MINUTES
EMERGENCY MEDICAL SERVICES
MEDICAL ADVISORY BOARD MEETING
MARCH 6, 2002 – 6:00P.M.

MEMBERS PRESENT

Allen Marino, M.D.
Blain Claypool
Bryan Lungo, M.D.
David Daitch, D.O.
Chief David Kalani
David E. Slattery, M.D.
David Watson, M.D.
Donald Kwalick, M.D.
Donald Reisch, M.D.
E. P. Homansky, M.D.
Jeff Davidson, M.D., Chairman
Jeff Greenlee, D.O.
John J. Fildes, M.D.
Jon Kingma
Karen Laauwe, M.D.
Nicholas Han, M.D.
Joseph Calise, R.N.
Pete Carlo
Philis Beilfuss, R.N.
Richard Henderson, M.D.
Steve Hanson
Timothy Vanduzer, M.D.
Todd Jaynes

MEMBERS ABSENT

Randy Howell
Steven Peterson

ALTERNATES

Aaron Harvey
Steven Kramer

CCHD STAFF PRESENT

Jane Shunney, R.N.
Jennifer Carter – Recording Secretary
Joe Heck, D.O.
Kelly Quinn
LaRue Scull
Mary Ellen Britt, R.N.
Shannon Randolph

PUBLIC ATTENDANCE

Brian Herterick, CCSN
Brian Michals, HFD/CCSN
Clay Fontane, CCSN
Derek Cox, AMR
Michael Zbiegien, M.D, Sunrise Hosp.
Jennifer Hunt, CCSN
John Wilson - SW
Kathy Sneed, St. Rose
Kirk Estes, CCSN
Mary Levy, R.N., UMC
Mike Griffiths, R.N., Mercy Air
Missy Greenlee, R.N., Mercy Air
Nancy Cassell, CCSN
Nancy Harland, R.N., Sunrise Hosp.
Nancy Newell, NV-1 DMAT
Paul Fischer, M.D., Sunrise Hosp.
Paul McGuire, CCSN
Paul Myers, CCSN
Randy Skinner, CCSN
Scott Ash, CCSN
Scott Johnson, LVF&R
Sue Hoppler, R.N., DSH
Virginia Deleon, R.N., St. Rose

I. CONSENT AGENDA

Dr. Davidson asked for a motion to approve the February MAB minutes. A motion was made, seconded and passed unanimously.

II. REPORT/DISCUSSION/POSSIBLE ACTION

A. Drug Committee

Discussion of Phenergan Protocol

Dr. Marino discussed the selection of committee members for the Drug/Device Committee. The agencies agreed they would alternate with a partner representative every six months. There are four physician representatives, which are Dr. Henderson, Dr. Watson, Dr. Lungo and Dr. Higgins.

The Henderson Fire Department has requested that the Phenergan protocol be revised to allow Phenergan to be given as a standing order. Morphine is a standing order for certain indications. Paramedics are finding a number of patients have nausea after receiving Morphine and would like to be able to administer Phenergan without an order. The Drug/Device Committee voted to revise the Phenergan protocol to not require a physician's order. The recommended changes to the Phenergan protocol from the Drug/Device Committee are as follows:

- Remove the word *recurrent* from Indication I.
- Remove the current language from Indication II and replace it with "Nausea or vomiting secondary to Morphine administration" and change the Physician's Order to "NO" for this indication.
- Add a third Indication (Roman numeral III) "Repeat doses" with the Physician's Order as "YES".

Dr. Marino made a motion based on the recommendations from the Drug/Device Committee to endorse the above-mentioned changes to the Phenergan Protocol. The motion was seconded. Dr. Davidson called for discussion on the motion. Dr. Henderson suggested an amendment to the Physician's Order on Indication I to be changed to "NO".

Dr. Slattery agreed stating Phenergan is a benign medication and it would simplify the protocol to say "Control of nausea and vomiting" with no physician's order required.

Dr. Marino said the physicians discussed the issue in the Drug/Device Committee and the medication was not considered benign. There are some physicians who choose not to administer Phenergan and there are only a number of doctors who decline it when paramedics request it for nausea and vomiting.

Dr. Davidson pointed out that at lower doses Phenergan tends to augment the response of narcotics more than the higher dose.

After a brief discussion Dr. Davidson called for a vote on the motion to approve the Phenergan protocol with the changes recommended by the Drug/Device Committee. The motion did not pass with 15 members opposed and 6 members in favor.

A second motion was made to amend the protocol to change the physician's order from YES to NO for Control of nausea and vomiting. The motion was seconded and passed with a majority in favor and one member abstaining.

Dr. Slattery said it didn't make sense to approve Phenergan without a physician order for Morphine for a specific cause of nausea and not approve it for all causes of nausea and vomiting. He didn't see the difference in safety by distinguishing just those patients that get nauseated from Morphine and those patients that are nauseated for any other reason. The idea is to streamline the paramedic's evaluation and keep ED physicians off the phones when possible.

Dr. Watson said a majority of the discussion at the Drug/Device Committee meeting centered on the fact that the Morphine is a main reason why the medics call in for the Phenergan. The reason the Drug/Device Committee elected not changing the Physician Order to "NO" is that there are contraindications; i.e., bowel obstruction. There are physicians who do not want to give the order for Phenergan and they have that right. The physicians are the ones caring for the patient medically/legally for hours on end in the emergency department.

Dr. Slattery commented the reason we have the Medical Advisory Board is to set up pre-hospital protocols. There are a lot of things individual physicians may disagree with, but this Board needs to decide what will be used as off-line medical control. The MAB has to decide as a group what is best for the patient.

Dr. Fildes said the issue has less to do with the protocol than it does about the bigger picture. The members are considering exceptional reasons why something should or shouldn't be used as opposed to looking at what the practice has been and trying to see in 400 – 500 cases how many adverse reactions or misdiagnoses or problems occurred. The value of systematic data collection has been discussed on numerous occasions for similar issues to use as evidence to guide MAB decisions. The Board finds itself trying to poll the room on a majority of expert opinions leaning one way or the other on an issue. He made a plea that in the future, systematic data collection is given careful consideration; similar to the way this would be studied in the hospital or another setting.

Dr. Davidson said the original motion on the floor was seconded which was the Phenergan protocol revision as Indications I, II and III Physician Order's being listed as "Yes, No, Yes".
Dr. Davidson called for a vote on the original motion. The motion did not pass with 15 opposed and 6 in favor.

Dr. Henderson amended the motion so the protocol would read Physician's Orders "NO" for Indication I.

The motion was seconded and passed with one member abstaining.

Dr. Slattery called for a friendly amendment, to strike Indication II since I is all inclusive of nausea and vomiting.

Dr. Henderson stated one reason Indication I was included was because it seems almost routine that the paramedics are giving Morphine followed by Phenergan as if it's one drug. It happens commonly and Morphine doesn't always cause nausea and vomiting.

Dr. Davidson recommended leaving the protocol as currently approved.

B. Education Committee

Dr. Lauwwe reported the Education Committee discussed the District Procedure for EMT Paramedic Training. The procedure lists the required content and didactic and laboratory hours needed for

paramedic certification in Clark County. The requirements meet the minimum national DOT standards and the number of hours represents the middle range of hours being taught across the country. The paramedic program directors and instructors from UMC and CCSN worked together so that all paramedics will be getting the same amount of laboratory and didactic time. Dr. Lauwwe motioned for MAB endorsement of the Draft District Procedure for EMT-Paramedic Training. The motion was seconded and passed unanimously.

C. Procedure/Protocol Committee

Discussion of Pediatric Closure Issue

Dr. Han reported the Procedure/Protocol Committee met for the first time March 6, 2002. He made a motion for the MAB to endorse the recommendation of the Procedure/Protocol Committee to add to the EMS Procedure for Emergency Department Closure Protocol, under Exceptions, Roman numeral IV to read "*If a patient has been treated at a pediatric emergency department within the previous 48 hours the patient may be transported back to that facility regardless of its closure status"*.

The question was raised if the language was intended to extend to all emergency departments that treat children or only the two designated pediatric emergency departments at UMC and Sunrise. Some members felt it should apply to all emergency departments because the objective is to take the patient back to the facility where the initial work-up was done. Others thought the focus was to transport the patient ideally to a tertiary pediatric facility.

After a brief discussion the MAB agreed to change the language under EXCEPTIONS: IV to read "*If a patient has been treated at UMC or Sunrise pediatric emergency departments within the previous 48 hours the patient may be transported back to that facility regardless of its closure status"*. The motion was seconded and passed unanimously.

Discussion of Intravenous Therapy Protocol

Dr. Han reported the Procedure/Protocol Committee discussed the proposed revisions to the Intravenous Therapy Protocol. The changes effect only pediatric patients which the committee decided to define as children <12 years of age for this protocol. Under Pediatric Indications Roman numerals I and II will remain unchanged. Roman numeral III will be changed to read "*Children that meet Trauma Patient Destination Criteria*" instead of "Major Trauma that meets Trauma Patient Destination Criteria". Indications IV – VI remain unchanged. The committee recommended that Roman numeral VII "*Deformed Extremity with persistent pain despite adequate immobilization"* be deleted and instead read "*All Other Indications*". Under SPECIAL NOTES Roman numeral IV new language was added which will read, "*Patients should have IV access attempted en route*".

Dr. Han made a motion for the MAB to endorse the protocol as presented. The motion was seconded and Dr. Davidson called for discussion on the motion.

Dr. Lungo commented the reason this came about is there is a difference of opinion in the community about who should have IV access started in the field. In the last month four cases were reviewed through the QI process in the EMS office and there was a difference of opinion about how certain cases should be managed. The goal is to have a set of criteria that the paramedics can use. The

recommended pediatric indications are designed to solve the dual problem of IV's being started unnecessarily and also IV's not being started when they should be specifically in the pediatric age group.

Dr. Henderson asked why a physician's order would be required for a child with an extremity fracture or a deformed extremity. Dr. Lungo responded the Morphine protocol requires the paramedic to get an order for Morphine in this age group.

Dr. Homansky said he thought that pediatric patients were defined by weight. Dr. Lungo responded he recognizes there are inconsistencies within the protocols regarding defining the age of pediatric patients. This issue will be addressed when the protocols are reviewed and revised.

After some discussion on the motion, Dr. Davidson called for a vote. The motion passed unanimously.

D. Divert Task Force

Dr. Davidson reported the Divert Task Force discussed the following four items:

1. Adjustment of Closure Time

   ED physicians and ED staff have voiced a concern that after the one hour of closure has begun, ambulance traffic continues to flow into the ED, anywhere from the first ten to thirty minutes of that hour. The Divert Task Force considered the possibility of lengthening the closure time from 60 minutes to 75 or 90 minutes. Dr. Vanduzer asked at what point the ambulances are assigned to an ED and if that issue was impacting the flow of ambulance traffic. Dr. Davidson stated the Divert Task Force has looked at several issues and is working on ways to ensure that ED's get a full hour of closure. After further discussion, increasing the period of time a hospital can be closed was not recommended.

2. Internal Disaster Education

   The task force felt that in light of occurrences in recent months when there have been facilities either declaring an internal disaster or facilities suggesting they might need to do so, it would be in the best interest of the community to implement an internal disaster review process. It was suggested that within 48 hours (2 working days) a review of the incident be conducted by that facility. It would be hosted by the Health District, as are all the disaster reviews. For educational purposes, this would allow the rest of the community to understand why the facility declared the internal disaster and how they worked through it. Obviously, a facility calling for internal disaster has great impact on the rest of the closure system and it was felt everyone would benefit from reviewing the incident. The recommendation passed unanimously with one abstention.

   Dr. Davidson called for a motion on the recommendation of the Divert Task Force to implement an internal disaster review process. The motion was seconded. Dr. Davidson called for discussion.

   Dr. Vanduzer suggested the review could be done at the facility that declared the disaster. Other board members expressed concern that the issue should be referred to the Facilities Advisory Board (FAB).

Dr. Davidson replied the Divert Task Force discussed that it would be better to maintain consistency and have the presentation take place at the Health District, a neutral site, as is done with the MCI critiques. Blaine Claypool stated that hospitals are already required to report to the state if they declare an internal disaster, however the task force felt by reviewing the incident others could learn how to prevent a similar situation in the future, if possible. The Divert Task Force also felt that if the MAB voted to endorse this recommendation it would be sent to the FAB for their endorsement before the process was implemented.

Dr. Davidson called for a vote and the motion passed unanimously.

3. Boulder City Divert Participation

Dr. Davidson reported he, Dr. Heck, and representatives from Siena St. Rose Hospital and Boulder City Hospital met before February's MAB meeting. Between that meeting and follow-up meetings it was decided to put Boulder City Hospital on the EMSystem. They are going to appear under the specialty area. When they get full, meaning their two critical care beds are full, the screen will read "critical care/closed". They will also be able to monitor the closure status of the other hospitals in the greater Las Vegas valley and then the fire department will know where to transport patients.

4. Possible Region Re-Evaluation

The task force re-evaluated the structure of the regions within the system. After considering other options, it was decided that the current regions are still the best way to organize closure status. Dr. Davidson stated the EMS agencies are seeing an increase in drop times at the hospitals. He added members of the EMS community and the FAB are working on the issue of transfer of patient care in the emergency departments.

Steve Kramer from AMR, reported their call volume is up by approximately 20%. The task force members have observed that when all of the urgent cares and quick cares begin to close and send patients out that need to be transported there is a big impact on the ED's. It was suggested the task force look at a mechanism to recommend that the urgent cares and quick cares stagger hours of when they open and close to reduce the sudden influx of patients back into the system.

Dr. Heck commented about the use of Legal 2000 forms. All of the emergency departments are reporting they are holding mental health patients. He asked the MAB members to take the message back to their physician groups that once the Legal 2000 form has been initiated, it does not always have to be completed if the patient is medically cleared and their mental status has improved. Some people that fall into the Legal 2000 category can be taken off the form and do not have to wait for ultimate disposition to mental health services.

III. INFORMATIONAL ITEMS/DISCUSSION ONLY

A. ED Nurse Manager Report

Joe Calise reported the nurse managers met at Lake Mead Hospital. Lt. Moody from the Metropolitan Police Department attended the meeting and discussed some of the legal issues involved with patient transports. Sheriff Keller put together a task force that's working on trying to change rules that would make it easier to move patients into facilities. He encouraged the nurse managers to join the

meetings. The new field representatives from Las Vegas Fire & Rescue were introduced. They will help deal with some of the issues that occur between the field personnel and the ED's.

B. QA Report

Dr. Slattery reported the QA Directors finished the Morphine Protocol compliance study as was directed by the MAB. Each of the agencies looked at their Morphine use and the compliance is very good. There were a few minor problems but for the most part, the use was appropriate and the protocol was being followed. A decision was made the first of January to collect data on every patient that was not transported countywide because there have been some problems with the patients not being transported. He and Dr. Heck are reviewing and abstracting over 5000 charts into a database. Once that is completed they will present that information to the MAB and based on their finding they will be presenting some recommendations for improvement to the Education and Procedure/Protocol Committees.

C. ED Divert Statistics

February statistics will be available at the April 3, 2002 MAB.

IV. PUBLIC APPEARANCE/CITIZEN PARTICIPATION

Dr. Heck reported there is a nation-wide shortage of Valium. But the District has been told that White Cross has a shipment that should probably hold us for another six months. By that time the national shortage will be over. If not the issue will need to go to the Drug/Device Committee to look at how to replace valium and consider using Versed or another diazepine. Dr. Heck stated a Regulation workshop was held and was well attended with a lot of good discussion. The third workshop is scheduled for Tuesday, March 19 at 1:30. He is hopeful that will be the final workshop and the plan is to bring the Regulations before the MAB at April's meeting and then to the Board of Health.

Dr. Kwalick presented a draft of "The Patient Delivery to Emergency Medical Facilities" Operation's Protocol originally created by the providers. The reasonable transition time" mentioned in the draft is still very flexible. He would like to develop a definition of a "reasonable transition time". Otherwise, the protocol is straightforward. He asked the MAB members to review the draft during the next month, as it will be on the MAB as an action item in April. There will be an FAB meeting scheduled to come up with recommendations of a reasonable transition time definition.

Dr. Davidson added he hoped that an agreement can be reached between the transport agencies and the hospital emergency departments to work together to get the transporting agencies back out into the community.

Dr. Davidson stated he wanted to make some comments on the current medical malpractice insurance issue in Clark County. In response to their concern, many of the primary care and OB/GYN physicians closed their offices on Monday, March 4, for most of the morning, to rally down at the Grant Sawyer Building. The issue did get some very good national press coverage on CBS from Dan Rathers. What the community is facing will directly impact our EMS system in that if there is no trauma center to provide 24/7 coverage and if there are no ED physicians that can stay in practice to provide 24/7 coverage we are going to see a very big problem.

Dr. Kwalick added he was putting together a panel of experts for the March 28 BOH meeting to discuss this issue of medical malpractice insurance. It will be re-broadcast for the four weeks following the board meetings, 3 or 4 times a week which provides another way for the public to be informed about the whole issue of malpractice insurance and access to care.

A video of the CBS coverage was shown to the MAB members. Dr. Davidson said the segment was shown multiple times on the local stations and CNN.

The malpractice insurance companies are reporting emergency department physicians, general surgeons, obstetricians and gynecologists are the "highest loss ratios" and those in danger of losing coverage. Many people do not have health insurance; many people are using ED doctors as their primary care physicians. The pressure is placed on the ED physicians at this point and physicians' careers have changed tremendously compared to 5-10 years ago when the goal was to safely evaluate people and make a correct disposition, meaning they were okay to be managed out of the hospital, in some cases stay in the hospital. Dr. Davidson said he appreciates all the support that has come from the trauma center and from all the ED physicians. He encouraged them to continue to rally fellow physicians, patients and other supporters so the legislature does not lose site of what is going on and does not try to put a temporary band aide on an issue that is ultimately going to require a very long term solution and possibly tort reform.

Dr. Fildes reported that on March 5 the County Board of Commissioners authorized UMC's CEO, Mr. Hale, to negotiate contracts with trauma physicians for not more than 90 days. At present only one physician can meet the criteria. That individual will hopefully be employed as a hospital-based physician and will be barred from any form of private practice while he is employed by the hospital. If other surgeons pull out, he is not sure they can find individuals that will accept that employment situation willingly. He encouraged everyone to keep pressure on the issue and to continue to educate the public that this isn't an issue that has to do with emergency medicine, trauma or obstetrics only. This is an issue that is going to change the way people access health care when they themselves or their parents have cardiac problems or cancer, physicians won't be there. This could potentially degrade access in quality of care if it's not corrected.

Dr. Davidson added that if it ever came to a point where a facility in town, meaning one of our ED's or our trauma center was going to close, he would hope we would be able to call an emergency session of the Medical Advisory Board prior to that closure to discuss what can be done as a community to continue EMS traffic flow, because obviously it would impact the rest of the community.

Dr. Fischer announced that the Governor has created a Nevada Physicians Task Force and there are currently about 8 voting members. He is currently the designated ED representative through Nevada Chapter of ACEP. The meetings will take place every Thursday and they hope by the end of the month they are going to have 1 million dollars of funding against the 3 million dollars that the trial lawyers have to address the issue. He feels they are moving in the right direction.

As there was no further business, Dr. Davidson called for a motion to adjourn. A motion was made, seconded, and carried unanimously to adjourn the meeting at 7:06PM.