MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

MEDICAL ADVISORY BOARD MEETING

August 5, 2009 – 11:00 A.M.

MEMBERS PRESENT

Allen Marino, MD, Chairman, MedicWest Ambulance
Chad Henry, EMT-P, American Medical Response
Christian Young, MD, Boulder City Fire Dept
David Slattery, MD, Las Vegas Fire & Rescue
Jay Craddock, EMT-P, North Las Vegas Fire
Chief Scott Vivier, Henderson Fire Department
Jim Vivone, EMT-P, Boulder City Fire Dept (Alt)
Mark Calabrese, EMT-P, MedicWest Ambulance
Richard Henderson, MD, Vice Chairman, HFD
E.P. Homansky, MD, American Medical Response
Jarrod Johnson, DO, Mesquite Fire & Rescue
Dale Carrison, DO, Clark County Fire Department
Chief David Petersen, Mesquite Fire & Rescue
Troy Tuke, RN, EMT-P, Clark County Fire Department
Sandy Young, RN, LVF&R (Alt.)

MEMBERS ABSENT

Chief Bruce Evans, North Las Vegas Fire
K. Alexander Malone, MD, North Las Vegas Fire
Chief Mike Myers, Las Vegas Fire & Rescue
Chief Kevin Nicholson, Boulder City Fire Dept

SNHD STAFF PRESENT

Rory Chetelat, EMSTS Manager
John Hammond, EMS Field Rep.
Lan Lam, Recording Secretary
Mary Ellen Britt, Regional Trauma Coordinator
Trish Beckwith, EMS Field Rep.
Judy Tabat, Administrative Assistant

PUBLIC ATTENDANCE

Brian Rogers, EMT-P, HFD
Eric Dievendorf, EMT-P, AMR
Steve Patraw, Boundtree
Dan Petcavage, UMC
Rebecca Dennon, UMC
Susan Crowder, MountainView Hospital
Nancy Harpin, UMC
Ian Smith, EMT-P, North Las Vegas Fire
Sam Kaufman, Desert Springs Hospital
Kristine Bruning, RN, Summerlin Hospital
Kimberly Berry, Sunrise Hospital
Paula Gray, UMC
Afton Beckner, Valley Hospital
John Wilson, AMR/Medic West
Jacob Parr, NCTI
Patrick Bellay, NCTI
Mary Ann Dube, St Rose Siena
Patrick Bellamy, NCTI
Larry Johnson, EMT-P, MWA
J.D. Melchiode, MountainView Hospital
Michele McKee, MD, UMC
Shawn Underwood, EMT-I, AMR
James Holtz, RN, Valley Hospital
Amy Bochenek, Centennial Hills Hospital
Jackie Levy, UMC
Jennifer Poyer, RN, Desert Springs Hospital
Tricia Klein, NCTI
James Swift, MD, Sunrise Hospital
Evelyn Lundell, UMC
Anna Smith, Valley Hospital
Joseph Richard, Las Vegas Fire & Rescue
Shane Ford, Touro University
Jake Fan, NCTI
Lyndee Leifeste, Valley Hospital
Mike Rovere, NCTI
Nancy Harland, Sunrise Hospital

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The Medical Advisory Board convened in the Clemens Conference Room at the Ravenholt Public Health Center at 11:00 a.m. on Wednesday, August 5, 2009. The meeting was called to order by Chairman Allen Marino. 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 Marino noted that a quorum was present.

I. CONSENT AGENDA

Chairman Marino 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 following items on the Consent Agenda was made, seconded, and carried unanimously.

Minutes Medical Advisory Board Meeting June 3, 2009

II. REPORT/DISCUSSION/POSSIBLE ACTION

A. Report from Drug/Device/Protocol Committee

Dr. Henderson referred the Board to the finalized version of the BLS/ILS/ALS Protocol Manual. He commended the subcommittee for their efforts and for maximizing the time they were given. A motion was made to approve the draft BLS/ILS/ALS Protocol Manual as written. The motion was seconded and carried unanimously.

B. Report from QI Directors Committee

Dr. Slattery noted that the Committee met the prior month. The primary discussion was focused on the need to develop a performance measure to address improving the number of non-transports in our system, while keeping it safe. Also discussed was the desire to base future decisions on the principles of evidence based medicine.

C. Report from Pediatric Destination Task Force

Dr. McKee reported there was a lot of discussion about the pediatric destination protocols, and at this time there is no definitive recommendation from the Committee. At the next meeting they will continue to discuss whether the facilities' and state's 3-tiered system would work locally; consider appropriate tier levels for certain areas; and define what constitutes the benchmark of care for pediatric emergency medicine.

D. Best Practice Presentation

Tony Greenway thanked the MAB for the opportunity to speak to the MAB about the exciting research being conducted by MedicWest and AMR. He stated the Southern Nevada Frequent Users Group is a project that was born out of a paramedic intuition that they were transporting the same patients on a frequent basis. That anecdotal evidence was supported by personnel from healthcare facilities and emergency departments; they would be able to name patients as they were being wheeled into the ED without having to look at their charts. So, a few questions arose such as, "Is there truly a frequent users group in Southern Nevada? And if so, what does it look like and why would it exist?"

Mr. Greenway stated that the inclusion criterion for the study was 911 transports; they did not include interfacility and non-emergency transports. They looked at people who utilized the service at least four times in a month or more, which averages out to one transport by ambulance per week. They collected the data through building a search engine from both AMR's and MedicWest's billing database. This gave them the advantage to identify patients who utilized both services and thereby depict a more accurate picture. The research period was from June 2008 through December 2008.

The primary question was, "Does this population exist?" The answer is yes. They found 277 people who fit the inclusion criterion, which was a staggering number to the research team. There were a total of 2106 ambulance transports to area EDs. This subset of patients accounted for 13% of that total. The average range per patient

went from a low of 4 transports, to a high of 22 transports by one patient per month. For the six month period the range went from a low of 4 transports, to a high of 57 transports by one patient.

Following a PowerPoint presentation, Mr. Greenway listed the study group's findings:

1) The patients were predominantly middle aged males;
2) Drugs and alcohol were a factor most of the time;
3) The majority of the patients were stable, oriented, self-referred and typically uninsured or underinsured; and
4) This subset of patients significantly impacts the overall health system.

Mr. Greenway reported that the ambulance agencies estimate a $4 million impact annually, in addition to the impact on the overall health system when we consider the cost of emergency department visits. One question that arose was, "Are there places to address services to these patients outside of an emergency acute setting?"

Due to the fact this was a retrospective analysis based on patient care records, and the fact that EMTs don't usually document frequent users, the data may be understated. Also, the study included patients who utilized the service at least four times in one month, so if they utilized the system twice in one month and twice in the next month they were not included.

Mr. Greenway related that AMR and MW are committed to continuing the study and are looking for community partners to potentially identify services that may be available but aren't being utilized, such as Clark County Social Services (CCSS).

Dr. Slattery noted that an article was published addressing this issue with frequent users in the emergency departments. He asked what they plan to do with the information. Mr. Greenway stated they are not addressing the issue with patients on scene, but they are forwarding the information to CCSS to identify whether the frequent users are covered under any of the programs, and if so, creating a feedback loop to identify misuse of the 911 system in an effort to re-educate them. Dr. Slattery commended the study and stated the article he read referred to a similar process of intervention. The hospital actually paid for a full-time social worker to manage these patients and the amount of money they were able to save was incredible. The data showed there was a cyclical nature with regard to hot and cold weather. Most of the intervention had to do with the need for shelter and food, and not related to the seeking of drugs.

Dr. Carrison stated that he attended a meeting at WestCare along with Rory and Dr. Heck with regard to the current mental health issues. One of the major cuts is going to be in social services, which will affect care for the homeless. So the problem does not only exist, it's going to get worse. The burden will ultimately fall to the hospitals and the community. He related that three weeks ago 100 mentally ill patients were being held in valley EDs. These people don't need care, they have social needs; some of them are pure abusers of the system, but if we don't address this issue in some way there's going to be a domino effect that's going to affect our entire EMS system and hospital surge capacity. He argued that it may need to be addressed on a local, state and national level. It's a severe problem that may worsen if there's an H1N1 epidemic like London is experiencing right now.

Dr. Marino related that Houston and Wake County, NC are tackling this issue in various ways; they're actually providing resource manuals to the paramedics so they can help with referral and education of these patients. He agreed that we need to work with our community partners from that standpoint.

III. INFORMATIONAL ITEMS/ DISCUSSION ONLY

A. Report from Transfer of Care Committee (TOCC)

Brian Rogers reported First Watch is now active within all the facilities. He reported a few minor issues including: button pushes by medics, nurses not checking patients out, and information not being transmitted when ambulances are under awnings. These issues are being investigated and a resolution should be provided shortly; otherwise, the system is working great and average times are within range.

B. Report from Regional Trauma Advisory Board (RTAB)

Mary Ellen Britt noted the new members and their positions on the Board:

Dr. John Fildes, Trauma Medical Director, UMC
Gregg Fusto, Trauma Program Manager, UMC
Dr. Michael Metzler, Trauma Medical Director, Sunrise
Melinda Case, Trauma Program Manager, Sunrise
Dr. Sean Dort, Trauma Medical Director, St. Rose – Siena
Kim Dokken, Trauma Program Manager, St. Rose – Siena
Dr. Allen Marino, Chairman, Medical Advisory Board
Scott Cassano, Health Plan of NV, payor of medical benefits representative
Suzanne Cram, CEO Desert Canyon Rehabilitation Hospital, rehabilitation services
Larry Johnson, AMR-LV/MedicWest, private franchised provider of advanced emergency care
Susan Hilger, general public
Deborah Kreun, ThinkFirst NV, health education and injury prevention services representative
William Wagnon, MountainView Hospital, administrator from a non-trauma hospital
Sandy Young, Las Vegas Fire & Rescue, public provider of advanced emergency care

Ms. Britt stated that members will now be serving a two year term. The trauma field triage criteria were recently reviewed per the request of the MAB; they've decided to recommend the language of the CDC (Centers for Disease Control and Prevention) criteria for Steps 1 and 2. The Board felt the Step 3 criteria required additional data before moving in that direction.

C. TIIDE Annual Report Summary

Ms. Britt reported that a recent TIIDE (Terrorism Injuries Information Dissemination & Exchange) project identified a need to train security officers at hotel casinos. The goal of this project was to train hotel security officers in scene management, incident command system principles. An educational program was developed and presented to the Las Vegas Security Chiefs Association. Dr. Heck utilized the curriculum created by the CDC and ACEP which was designed to train physicians and nurses about how to care for patients whom are victims of explosive injuries and modified it for security officers. The educational DVD is approximately one hour in length and will be distributed to all the major properties. Ms. Britt invited everyone to share the educational program with EMS providers to give them a better understanding when responding to a scene.

Dr. Carrison noted that a CD presented by Dr. Conway is also available to EMS providers. The CD includes the identification of critical infrastructures for the state of Nevada and everything involved with schools, transportation and food supplies.

IV. PUBLIC COMMENT

Rory Chetelat read a letter written to him by Dina Matos, Executive Director of the CARES Foundation expressing her disappointment with the decision to rescind the motion to add Solu-Cortef to the Southern Nevada EMS System's formulary (See Attached).

V. ADJOURNMENT

As there was no further business, Dr. Marino called for a motion to adjourn. The motion was seconded and passed unanimously to adjourn at 11:37 p.m.

Attachment

CARESFoundation
research, education and support for CAH

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July 31, 2009

Rory Chetelat
Manager
Emergency Medical Services and Trauma System (EMSTS)
Southern Nevada Health District
PO Box 3902
Las Vegas, NV, 89127

Re: **Appeal for Adrenal Insufficiency Emergency Medical Response Protocol**

Dear Mr. Chetelat and EMS Medical Advisory Board Members,

I am disappointed to learn that at the June 3, 2009, meeting of the Drug/Device/Protocol Committee members refused to consider the addition of language to the existing shock protocol for the emergency treatment of adrenal insufficiency and an earlier motion to add Solu-Cortef® to the Southern Nevada EMS formulary was rescinded. The committee's reversal is particularly disturbing given that:

1) Mortality caused by adrenal complications has been shown to be 24% whereas the risk of death due to anaphylaxis is estimated to be 0.002%, or about as common as being struck by lightning, for both of which Nevada already has protocols in place.

2) The cost of Solu-Cortef® is $3 per vial; it is an incredibly safe drug; has a five-year shelf life; and contrary to Drug/Device/Protocol discussion subsequent to moving to add it to the formulary, its life-saving effect for the adrenal insufficient is *immediate*. Allowing for double doses on all 300 units within the Southern Nevada system, this means a cost of less than $2000 for a five year supply - less than a single Emergency Room transport. Additionally, it would be used not only for adrenal insufficiency but also allergy and asthma patients.

3) The Southern Nevada Health District estimates the cost of training emergency response personnel in a new protocol to be $20,000. The system, however, is currently undertaking a complete overhaul of all protocols and procedures; therefore, if added now, the incremental cost would be minimal. Moreover, local medical professionals have pledged their assistance in the development and implementation of a training program. In our community's experience, the physical, emotional, and financial cost of delayed treatment of adrenal crisis easily can run to many times that amount, if the affected individual does not die.

4) While National Emergency Medical Service statistics indicate only 10-percent of all 9-1-1 calls are for true medical emergencies every illness or trauma incident is potentially fatal for the adrenally insufficient.

In short, the addition of Solu-Cortef® to the EMS formulary would serve a much larger community than just the adrenal insufficient alone and the benefits far outweigh the costs. All protocols serve some special need; why should an individual be left to die just because their medical condition is relatively rare?

We understand and respect the system's need to develop a model for reviewing additions/deletions to/from the formulary. We regret that despite having presented clear and compelling evidence for the addition of Solu-Cortef® to the EMS formulary and the committee having quickly moved to do so upon our initial request, the motion suddenly was rescinded. In the meantime, New York is writing protocols; Maryland is assigning a medical director to sponsor our request; and Tennessee, North Carolina, New Mexico and Nebraska are all starting to work toward emergency medical treatment of adrenal insufficiency.

If Nevada is not prepared adopt protocols for emergency treatment of adrenal insufficiency at this time, I strongly urge at least the implementation of specialized care plans for individuals with special healthcare needs allowing the home communities of the adrenal insufficient to be prepared to treat in the case of emergency.

Sincerely,

Dina M. Matos
Executive Director