MINUTES
EMERGENCY MEDICAL SERVICES
MEDICAL ADVISORY BOARD MEETING
May 3, 2006 – 11:00A.M.

Richard Henderson, M.D., Chairman, Henderson Fire
Tim Crowley, EMT-P, Las Vegas Fire & Rescue (Alt.)
Allen Marino, M.D., NLVFD and MedicWest Ambulance
Lawrence Pellegrini, D.O., Las Vegas Fire & Rescue
E. P. Homansky, M.D., American Medical Response
David Daitch, D.O., Boulder City Fire Department
Jon Kingma, EMT-P, Boulder City Fire Department
Trent Jenkins, EMT-P, Clark County Fire Dept (Alt.)
Brian Rogers, EMT-P, MedicWest Ambulance
Kurt Williams, American Medical Response
Chief David Petersen, Mesquite Fire & Rescue
Randy Howell, EMT-P, Henderson Fire Department
Thomas Geraci, D.O., Mesquite Fire & Rescue
Philis Beilfuss, R.N., North Las Vegas Fire Dept

MEMBERS ABSENT

Dale Carrison, D.O., Mercy Air and Clark County Fire Dept.
Russ Cameron, EMT-P, Clark County Fire Dept
Brian Fladhammer, Mercy Air Service, Inc
Chief Mike Myers, Las Vegas Fire & Rescue

SNHD STAFF PRESENT

Rory Chetelat, M.A., EMT-P, EMS Manager, SNHD
Joseph J. Heck, D.O., Operational Medical Dir
David E. Slattery, M.D., Asst. EMS Medical Director
James Osti, Administrative Analyst
Mary Ellen Britt, R.N., Quality Improvement Coordinator
Moana Hanawahine-Yamamoto, Recording Secretary
Eddie Tajima, Administrative Assistant
Trish Beckwith, Field Representative

PUBLIC ATTENDANCE

Jo Ellen Hannom, R.N., Clark County Fire Department
Roy Carroll, American Medical Response
Ann Lynch, Sunrise Hospital
Davette Shea, R.N., Southern Hills Hospital
Ken Wong, Sunrise Hospital
Debbie Estes, R.N., Sunrise Hospital
Rob Nichols, EMT-P, American Medical Response
Susie Kochevar, RN, MedicWest Ambulance
Wade Sears, M.D., MountainView/Southern Hills
Natalie Seaber, R.N., MountainView Hospital
Steve Patraw, EMT-P, MedicWest Ambulance
Steve Kreps, Mercy Air Service, Inc.
Lauri Carlson, Red Rock
Nancy Harpin, R.N., Univeristy Medical Center
Derek Cox, EMT-P, Las Vegas Fire & Rescue
Jerry Newman, Specialized Medical Services
Larry Johnson, EMT-P, MedicWest Ambulance
Nicole Bachmann, Touro University
Ron Tucker, MedicWest Ambulance
John Higley, EMT-P, Mesquite Fire & Rescue
Tricia Klein, EMT-P, American Medical Response
Rod Hackwith, EMT-P, Community College of S. Nevada
Joseph Melchiode, MountainView Hospital
Jayme Ching, R.N., University Medical Center
Sheryl Hiller, APN, WestCare
Maurice Lee, WestCare
Stella Brysken, Montevista

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The Medical Advisory Board convened in the Clemens Room at the Ravenholt Public Health Center at 11:01 a.m. on Wednesday, May 3, 2006. 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

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. Minutes Medical Advisory Board Meeting April 5, 2006

A motion for Board approval of the minutes as written was made, seconded and carried unanimously.

B. Discussion of Revisions to Trauma Field Triage Criteria Protocol to be Referred to Procedure/Protocol Committee

The revisions to the Trauma Field Triage Criteria Protocol were referred to the Procedure/Protocol Committee.

C. Discussion of Standardized Format for Trauma Telemetry Reporting to be Referred to Procedure/Protocol Committee

The Standardized Format for Trauma Telemetry Reporting was referred to the Procedure/Protocol Committee.

II. REPORT/DISCUSSION/POSSIBLE ACTION

A. Drug & Device Committee

Discussion of Request to Pilot The Intubate Mate™

Dr. Allen Marino advised that the committee did not have a quorum so the meeting would be deferred until next month.

B. Procedure/Protocol Committee

1. Discussion of Revisions to BLS/ILS/ALS Protocols due to changes in AHA Guidelines

Dr. Heck noted that the American Heart Association is a guideline and as such we adopted those changes that we deemed to be appropriate for our system based on the practices that go on within our community in cooperation with the emergency department physicians and the practicing cardiologists.

Dr. Heck then reviewed each protocol noting the changes that were recommended:

- Acute Coronary Syndrome (Suspected) – To clarify intent of when Nitroglycerin should be administered; removed "chest pain" and replaced with "ischemic discomfort"
- Cardiac Arrest – Housekeeping changes using the phrase "has return of spontaneous circulation" as opposed to successful AED use; discussed the differences between witnessed and unwitnessed arrest and implementing the (2) minutes of uninterrupted CPR in unwitnessed arrest prior to defibrillation
- Cardiac Dysrhythmia: Asystole – Dr. Heck noted that transcutaneous pacing was removed since it was no longer recommended in asystolic arrest; changes were made to the Atropine dose of 1 mg to a total of 3 mg; it is no longer a weight based dose; the pediatric epinephrine dose will go up to a total not to exceed the adult dose; and we will continue to include Sodium Bicarbonate.
- Cardiac Dysrhythmia: Bradycardia – Changes to the dose of Atropine to reflect the total maximum dose of 3 mg
- Cardiac Dysrhythmia: Monomorphic Ventricular Tachycardia – Removed the telemetry requirement for cardioversion in the pediatric patient; made the changes from Versed to Etomidate for sedation in the pediatric patient; put in the opportunity to reassess for additional sedation prior to further

cardioversion and added a repeat dose of Amiodarone as opposed to Lidocaine. Dr. Heck also noted that Lidocaine will be removed from the formulary.

- Cardiac Dysrhythmia: Pulseless Electrical Activity – The substantive change was the Atropine dose.
- Cardiac Dysrhythmia: Supraventricular Tachycardia (Narrow Complex) – The pediatric dose of Adenosine was added; changed the sedation from Versed to Etomidate and deleted the use of Amiodarone for SVT
- Cardiac Dysrhythmia: Torsades De Pointes – Removed the telemetry requirement for an unstable pediatric patient; made the change from Versed to Etomidate for sedation of the pediatric patient and removed Lidocaine.
- Cardiac Dysrhythmia: Ventricular Fibrillation or Pulseless Ventricular Tachycardia – Made changes for witnessed and unwitnessed cardiac arrest and the (2) minutes of CPR in the unwitnessed arrest; Amiodarone in lieu of Lidocaine which would make the 1st dose at 300 mg IV and the 2nd dose would be 150 mg IV. Dr. Heck explained that the 3rd dose in renumbered #8 will be deleted along with renumbered #9; there were two repeat doses of amiodarone but there should only be one.
- Defibrillation – Reflects the changes for witnessed and unwitnessed cardiac arrest; a witnessed arrest is a witnessed arrest by EMS personnel not a bystander witness.
- Synchronized Cardioversion – Dr. Heck stated that the two paragraphs under #6 regarding pediatric cardioversion will be deleted. They were put in for clarification but it made it more confusion so they will be removed.
- Formulary – The respective changes that reflects what was done in the treatment protocols will be made.

Dr. Heck added that the treatment for ventricular ectopy is Lidocaine and since Lidocaine has been taken out of every other ventricular dysrhythmia protocol and the AHA no longer treats ventricular ectopy we should delete this protocol entirely. The only place that Lidocaine appears in any of the protocols is in the advanced airway for the pre-medication of the head injured patient upon intubation. There was discussion on the literature in support of using lidocaine in that type of a situation and it is weak at best so it was recommended to remove lidocaine from the advanced airway management protocol. Once this is removed, lidocaine will no longer appear in the Health District's protocols and therefore, lidocaine will come off of the formulary.

Dr. Allen Marino made a motion to approve the recommended changes and modifications as discussed. The motion was seconded and passed unanimously.

2. Discussion of Revisions to Prehospital Death Procotol

Dr. Slattery stated that the recommended revisions to the Prehospital Death Determination protocol were based on areas that were identified during the study. All (5) presumptive signs of death and at least (1) conclusive sign of death must be identified for the prehospital death determination protocol to be in effect. The first change is that there are now (5) presumptive signs of death: unresponsiveness, apnea, pulselessness, fixed dilated pupils and no electrical activity present on cardiac monitor. No electrical activity present on cardiac monitor was removed as a conclusive sign of death to a presumptive sign of death. The literature is clear that lividity, rigor mortis and body decomposition are conclusive signs of death. Injuries incompatible with life is somewhat vague therefore it was modified to the only true injuries incompatible with life: decapitation, transection of thorax (hemicorpectomy) or incineration. Finally, arrest from severe blunt trauma and penetrating head or neck injury were removed. The caveat for potential hypothermia in this protocol allows resuscitation to be initiated.

Trent Jenkins from Clark County Fire Department and Tim Crowley from Las Vegas Fire & Rescue voiced their concerns that no electrical activity present on cardiac monitor was moved to a presumptive sign of death. Their concern is due to the fact that when the call comes over from dispatch as an obvious death, it gets coded as an alpha call. Some of the units responding to these alpha calls are BLS/ILS units which do not carry monitors. This would require another unit to be dispatched for this requirement to be

made. Brian Rogers from MedicWest ambulance also noted that under the franchise agreement, they have twenty minutes to respond to alpha calls.

Dr. Marino suggested that since lividity and rigor mortis have not been studied and there is no validity for identifying lividity and rigor mortis in the field, remove no electrical activity present on cardiac monitor from a presumptive sign of death and modify conclusive signs of death so that lividity of any degree requires no electrical activity present on cardiac monitor and rigor mortis of any degree requires no electrical activity present on cardiac monitor as well.

Due to concerns raised in the meeting, Dr. Slattery suggested that the dispatch card for obvious death be reviewed and the prehospital death determination protocol come back next month for further discussion.

Dr. Marino made the motion to refer the Prehospital Death Determination protocol back to the Procedure/Protocol committee. The motion was seconded and passed unanimously.

Initially, the Prehospital Death Determination and termination resuscitation were lumped together in one protocol but the recommendation was to separate them into individual protocols. This protocol will include the patients that do not fall under the prehospital death determination protocol. There is a method and mechanism for termination of resuscitation so the changes that were made would be to specify the amount of time the resuscitation with ACLS care will be performed on scene. If the patient remains in persistent asystole or agonal rhythm after (20) minutes of appropriate ALS resuscitation to include:

- CPR
- Effective ventilation with 100% oxygenation
- Administration of appropriate ACLS medications
- Needle Thoracentesis for traumatic arrest

Then EMS personnel can call a code with a physician order. It was clarified that you do not have to achieve 100% oxygen saturation if you've got the patient intubated or you're ventilating with BVM with 100%, O_2.

In section 5b, item # 3, injuries incompatible with life was removed because that was vague.

Dr. Marino made the motion to break out termination of resuscitation into a separate protocol and approve the revisions suggested. The motion was seconded and passed unanimously.

III. INFORMATIONAL ITEMS/DISCUSSION ONLY

A. Trauma System Development Update

Mr. Chetelat advised that Mary Ellen Britt is the new Regional Trauma Coordinator. He also mentioned there would be a meeting following the MAB to discuss trauma telemetry reporting.

B. Presentation of STM

Bob Waddel introduced the Sacco Triage Method (STM) which is an evidenced based Triage method that will maximize the number of lives saved while using resources effectively. It was developed by Dr. Bill Sacco. Typically during a mass casualty incident, the system is designed to bring the worst patients first but this locks up resources quickly and at the sacrifice of other patients in the system. Dr. Sacco reviewed 35-40 years of research to find a better solution and found that one problem was that we can't get the prehospital, hospital and outcome data connected.

A tabletop was developed in Pennsylvania to study the way triage was performed. 270 providers participated from six regions and separated into teams of 3-5 people. There were 45 patients (20 red and 25 yellow). Cards were created and the providers were asked to triage these 45 patients into four color categories and prioritize them with #1 as the highest priority. Out of their top ten patients, all of these teams only had one patient in common. This exercise showed random selection.

The STM method would be used on every trauma patient. The system would be used as part of the normal daily routine. It puts a coded value with a score from 0-12 with no signs of life scoring a 0. Based on 102,000 patients, the STM method can give a 90% accuracy of how critical that patient is at the time of the assessment and 95+% accuracy of their potential discharge alive from the hospital. This method also covers the entire life span from cradle to coffin.

Mr. Waddel noted that the Nevada Hospital Association has begun training and will evaluate the process for implementation.

C. Clearance for Admission to WestCare Crisis Unit

Dr. Heck stated that a screening tool was developed to speed up the process of moving mental health patients out of the Emergency Departments (ED) to the WestCare facility. When a patient on a Legal 2000 is medically cleared, initially that patient would need to be evaluated by the Southern Nevada Adult Mental Health Services (SNAMHS) Crisis Team before they could be placed at WestCare or SNAMHS. This tool allows the ED physicians to evaluate the individual on ten criteria. If the answer to all of these criteria is No, then that person is cleared to go to WestCare without having to wait for the crisis team's evaluation. If any one of the boxes is checked yes, then that person must be evaluated by the crisis team. Dr. Heck mentioned that the form may be used immediately. Natalie Seaber requested that an electronic version be emailed to all of the ED Nurse Managers.

IV. PUBLIC APPEARANCE/CITIZEN PARTICIPATION

Debbie Estes, Stroke Coordinator at Sunrise Hospital, announced that as of February 21, 2006, Sunrise is the only Joint Commission on Accreditation of Healthcare Organizations (JCAHO) primary stroke center in southern Nevada.

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 12:01 p.m.