley mostly. Mesquite goes to a different State, and we don't have the 5 to 10 minute transport times. So there's a lot of issues that maybe we could bring up that aren't currently being brought up to the Board.

Dr. Davidson said I certainly want you to feel that the Board serves this entire area, and I would welcome your ideas. It would probably help us with both even local, I call it local rural.

Dr. Henderson said for instance, Tim did the EMS protocol without actually being on the Board. I think that you could accomplish your goals and ends without sitting on the Board.

Todd Jaynes said I could probably be on more committees.

Dr. Henderson said when you have items that need to be addressed, I would suggest you follow it through just like Tim did.

Dr. Slattery said so if a problem comes from, let's say, Boulder Fire Department, who's not represented, who feels they should be represented on the Board, what do you do with them? Or as new hospitals come on board, do you keep expanding?

Dr. Davidson said Boulder City is here tonight, correct? Because they were in the prior meeting that we were in, and there's usually a representative who at least comes for the public participation?

Brian Rogers said from someone who was 4 or 5 months ago sitting on that Board to now, I have just as much exposure to any one of you that I did 4 or 5 months ago and I'll talk just as much as I would if I were still on the Board. I think if you want your say, you're going to have your say either way you go.

III. INFORMATIONAL ITEMS/DISCUSSION ONLY

A. CPI Training – Jane Shunney, R.N.

The CPI Training will be held August 6th and 8th here at the Health District at 8:00 a.m. The course will last 4 hours each day and be repeated each day. We've sent out fliers and invited all of the EMS providers, hospital ED nurses, and physicians. Everybody is welcome to attend the training.

B. ED Nurse Managers Report – Virginia DeLeon

Joe Calise said I'm actually sitting in for Virginia today. At our last meeting we talked about the new EM system that Mike Meyers says that he has arranged to purchase and has actually paid for the next 2 years, plus another year. The equipment is being ordered and is being bid on and hopefully it will all be up and running by January. We did have some issues with closure/divert, whatever term we're using this week. We had a meeting the other day with Fire Rescue and all the provider ambulances and decided that we need to have a Divert meeting if possible scheduled as soon as possible, so that we can work out some of the kinks that are in the amour. The last 60 days we've identified some issues that we thought might come up and they have, and we need to try to fine-tune it a little bit, until the whole EM system is working.

Dr. Davidson said the consensus of the nurse managers is that you would want to have a meeting prior to the MAB meeting next month?

Pam Turner said we'd like a meeting in the next 2 weeks.

Joe Calise said we'd like to meet again because we need to address this at our next nurse managers meeting, in case there is fine tuning needed. We of course invite you to that meeting.

Dr. Davidson said I don't have a problem scheduling a meeting. I'll talk with Jane and Mary Ellen and we'll go ahead and schedule a Divert meeting, if possible, in the next two weeks.

IV. PUBLIC APPEARANCE/CITIZEN PARTICIPATION

Joe Calise said I know that the ER nurse managers that came to the review of the bus critique were really impressed. You noticed things were spread out. Everybody got a little bit of action so that ER's didn't get overloaded and the fact that the volunteer crew worked superior – they did a great job and coordinated well considering certain constrictions. It was good to hear that they had trouble communicating too so that we could really address this communication issue among the whole EMS system.

Dr. Davidson said there is an FAB meeting scheduled August 30 at 8:00AM. I'm sure the open/closure divert will come up then.

V. ADJOURNMENT

As there was no further business, Dr. Davidson called for a motion to adjourn. A motion was made, seconded, and unanimously carried to adjourn the meeting at 7:13PM.