MINUTES
EMERGENCY MEDICAL SERVICES
MEDICAL ADVISORY BOARD MEETING
MAY 7, 2003 – 3:30P.M.

MEMBERS PRESENT

Allen Marino, M.D., St. Rose Siena Dominican Hospital
Bryan Lungo, M.D., University Medical Center
Darrin Houston, D.O., Lake Mead Hospital
David Daitch, D.O., Boulder City Hospital
David Watson, M.D., Sunrise Hospital
Division Chief Randy Howell, Henderson Fire Department
E. P. Homansky, M.D., Valley Hospital
Frank Pape, D.O., Summerlin Hospital
Jeff Davidson, M.D., Chairman, Valley Hospital
John J. Fildes, M.D., University Medical Center
Jon Kingma, EMT-P, Boulder City Fire Department
Asst. Chief Mike Myers, Las Vegas Fire & Rescue
Pete Carlo, EMT-P, Southwest Ambulance
Philis Beilfuss, R.N., North Las Vegas Fire Department
Richard Henderson, M.D., St. Rose DeLima
Rick Resnick, Mesquite Fire & Rescue
Chief Steve Hanson, Clark County Fire Dept.
Steven Peterson, American Medical Response
Timothy Vanduzer, M.D., Mountain View Hospital
William Harrington, M.D., University Medical Center

ALTERNATES

Pam Turner, Valley Hospital, Nurse Manager

MEMBERS ABSENT

Alice Conroy, R.N., Sunrise Hospital, Nurse Manager
Blain Claypool, Valley Hospital
David A. Rosin, M.D., Mental Health & Development Srvcs.
Donald Kwalick, M.D., Clark County Health District
Donald Reisch, M.D., Desert Springs Hospital

CCHD STAFF PRESENT

David Slattery, MD, EMS Assistant Medical Director
Jane Shunney, RN, Assistant to the Chief Health Officer
Jennifer Carter, Recording Secretary
Michael MacQuarrie, EMS Field Representative
Rae Pettie, Sr. Administrative Clerk
Rory Chetelat, EMS Manager

PUBLIC ATTENDANCE

Brian Rogers, SWA
Davette Shea, WestCare Nevada
David Nehrease, AMR
Jim Osti, WestCare Nevada
JoAnn Lujan, Westcare
Mary Jo Solon, Southern Hills Hospital
Michael Zbiegien, MD, Sunrise Hospital
Michael Zbiegien, MD, Sunrise Hospital
Molly McCarroll, Valley Hospital
Roy Carroll, AMR
Sam Wilson, SMS
Shawn White, HFD
Steve Hanson, CCFD
Steven Kramer, AMR
Todd Rush, CTC

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The EMS Medical Advisory Board convened in the Clemens Room at the Ravenholt Public Health Center at 3:40 p.m. on Wednesday, May 7, 2003. The meeting was called to order by 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. Chairman Davidson noted that a quorum was present.

I. CONSENT AGENDA:

Minutes Medical Advisory Board Meeting April 2, 2003

Chairman Davidson asked for a motion to approve the April 2, 2003 meeting minutes. A motion was made, seconded and passed unanimously.

II. REPORT/DISCUSSION/POSSIBLE ACTION:

A. Divert Task Force Report

1. Discussion of Legal 2000 Divert Operations Protocol

Chairman Davidson recalled the decision by the MAB to accept the L2K Divert Operations Protocol as an operations protocol with month-to-month reviews for improvements as needed. He explained the Divert Task Force has put forth the following addendums to the current L2K operations protocol for MAB endorsement.

- Southwest Ambulance has been named the facility to be a central dispatch for L2K patients.
- The transport agency will contact Southwest Ambulance Dispatch to determine the appropriate open hospital or next hospital in rotation for transport of a Legal 2000 patient.
- When all facilities reach five a 1-9 rotation will be enforced so that there is no more east/west distribution.
- When the patients arrive at the facility they must be transferred to the care of the facility within 45 minutes.

Chairman Davidson called for motion to endorse the above-mentioned addendums to the Legal 2000 Divert Operations Protocol. The motion was seconded.

Chairman Davidson called for discussion on the motion.

Concerns were raised both from Henderson Fire Department (HFD) and facility perspectives. Although there are a small number of L2K patients transported by HFD, the concern is the length of time involved with transporting to the northwest area facilities from the Henderson area.

A facility representative voiced concern regarding the 45-minute transfer of care, which would potentially require transfer of care of non-critical patients, prior to the transfer of care of patients with chest pain.

Chairman Davidson explained the reason the Divert Task Force agreed on the 45-minute transfer of care is to avoid long wait times. For example if the west side is feeling a heavy burden and all those facilities are up to eight and nine L2Ks and they are still receiving patients, and if one of the facilities closes, ambulance providers can be waiting with L2K patients for hours. So the task force agreed that setting a specified time to transfer the care of L2K patients, with a 1-9 rotation compromise to continue the flow, would level off the wait times and the flow of L2K patients when all hospitals are at five.

After brief discussion the motion passed with 15 yes votes, 4 no votes, and 2 abstained.

2. Discussion of Patient Transfer to Receiving Facility Operations Protocol (PTRF)

   Chairman Davidson reported the Divert Task Force agreed that the PTRF Operations Protocol should be discontinued, as it is ineffective and not contributing to any type of benefit. Chairman Davidson made a motion to discontinue the PTRF Operations Protocol. The motion was seconded.

   A question was raised regarding the issues around the decision to remove the protocol.

   Brian Rogers, Southwest Ambulance explained the protocol creates a conflict between the two regulating bodies for ambulance providers. Ambulance providers are required by The Ambulance Oversight Committee (AOC) to respond to every 911 call. The PTRF Operations Protocol requires ambulance providers to monitor non-monitored patients for up to sixty minutes. When ambulance providers are waiting to transfer care of patients to the hospitals, and system levels reach zero, ambulance providers are obligated by the franchise agreement to potentially leave a patient at the hospital prior to sixty minutes, which violates the PTRF Operations Protocol.

   A concern was raised that without this protocol in place the ambulance providers would be free to leave patients at their discretion.

   Chairman Davidson commented the general sense of the Divert Task Force is that when system levels are at zero and ambulance providers have to respond to a high level call, the providers currently make accommodations by doubling up patients with the paramedics in the hallways, etc. Therefore, the task force agreed, the elimination of the PTRF Operations Protocol would not have an adverse affect on the system.

   The motion passed with 20 yes votes and 1 no vote.

3. Discussion of Draft Hospital Divert Policy

   Chairman Davidson reported the Divert Task Force discussed the Draft Hospital Divert Policy at length in an effort to determine the restructuring of regions A, B, and C with regard to closure capabilities, considering the openings of the new hospitals. Spring Mountain Hospital is scheduled to open October 1, 2003. Southern Hills is scheduled to open February or March of 2004. Two ideas from the task force were:

   - To put Spring Mountain Hospital in region A. That region would then have five hospitals. The proposal was two of those hospitals in that region would simultaneously close. Regions B and C would remain the same.
   - To put Spring Valley Hospital on the west side and create an east/west type of distribution where there would be five hospitals on the east side and five on the west side. On each side one hospital could close at a time.

   The task force tabled the discussion until June to give the nurse managers and FAB members time to reflect on these ideas. He pointed out the reason he asked for everyone to start thinking about this now, is because there will be an MAB meeting in June and typically MAB does not meet in July. Therefore given the short time frame, the goal of the Divert Task Force is to have something prepared for the MAB to vote on by August or September.

   A concern was raised regarding potential neurology-surgical emergencies being transported to the closest facility rather than a neurology surgery center. Dr. Vanduzer pointed out it would be in the best interest of a patient, suffering from intercranial hemorrhage, to be transported to a hospital where neurology surgeons are on staff.

Dr. Slattery mentioned the QI Committee has written an abstract with the data collected on intercranial hemorrhage diversions. He said he will present that information to the MAB at the June meeting.

B. FAB Report

1. Discussion of Legal 2000 Patients

Chairman Davidson announced Blaine Claypool, who is the current FAB representative, would miss the May and June MAB meetings. He mentioned Dr. Kwalick would be appointing a new FAB representative at the August or September MAB meeting. He asked Rory to give the FAB reports.

Rory reported the FAB was asked to consider alternatives to the current L2K patient level-loading plan of five patients per hospital in an effort to address concerns of the smaller hospitals. After much discussion the FAB decided to leave the current level-loading plan in place.

2. Discussion of Draft Hospital Divert Protocol

Rory reported a Draft Hospital Divert Protocol was presented to the FAB for consideration. The final decision of the FAB was to have the nurse managers work on an alternative plan, which Pam Turner will be presenting to the MAB.

3. Hospital Smallpox Adverse Reaction
Training/Education

Rory reported the FAB was given an update on the Hospital Smallpox Adverse Reaction training and education that is being conducted by the CCHD Bioterrorism team.

C. Pilot Project: Henderson Fire Department

Rory referred to the handout, which was a letter that was submitted to the Health District by Henderson Fire Department, requesting that EMT-Basics be allowed to be trained and utilized to start IVs in the field under the direction of a paramedic. Rory mentioned all the EMT-Basics at HFD were once EMT-Intermediates and the training program that the EMT-Basics would be receiving is the same training that the EMT-Intermediates receive for IV starts. Dr. Heck reviewed the proposal and he thought it was a good sound proposal, Rory stated. A motion was made to allow Henderson Fire Department to start a pilot program, which would allow EMT-Basic practitioners to start IVs (peripheral lines only) in the field, after receiving adequate training, under the supervision of a paramedic.

Randy Howell commented HFD identified, in some of the outlying areas, where an engine company responds with one paramedic, that in critical situations, if someone else could start the IV, the treatment intervention can be applied faster, and having EMT-Basic practitioners start IVs will assist in those types of situations.

The motion was seconded and passed unanimously.

D. Update on Trial Protocols
Rory reported there is no current data to report on the PTRF and L2K Divert protocols.

III. INFORMATIONAL ITEMS/DISCUSSION ONLY

A. Update for Community Triage Center

James Osti, Director of the Community Triage Center, submitted a document to the board members on statistics collected by the CTC showing the first three full months of operation for the CTC. There were 265 admissions to the CTC in February and 486 total admissions in April. He explained the admissions come from four primary sources.

- First source is Chronic Public Inebriate (CPI) transfers. These are the EMS Procedure for Chronic Public Inebriate Operations Protocol transfers. In April 45 individuals were admitted to the CTC by EMS using the EMS Procedure for Chronic Public Inebriate Operations Protocol and the CTC will be tracking that number.
- Next group of individuals are those individuals who are transported to the CTC by law enforcement. These are CTC transfers. With the emergents of the metro community involvement teams, the CTC went from 53 admissions in February to 155 admissions in April. These are individuals who previously might have been picked up by EMS. EMS may have been called and the patients may have been put on a Legal 2000 form and transported to a facility ED.
- The CTC is also tracking the hospital transfers, which are confirmed transfers out of the hospitals to the CTC. In February the CTC admitted 3 hospital transfers. Now that the CTC has full time transport functioning, in April there were 99 admissions. 125-150 hospital transfers are estimated to be admitted to the CTC for the month of May.
- Of 485 admissions to the CTC from 911 calls, 14 of those individuals had to be transported to the hospital for a higher level of care. He noted that the goal of the CTC is to stay below 5% of the call back ratio.

A Medical Advisory committee has been comprised of members who volunteered to meet after the MAB, Mr. Osti stated. One of the things that will be discussed in the meeting is liberalizing the EMS Procedure for Chronic Public Inebriate Operations Protocol. There is evidence that confirms the CTC can handle an individual, who has more abnormal ranges of their vital signs and other things, without any consequences. Therefore, he mentioned, the MAB will be asked to consider a very liberalized protocol for use with EMS.

Mr. Osti announced the CTC is conducting trainings throughout the hospitals, describing the transport services and the programs that are offered by the CTC. He mentioned the hospital EDs have been very receptive to the trainings.

A question was raised, are there ever times when the CTC is saturated and closed to facility transports?

Mr. Osti replied there is never a time when the CTC is closed to facility transports, as local facilities have priority admission to the CTC. He explained if the CTC is full, arrangements are made for alternative placements. The CTC has a strategic plan in place for taking people out of the facility when the CTC is at total capacity. He stressed that if a facility has been turned away by the CTC he needs to be notified. He mentioned that when the CTC first started there were isolated incidents when EMS was turned away. However those glitches have been identified and corrected and if a facility calls for CTC admission of a patient that meets the criteria, that patient will be accepted, as the CTC has an open policy to local facilities.

A question was raised regarding prescriptions. Is the CTC able to distribute medications independent of the attending physician?

Mr. Osti replied in a three-step process, the CTC is at step two right now. The CTC has hired a full time Family Nurse Practitioner who came on board a week ago. Therefore, the CTC will have seven day per week physician extender coverage. Currently the CTC is not licensed as a modified medical facility. Therefore, prescriptions are written and sent to the pharmacy, at which time the pharmacy fills the prescription then brings it back to the CTC and a self-administration protocol is applied. He mentioned this process is working, however he requested prescriptions that require immediate administration, be filled for a short period of time by the attending physician.

A question was raised regarding the CTC's ability to fill prescriptions during the graveyard shifts.

Mr. Osti replied there is a process in place to accommodate the need for immediate medications. The CTC has 24-hour physician coverage and if there is an acute situation for an individual to get medications immediately, the physician would be called and the physician can order the prescription. The CTC has a contract with a pharmacy that is open 24 hours to accommodate filling prescriptions. However, he mentioned from a financial perspective, the CTC is a non-profit organization, and the preferred route would be to wait until the day shift to fill the prescriptions at which point the prescription would be filled first thing in the morning.

Dr. Watson commented the CTC is doing a wonderful job and is a great asset to the community. When Sunrise hospital has limited bed capacity and the CTC is called, the CTC transport is always there within 30 minutes. He acknowledged the CTC has made a huge difference in the community.

Mr. Osti expressed gratitude for that feedback.

B. ED Nurse Managers Report

Chairman Davidson announced Pam Turner would substitute for Alice Conroy as Mrs. Conroy's husband passed away recently.

Pam Turner reported the nurse managers met April 26, 2003 at LVF&R. The nurse managers reviewed the L2K Divert Operations Protocol and the March FAB meeting. In response to a request made by the FAB to have the nurse managers prepare standard triage guidelines for EMS patients, Ms. Turner announced that Sandy Young, Scott Rolfe and she met Wednesday, May 30 to develop language for those guidelines. Ms. Turner handed out a draft of the Triage Guidelines to the MAB committee members. She mentioned Karla Perez, FAB Chairperson, reviewed the draft and the draft was distributed to the FAB members. She received suggested modifications to the draft and the modified draft will be redistributed throughout the community. The nurse managers received direction from Chairperson Perez that if there is no response to the modified draft within a week, the Triage Guidelines may be implemented. The goal of the nurse managers is to try and offload all ambulance patients within 30 minutes, no matter what the diagnosis is, Ms. Turner continued. Upon implementation of the Triage Guidelines, when an ambulance arrives at the ED, a nurse or the designee at the facility will triage the patients within 15 minutes. The nurse or designee will then make a determination as to an appropriate placement for the patients in order to free up the EMS crew. That may require, removing an IV, taking the patient off the cardiac monitor and placing them in the waiting room or into another holding area, depending on what the facility resources are. Ms. Turner asked the MAB committee members to review the draft and she requested endorsement from the MAB to implement the Triage Guidelines.

Rory volunteered to relay the information to the FAB that the Triage Guidelines for EMS Patients is supported by the MAB.

C. QA Report

Dr. Slattery reported the QA Committee has been working for the last six months on developing some global clinical performance measures of the EMS system. The three pronged attack adopted by the committee is:

- Examining Cardiac Arrest Resuscitation Rates
- Researching AED and CPR bystander CPR and AED use in the community, and
- Data collection of Critical Trauma Intervals.

He acknowledged the QA committee members for the hard work invested to work on these issues in addition to managing their other jobs and duties. He mentioned the Critical Trauma Data might be presented to the MAB at the June meeting.

D. ED Divert Statistics

Statistics were available as handouts.

Brian Rogers announced SWA is now in the Special Event Business and Mark Calibrese has been hired by SWA as the new Special Event Manager.

Sam Wilson, Specialized Medical Services (SMS), commented SMS responds to 911 emergency calls and provides transport for the Lake Mead Recreational area during the summer months. He mentioned SMS is scheduled to begin providing this service the weekend of May 10, 2003. He passed around the Trauma Patient Destination Protocol (TPDP) to the MAB committee members and mentioned SMS experienced issues with transporting these patients last year. SMS received direction from the Health District by way of a letter from Dr. Heck, indicating that because the Lake Mead Recreational area (LMRA) is more than 30 minutes from the Trauma Center, patients should be transported to the closest facility, which is defined in the Trauma Patient Destination Protocol under section IV, Mr. Wilson continued. It states in the protocol, "If the transport time to the Trauma Center is more than 30 minutes, transport the patient to the nearest appropriate hospital". He said SMS met a lot of resistance adhering to the protocol, by transporting the patients to the closest appropriate hospital. His interpretation of that section of the protocol is the 30 minutes begins from the time the patient is injured versus the time paramedics arrive on scene. And the response time for any provider to the LMRA is easily 15-20 minutes from the time of the call to the time of access to the patient. Then there is additional time spent on scene. In the event of a water incident, the patient has to be extracted from the water to the land, to get them either in an ambulance or a helicopter, and transported. So even if the patient is transported by helicopter the transport time is over the 30-minute time limit, from time of injury to time of transport, he attested. He asked the MAB and the facility EDs involved, which are St. Rose Dominican, St. Rose Siena, and Boulder City, to honor the TPDP or give him some direction as to what his crew should do when they have patients that fall under this protocol for ground or air transport.

A comment from the board was the 30 minutes is meant to be interpreted as transport time not scene time.

Dr. Slattery asked Mr. Wilson why wouldn't he take a patient that meets destination criteria to the Trauma center.

Mr. Wilson replied, "I'm not saying we wouldn't. I'm saying by protocol we're told to take them to the closest facility". He pointed out that the patient is always more stable in the facility EDs than in the back of an ambulance. The patient is always going to receive a higher level of care in the ED. So even if the patient meets destination criteria and they are transported to the nearest appropriate hospital, the hospital ED can stabilize them, evaluate them and then transfer them to the Trauma Center.

Dr. Slattery pointed out the TPDP is a guideline and by State Regulation there are two types of trauma patients that should be taken to the closest facility; patients with unsecured airways, and the patient in traumatic arrest. However, that this doesn't preclude SMS from transporting patients to the Trauma Center. It is in the best interest of the patient to be transported to the Trauma Center.

Mr. Wilson explained the issue is a complex one-two issue. One is the patient meets criteria based on mechanism but their injuries do not show that and the TPDP protocol does not correspond with what the American College of Surgeons' new Trauma Destination Protocols are. He inquired if the patients meet protocol by mechanism, but their injuries do not coincide with that, why couldn't a stable patient who meets protocol go to the closest facility?

Dr. Davidson noted this issue is listed on the agenda as a non-action item, therefore he suggested the issue be added to the next MAB consent agenda and referred to the appropriate committee or task force.

Rory suggested having Mr. Wilson's request reviewed by Dr. Heck, Dr. Slattery and the EMS staff and brought back to the MAB rather than starting a whole committee.

A comment from the audience was the issue is SMS prefers to transport by ground. They refuse to use helicopter transport. Patients who meet trauma criteria should be transported to the Trauma Center via air flight.

Physician comments were:

- Taking a trauma patient to a facility other than the Trauma Center delays the care of the patient, therefore a patient meeting trauma criteria should be taken to the trauma center via air flight.
- The protocol specifically states the appropriate facility, and in this valley the appropriate facility for a trauma patient is the trauma center.
- Short term, it is advisable to bring patients who meet trauma criteria to the trauma center by aircraft as quickly as possible. Long term, the language in the Nevada statutes and the TPDP should be modified so that there is no question that these patients should be transported to the trauma center.
- There appears to be confusion with patients who are stable in the A category but they meet criteria based on mechanism. If the patient meets trauma criteria in any way they should be put in the high risk trauma category and transported by air, regardless of whether they are stable or not.

Dr. Daitch commented many times patients were transported to Boulder City Hospital (BCH) based on the assessment in the field that the patient was thought to be stable even though they ended up having a ruptured spleen and descended by the time they arrived at the hospital. Protocols are set up not because the patient is unstable but because it was the mechanism of the injuries that created an unstable patient. Patients become unstable and that is what the golden hour is all about and the 30 minutes transport time is a recommendation. If the estimated transport time for a trauma patient is longer than 30 minutes, they should be transported to the Trauma Center via air. Because in transporting them to BCH, the time involved to get a surgeon in to treat that patient would be long beyond the time when the patient is going to be able to be resuscitated. Many times the situations when BCH have had to transport those patients to the Trauma Center, from the time that the helicopter arrives at the facility, and the transport limit, there is another hour of delay and the patient is going to elapse on the way.

After much discussion it was decided to have the issue reviewed by EMS staff and brought back to the MAB committee.

IV. PUBLIC APPEARANCE/CITIZEN PARTICIPATION

No Response.

V. ADJOURNMENT

As there was no further business, Chairman Davidson called for a motion to adjourn. The motion was seconded and passed unanimously to adjourn at 4:41 P.M.