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

MEMBERS PRESENT

Allen Marino, M.D., St. Rose Siena Dominican Hospital
David A. Rosin, M.D., Mental Health & Development Srvcs.
David Daitch, D.O., Boulder City Hospital
David Watson, M.D., Sunrise Hospital
Donald Kwalick, M.D., Clark County Health District
Donald Reisch, M.D., Desert Springs Hospital
Jeff Davidson, M.D., Chairman, Valley Hospital
John J. Fildes, M.D., University Medical Center
Jon Kingma, EMT-P, Boulder City Fire Department
Kurt Williams, American Medical Response
Pam Turner, R.N., Valley Hospital, Nurse Manager
Philis Beilfuss, R.N., North Las Vegas Fire Department
Division Chief Randy Howell, Henderson Fire Department
Richard Henderson, M.D., St. Rose DeLima
Rick Resnick, Mesquite Fire & Rescue
Sam Kaufman, Desert Springs Hospital
Timothy Vanduzer, M.D., Mountain View Hospital
William Harrington, M.D., University Medical Center

ALTERNATES

Brian Rogers, Southwest Ambulance
Russ Cameron, Clark County Fire Department
Tim Crowley, Las Vegas Fire & Rescue

MEMBERS ABSENT

Darrin Houston, D.O., Lake Mead Hospital
E. P. Homansky, M.D., Valley Hospital
Frank Pape, D.O., Summerlin Hospital
Kevin Slaughter, DO, Spring Valley Hospital
Michael Zbiegien, MD, Sunrise Hospital
Asst. Chief Mike Myers, Las Vegas Fire & Rescue
Pete Carlo, EMT-P, Southwest Ambulance
Chief Steve Hanson, Clark County Fire Dept.

CCHD STAFF PRESENT

Brian Labus, MPH, Epidemiologist
David Slattery, MD, EMS Assistant Medical Director
Jennifer Carter, Recording Secretary
Joseph Heck, MD EMS Medical Director
Mary Ellen Britt, RN, QI Coordinator
Rory Chetelat, EMS Manager

PUBLIC ATTENDANCE

Connie Clemmons-Brown, UMC
Don Abshier, CCFD
Ed Irwin, D.A.G.
Jackie Mador, Summerlin Hospital
Jacqueline Taylor, UMC
Jim Osti, WestCare Nevada
Kathy Kopka, Sunrise Hosp.
JoAnn Lujan, CTC
Marci Krieger, Lake Mead Hospital
Michael Metzler, Sunrise Hosp.
Roy Carroll, AMR
Scott Johnson, LVFR
Sue Hoppler, DSH
Davette Shea, Southern Hills Hospital

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, December 3, 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:

A. Minutes Medical Advisory Board Meeting October 1, 2003

B. Education Committee to Review Request for Revision of District Procedure for EMT-Paramedic Training

C. Equipment Committee to Review Combitube/Combitube SA Procedure Protocol

D. Official Air Ambulance, Ground ambulance, and Firefighting Agency Inventory

Chairman Davidson asked for a motion to approve the Consent Agenda Items. A motion was made, seconded and passed unanimously.

II. REPORT/DISCUSSION/POSSIBLE ACTION:

A. Procedure/Protocol Report

Dr. Watson reported the Procedure/Protocol Committee unanimously agreed to approve the Final Draft Protocol Manual with the Protocol Manual Summary of Changes. The goal is to have the educational supplement in place by January 15, 2004 and implementation of the Protocol Manual by no later than 90 days after the educational supplement is prepared.

Dr. Watson made a motion to endorse the Final Draft Protocol Manual with the Protocol Manual Summary of Changes. The motion was seconded and passed unanimously.

B. Divert Task Force Report

Patient Transfer to Receiving Facility Pilot (PTRF) Operations Protocol

a. Update

Chairman Davidson reported the PTRF Operations Protocol is officially in effect and will remain effective henceforth. Revised language in roman numeral II of the protocol will read; "EMS offload advisory: A facility or transport agency may update the EMSystem EMS Offload advisory column indicating the wait time at the facility. When any unit has been waiting for 15 minutes or more the system will be changed to yellow, when any unit is waiting more than 30 minutes the system will be changed to red and when any unit is waiting more than 60 minutes the system will be changed to black. The transport agency and the hospital personnel should be discussing the approximate wait times with each other prior to changes to the system. This is an advisory to assist the transport agencies with information to be relayed to patients prior to arrival at the facilities".

A motion was made to accept the new language in roman numeral II of the PTRF Operations Protocol. The motion was seconded and passed unanimously.

b. EMS Offload

Chairman Davidson reported concerns were raised that there has been enough conflict with facilities trying to get on and off open and closure in their regions. Consequently, the decision was made in the Divert Task Force to reinstate AMR as the operator of facility open and closure. Therefore all facilities will call in to AMR when they would like to close, at which time AMR would log a waiting time or times for the facility, within its region, into the EMSystem.

Chairman Davidson called for a motion to reinstate AMR as operator for open and closure of all the facilities in regions A, B, and C. The motion was made seconded and passed unanimously. An effective date has not yet been determined, pending software evaluation, expectantly by the first of the year.

c. Diversion

Rory Chetelat summarized there has not been any major changes in the Emergency Medical Services (EMS) offload. A majority of the nurse managers voiced their comments that receiving the EMSystem telemetries is helpful.

III. INFORMATIONAL ITEMS/DISCUSSION ONLY

A. L2K Patients – Changes to NRS

Dr. Rosin informed the board of the change to Legal 2000 (L2K) holds as a result of the last legislative session. He explained the 72-hour clock on a L2K hold starts when the emergency department (ED) physician certifies that the L2K patient is ready for transfer. Southern Nevada Adult Mental Health Services (SNAMHS) has been advised to operate within that 72-hour timeframe. The issue this poses for ED physicians is after a L2K patient is certified by the ED physician the patient could remain in the ED longer than 72 hours. He solicited input from the board.

ED Physicians raised multiple concerns by which a decision was made to develop an ADHOC committee comprised of nurse managers, ED physicians, Facility Advisory Board members, Health District members, and anyone else who may be interested in participating, to discuss and formulate a uniformed approach to the legislative change of the L2K 72-hour holds.

Dr. Rosin affirmed SNAMHS received funding to build a 150-bed facility and will be increasing emergency triage beds to thirty. Initial plans and a building site, on the corner of Oakey and Jones, have been obtained for the new facility. The new facility is projected to open January 2005. He announced a community meeting was scheduled to be held at Easter Seals located at 6200 Oakey Street, to dispel community fears relative to the placement of the hospital. Residents are concerned and very vocal about allowing the building of the facility in the neighborhood due to the misunderstanding of the type of patients that will be treated at the facility. Residents are fearful that felons and similar types of patients would be treated there. SNAMHS will be conducting a high power presentation at the community meeting and Dr. Rosin solicited support from the group in enlightening concerned residents on what type of patients would be treated, and how, at the new facility.

B. Update for Community Triage Center (CTC)

Joann Lujan, CTC Director, distributed an October 2003 CTC monthly report to the board members. Ms. Lujan reported the CTC is operating at reduced staffing but that does not affect the CTC services. The CTC continues to provide 24-hour transport, mental health services, and substance abuse services. Contrary to the newspaper articles, the CTC is not closed and is not going to close.

The CTC is in the process of moving to bulk medications in an effort to reduce medication costs, Ms. Lujan continued. She submitted a list of the CTC's primary formulary, however the CTC will stock bulk medications on site. She asked the ED physicians to be conscientious of the cost of the medications prescribed to the patients.

The patients that recycle through the system on a frequent basis should be limited in the amount of time spent in the EDs. Those patients should be sent back the CTC as soon as possible by the EDs in an effort to discourage them from misusing the system, Ms. Lujan recommended.

Davette Shea announced the Blue Ribbon Committee is scheduled to meet in December and January for which the exact dates are currently being determined. Having received support from the State of Nevada, the committee plans to address the repeaters in the system. She further stated the committee assembled a group of resource individuals within the community and is collaborating to prepare interim solutions to bring to the FAB and MAB.

C. ED Nurse Managers Report

Pam Turner reported the nurse managers met at Boulder City Hospital, October 24, and at Mountain View November 21. At the Boulder City meeting the nurse managers spearheaded an effort to try to go through the Interim Finance Committee to get some additional funding for the mental health issues. The funding was not authorized, however there was a lot of effort by a lot of people that Ms. Turner felt deserved acknowledgement. She congratulated everyone for pulling together to obtain pertinent signatures, and compose letters in very short amount of time. She recognized Jim Osti for his hard work in organizing the effort.

D. QI Report

Dr. Slattery gave a presentation on non-transports. He pointed out that non-transports are a high-risk commodity in EMS. Several high-risk non-transport cases have surfaced in the past two years. In light of the volume of patients and the pressures that the paramedics have, with ED overcrowding, etc., sometimes decision making is sub-optimal. Some agencies in the last two years have had non-transport rates up to 50%, which is very high.

A study was conducted on every non-transport in the system in all of Clark County, January 2002. EMS agencies were blinded to the purpose of the study although they were given two weeks to understand what they needed to submit to the EMS office. Dr. Heck and Dr. Slattery reviewed every chart with a prospectively defined data collection tool. The purpose was three-fold:

1. To quantify and define the problem. How many high-risk patients were not getting transported and why?

High risk was defined as a patient with a high-risk chief complaint i.e., chest pain, patients with abnormal vital signs, patients with impaired decision making capacity or communication barriers, and patients that had some sort of advanced procedure done, i.e., EKG, an IV was established, ALS level of medications were given, and the patient was still released and non-transported.

2. To assess how well EMS evaluations are completed in terms of looking out for life threats, considering life threats, and then documenting that those risks were at least considered and communicated to the patient.

The assessment involved analyzing the adequacy of the history, physical exam, and abnormal vital signs if they were present, were they addressed, and were they repeated.

3. To evaluate how well EMS is doing in terms of the entire decision making process of completing an Against Medical Advice (AMA) form.

The assessment involved reviewing the documentation to determine whether or not risks were explained and understood where those were documented, and how much effort the provider put forth to encourage the patient to go to the hospital. Some surrogates of the amount of effort were the scene times, whether or not the paramedic enlisted the help of others and whether or not medical control was contacted.

The data set was made up of 732 charts with complete data within the time frame of one month. The average age was 40.3 years.

35% of the patients that were signed out AMA during that month were deemed high-risk. Six chief complaints included, shortness of breathe, chest pain, altered mental status, abdominal pain, and traumatic neck pain comprised 91% of all the high risk cases.

For documentation performance the providers did a very good job in terms of history and physical exams. There is room for improvement in recording vital signs; whether or not a complete set of vital signs were taken. A complete set of vital signs was performed less than half of the time on patients seen by EMS and then released; defining vital signs as blood pressure, pulse and respiratory rate. Chief complaints of chest pain or shortness of breath would require a pulse oximetry in the chart.

Paramedics repeated only 8% of abnormal vital signs prior to leaving the patients. Dr. Slattery stressed the importance of repeating vital signs on patients with abnormal vital signs. Decision-making capacity was assessed in approximately 40% of the patients, specific risks were explained in approximately 15% of the cases and an AMA form was completed in almost 90% of the cases.

In summary Dr. Slattery recommended the need to focus educational performance improvement efforts on the red flags in the system. Six high-risk chief complaints; be able to address and repeat abnormal vital signs; document better in terms of decision making capacity; and develop a process to integrate online medical control to assist with persuading those high-risk patients to go to the hospital.

E. ED Divert Statistics

Not available

IV. PUBLIC APPEARANCE/CITIZEN PARTICIPATION

Brian Labus, MPH, CCHD, Office of Epidemiology, presented a 2003 Influenza Update. Mr. Labus reported, for Epidemiology purposes, the clinical definition of influenza in the clinical surveillance system is “patients with a temperature over 100 Fahrenheit and either cough or sore throat”. The syndromic surveillance system is based on patient complaints listing fever and either cough or sore throat. The sentinel site surveillance chart indicated a substantial increase of cases in hospitals and clinics. The school-based system did not indicate as much of an increase.

The graphs presented by Mr. Labus indicated the influenza season is starting much earlier in Clark County this year, in comparison to the previous three years. In fact the Center for Disease Control (CDC) has indicated that since they

started their monitoring system in the 70's this is the earliest they have seen the onset of influenza nation wide. Early influenza onset typically means a much more severe flu season.

Mr. Labus presented a graph on the severity of the flu season, which indicated the numbers of influenza cases are increasing more rapidly than the previous three years. The majority of the widespread influenza activity is occurring in the Western United States, Mr. Labus reported, and for week 47, two weeks ago in Nevada, it became widespread as a result of a minimum of thirty-four confirmed cases involving Washoe County, Mineral County, and Clark County. A majority of the cases were Influenza A H3N2.

The antigenic characterization is based on 3000 samples of flu virus that the CDC has received this year, Mr Labus continued. Almost all of them are influenza A. The CDC typed out some of the influenza A cases and almost all of those were H3N2. Of the H3N2 18% were similar to the A/Panama/2007/99 strain which is in the vaccine. 82% are similar to a Fujian strain, which is called a drift variance of the vaccine strain. Therefore, it is similar to one of the strains contained in the vaccine but not identical. It is thought that the vaccine would give some protection against this variance strain.

In summary the flu season arrived much earlier than in the past three years; has the potential to be much more severe than previous seasons; and the predominant strains are covered by the vaccine. Recommendations at this point are to ensure that all staff has been vaccinated against influenza, Mr. Labus proceeded. One of the big problems, in Washoe County was, unvaccinated health care workers, who were also getting the flu, causing a shortage of medical staff. He emphasized hand washing among staff members in an effort to minimize transmission. He encouraged vaccination for all age groups, particularly children. Children have been hard hit by this year's flu strain. It was reported in Colorado that four children died from influenza this year, very early on, which is a rare occasion. It seems like there is a much stronger affect on children this year than in the past. CCHD requests that providers in outpatient settings provide masks for potential influenza outpatients when patients check in to the clinics. So if somebody comes in to the clinic with respiratory symptoms and they are coughing, provide a mask so as to hopefully minimize the spread to other people who have visited that clinic. An additional recommendation by some places, but not one that CCHD is officially making, is that some places cohort the patients by separating people with respiratory symptoms from those with other types of symptoms so as not to spread the flu from one group to another.

Mr. Labus was asked by the board to provide an influenza update at the next MAB meeting in January.

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 5:09 P.M.