MINUTES
EMERGENCY MEDICAL SERVICES
MEDICAL ADVISORY BOARD MEETING
OCTOBER 5, 2005 – 3:30P.M.

MEMBERS PRESENT

Richard Henderson, M.D., Chairman, Henderson Fire
Philis Beilfuss, R.N., North Las Vegas Fire Department
E. P. Homansky, M.D., American Medical Response
Chief Mike Myers, Las Vegas Fire & Rescue
Allen Marino, M.D., NLVFD and Medicwest Ambulance
Lawrence Pellegrini, D.O., Las Vegas Fire & Rescue
Dale Carrison, D.O., Mercy Air and Clark County Fire Dept.
Thomas Geraci, D.O., Mesquite Fire & Rescue
Chief Randy Howell, Henderson Fire Department
Rory Chetelat, M.A., EMT-P, EMS Manager, CCHD
Kurt Williams, American Medical Response
Chief Russ Cameron, Clark County Fire Department
Brian Rogers, EMT-P, Medicwest Ambulance
Brian Fladhammer, Mercy Air Service, Inc
Jon Kingma, EMT-P, Boulder City Fire Department
David Daitch, D.O., Boulder City Hospital
Chief David Petersen, Mesquite Fire & Rescue
Joseph J. Heck, D.O., Operational Medical Dir. (Alt.)

CCHD STAFF PRESENT

Trish Beckwith, Field Representative
Judy Tabat, Administrative Assistant
Lawrence Sands, D.O., Dir. Of CHS
Mary Ellen Britt, R.N., Quality Improvement Coordinator
Moana Hanawahine-Yamamoto, Recording Secretary

PUBLIC ATTENDANCE

Scott Vivier, EMT-P, Henderson Fire Department
John J. Fildes, M.D., University Medical Center - Trauma
Jo Ellen Hannom, R.N., Clark County Fire Department
Steve Patraw, EMT-P, Medicwest Ambulance
Dr. Craig Morrow, Southwes Medical Associates
Michelle McCallum, A.P.N., WestCare
Aaron Harvey, EMT-P, Henderson Fire Department
Donald Hales, EMT-P, Medicwest Ambulance
Donald Thompson, EMT-P, Las Vegas Fire & Rescue
Roy Carroll, American Medical Response
Sandy Young, R.N., Las Vegas Fire & Rescue
Derek Cox, EMT-P, American Medical Response
Larry Johnson, EMT-P, Medicwest Ambulance
Michael Coleman, Southwest Medical Associates
Trent Jenkins, EMT-P, Clark County Fire Department
John Higley, EMT-P, Mesquite Fire & Rescue
David Nehrbus, American Medical Response

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The Medical Advisory Board convened in the Clemens Room at the Ravenholt Public Health Center at 3:39 p.m. on Wednesday, October 5, 2005. The meeting was called to order by Chairman Richard Henderson. He stated that 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 Henderson noted that a quorum was present.

I. CONSENT AGENDA

A. Minutes Medical Advisory Board Meeting September 7, 2005

Chairman Henderson stated the Consent Agenda consisted of matters to be considered by the Medical Advisory Board that can be enacted by one motion. Any item may be discussed separately per Board member request. Any exceptions to the Consent Agenda must be stated prior to approval. A motion for Board approval of the minutes as written was made, seconded, and carried unanimously.

B. Endorse Draft Changes to EMS Regulations

A motion for Board endorsement of draft changes to EMS Regulations was made, seconded and carried unanimously.

II. REPORT/DISCUSSION/POSSIBLE ACTION

A. Priority Dispatch Task Force

Activation of Card # 33 and Determination of Acuity Levels I-III

Dr. Lawrence Pellegrini advised that the subcommittee initially added psychiatric social worker or mental health professional under key question #1 but then, decided to remove it. The subcommittee also deleted C6: Emergency Response Requested and removed Failure to Thrive and Psychiatric Evaluation without other medical component under Acuity Levels I-III. Finally, Urgent Care and Psychiatric Facility were added to Purpose and Use of Transfer, Interfacility, and Palliative Care Protocol. Philis Beilfuss from North Las Vegas Fire Department made a motion to approve the amendments.

Dr. Dale Carrison voiced his concern over the removal of psychiatric social worker or mental health professional because the Southern Nevada Adult Mental Health Services (SNAMHS) has difficulty handling their current volume of mental health patients.

Rory Chetelat from the Health District added that he spoke to Jonna Triggs at SNAMHS and explained that the Health District was uncomfortable adding the psychiatric social worker or mental health professional language under key question #1 because they cannot legally determine whether or not a person is medically stable for an interfacility transfer. Ms. Triggs advised that there are only about 5% of SNAMHS' patients that are not evaluated by a physician or nurse; therefore, she would work with her staff to ensure that a physician or nurse would evaluate every patient before the request for interfacility transfer was made. Dr. Joseph Heck also noted that the Health District has the ability to QA the number of calls from SNAMHS that end up in a Code 3 response.

Dr. Richard Henderson was concerned with the removal of C6. If a medical facility called about a patient who may be having an acute stroke and the patient's mental status is normal, how would a Code 3 response be triggered on card #33? Mr. Chetelat mentioned that a medically trained person would be able to put the patient into one of the categories on card #33 to receive the appropriate response.

Scott Vivier from Henderson Fire Department stated that 33C6 was the second most populous call in the city of Henderson for 2004. This amount of demand puts a huge burden on the fire departments. Russ Cameron from Clark County Fire Department added that his office met with some of these medical facilities and has been told that they are inappropriately changing the level of response to expedite transport.

Mr. Vivier noted that the subcommittee discussed defining the Acuity Levels as non-emergency responses but it may be better to define the Acuity Levels for emergency responses like suspected stroke. Dr. Henderson asked that C6 be removed after the Acuity Levels have been defined. Mr. Vivier added that the medical facilities should not be allowed to just say send an ambulance Code 3. They should be forced to go through the questions and let the key determinants determine the type of response. C6 is the only place in Emergency Medical Dispatch (EMD) where there is no determinant. Mr. Vivier did note that if the person on the other line is not able to answer any of the questions on card #33, it would fall under card #1-32 and receive the appropriate response. The goal is not to eliminate response but to determine which calls require dual response.

Dr. Joseph Heck noted that the subcommittee has already approved the low acuity or alpha calls which would be 33A1 and would receive a non-emergency response. All of the other calls would be 33A3 which would receive an emergency response. Dr. Heck stated that the subcommittee would make the criteria on the back

as the low acuity or non-emergency responses and the private ambulance companies would only respond to those calls while everything else would receive a dual response from the fire department as well. There would only be 33A1 and 33A3. Mr. Cameron stated that the community of Austin has been using Acuity Levels I-III as filters as well.

Mr. Cameron noted that he would like to see data on the affect these changes would have on the call volume for the fire departments because he is concerned that there may be a large increase to the call volume. Brian Rogers from MedicWest Ambulance stated that initially there will probably be a huge increase in the call volume for the fire departments but through community-wide education this amount will begin to drop.

Dr. Pellegrini withdrew the earlier motion made by Ms. Beilfuss and made a motion to refer card # 33 back to subcommittee for further discussion. The motion was seconded and carried unanimously by the Board.

B. Discussion of Maximum Allowable Dose of Etomidate in BLS/ILS/ALS Protocols

Dr. Heck explained there was some concern as to whether or not there should be a maximum allowable dose for etomidate. Currently, the protocol states the dosage for etomidate as 0.15 for sedation and 0.30 for induction. Ms. Beilfuss stated that the heavier patients are getting up to 40mg and higher.

Trish Beckwith stated that the previous protocol for etomidate was on a sliding scale of 0.2-0.6 and there was no clear direction of where to start or how to address repeat doses. Dr. David Slattery and Ms. Beckwith researched the issue and found 0.3mg/kg was the generalized dose for induction. Ms. Beckwith also noted that some field personnel have said that 20mg is not enough for heavier anxiety ridden patients.

Dr. Heck added that the previous version of this protocol had the sliding scale 0.3-0.6 (common dose 20mg) and there were reports that 20mg was not enough so during the recent revision to the the protocols it was changed to 0.15 for sedation and 0.30 for induction.

Dr. Carrison and Dr. Allen Marino asked that the etomidate issue to be referred to the QI committee to determine whether or not there is really a problem with the current dose in the protocol.

Dr. Henderson stated there would no action on this matter.

C. Discussion of Cardiac Dysrhythmia: Polymorphic Ventricular Tachycardia/Torsades De Pointes Protocol

Dr. Heck stated that there was a request to review the cardiac dysrhythmia protocols to make the format or flow more clear. The original request was to breakout hemodynamically unstable and stable but there was still some confusion.

The Monomorphic Ventricular Tachycardia addresses the hemodynamically unstable patients. There really was no significant change to the treatment other than making sure that they shock after each drug. All Polymorphic Ventricular Tachycardia will be considered torsades and magnesium was added for the unstable patient. The flow for unstable will be shock, sedate, magnesium, shock again, lidocaine, shock again. The only change to the Supraventricular Tachycardia protocol was a change to the format of unstable and stable patients so that it matched the rest of the cardiac dysrhythmia protocols.

Dr. Carrison made a motion to accept the changes to the Cardiac Dysrhythmia: Polymorphic Ventricular Tachycardia (Torsades de Pointes), Cardiac Dysrhythmia: Supraventricular Tachycardia (Narrow Complex) and Cardiac Dysrhythmia: Monomorphic Ventricular Tachycardia protocols. The motion was seconded and passed unanimously by the Board.

D. Discussion of Pediatric Dose of Diazepam (Valium) in BLS/ILS/ALS Protocols

Don Thompson from Las Vegas Fire & Rescue voiced a concern that the pediatric dose for Diazepam in the protocols was too high and he felt it should be changed to a standing order rather than requiring telemetry contact.

Mr. Thompson explained that he has had experience as a pediatric ED nurse and asked a physician in the ED about the pediatric dose noted in the current protocols. The physician stated that it should be between 0.1-0.2kg/mg for a child with a static seizure. The current protocol allows 0.3mg/kg IV with a maximum dose of 10mg. Therefore, a 33 kilo child can be given 10mg as an initial dose but an adult who has a seizure would only receive 5mg as an initial dose.

Mr. Thompson further stated that the requirement for telemetry contact delays treatment. Once they are dispatched, it could take several minutes to contact the hospital then give the report to the physician so that the physician can finally give you an order on the dose to give to the child. Mr. Thompson suggested having a standing order at 0.1-0.2mg/kg.

Mr. Thompson researched the pediatric dose for Diazepam given in Canada and some of the other states and submitted the handouts for review. He noted that most of them have lower doses per kg or a lower maximum dose of 5mg. Also, all of these protocols were standing orders that did not require telemetry contact.

Dr. Heck mentioned that the pediatric physicians really need to be involved in these discussions because they were all in agreement when this protocol was initially approved and they were adamant that it not be a standing order.

Dr. Carrison made a motion to refer the pediatric dose for Diazepam back for further discussion and to invite the pediatric physicians to take part. The motion was seconded and passed unanimously by the Board.

III. INFORMATIONAL ITEMS/DISCUSSION ONLY

A. Quality Improvement Meeting Update

Mary Ellen Britt stated each EMS agency reviewed their pediatric intubation cases. The larger EMS agencies reported 1-2 pediatric intubations per month while the smaller EMS agencies reported zero cases within the past 6 months. None of the agencies have received direct communication from any of the area Emergency Departments (ED) about problems with pediatric intubations performed in the field. The EMS office also has not received any complaints about problems with pediatric airway management. However, the committee has agreed that airway management is a very important issue and will begin a study on airway management for all ages by using the NAEMSP dataset. Then, stratify by age and review the etomidate issue as part of the study.

Dr. Michael Zbiegien mentioned that he has not seen any problems with successful intubations in the field but has noted the difficulty of having the tube adequately secured. The committee also encouraged good education. Paramedics are currently required to attend a PALS/PEPP course which stress bag valve mask as the first line of treatment for pediatric airway management. The committee also recommended that all pediatric intubations be reviewed by the EMS agencies medical directors and asked if the Board members could encourage ED personnel to communicate directly with the EMS agencies and EMS office.

B. Trauma System Development Update

Mr. Chetelat mentioned that the Regional Trauma Advisory Committee (RTAC) will not have an October meeting. He also noted that the some of the RTAC members participated in the After Action report regarding the Mass Casualty Incident that took place on the Strip.

C. Southwest Medical Associates/AMR Alternate Destination Transport Proposal

Kurt Williams reported that American Medical Response and Southwest Medical Associates (SMA) have been discussing a pilot study Alternate Destination Transport Proposal. Craig Morrow, Medical Director for SMA, explained that the pilot study would include SMA patients only. It would be by patient request and would follow strict protocol criteria. The intent is to help relieve some of the lower acuity level patients from the Emergency Departments which in turn would lower wait times for EMTs at the hospitals. The pilot study would take place at SMA's Urgent Care facility located on Rancho. It is a 24-hour facility which operates 365 days a year. This facility currently services almost 4000 patients a month. Dr. Homansky added that the current system isn't perfect and if there are additional services available that could improve patient care across the Valley, like having his/her medical records available in real time, it should at least be considered.

IV. PUBLIC APPEARANCE/CITIZEN PARTICIPATION

No response.

V. ADJOURNMENT

As there was no further business, Chairman Henderson called for a motion to adjourn. The motion was seconded and passed unanimously to adjourn at 4:39 p.m.