MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

MEDICAL ADVISORY BOARD MEETING

November 4, 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
Chief Bruce Evans, North Las Vegas Fire
Chief Scott Vivier, Henderson Fire Department
Mark Calabrese, EMT-P, MedicWest Ambulance
K. Alexander Malone, MD, North Las Vegas Fire
Chief Mike Myers, Las Vegas Fire & Rescue
James Vivone, EMT-P, Boulder City Fire Department
Jarrod Johnson, DO, Mesquite Fire & Rescue
E.P. Homansky, MD, American Medical Response
Chief David Petersen, Mesquite Fire & Rescue
Troy Tuke, RN, EMT-P, Clark County Fire Department
Richard Henderson, MD, Vice Chairman, HFD

MEMBERS ABSENT

Chief Kevin Nicholson, Boulder City Fire Dept
Dale Carrison, DO, Clark County Fire Department

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
Sam Kaufman, Desert Springs Hospital
Sandy Young, RN, LVFR
Billie Meader, Desert Springs Hospital
Bernie Olah, St. Rose DeLima Hospital
Walt West, EMT-P, Boulder City Fire Dept
Patrick Bellamy, EMT-I, AMR
Eric Anderson, MD, Southern Hills Hospital
Jackie Levy, UMC
Christopher Roller, AHA
Elisaveta Roeva, CSN
Justin Clift, CSN
Jodie Cannon, CSN
Tracy Thomson, RN, UMC
Jo Ellen Hannom, RN, CCFD
John Higley, EMT-P, MFR
Amelia Hoban, Sunrise Hospital
Michelle McKee, MD, UMC
Evelyn Lundell, UMC
Dan Petcavage, UMC
John Henner, DO, MountainView Hospital
Nancy Harpin, UMC
Jennifer Poyer, RN, Desert Springs Hospital
Minta Albietz, Sunrise Hospital
Craig Mills, CSN
Kyle Kravetz, CSN
Julie Gerth, Dixie Regional 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 11:08 a.m. on Wednesday, November 4, 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.

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II. REPORT/DISCUSSION/POSSIBLE ACTION

A. Report from Stroke System Executive Committee

Dr. Slattery presented the objectives presented and approved by the Stroke System Executive Committee:

***Objective 1A**: Assess current dispatch center(s) management of stroke*

- *Current Protocol – Remove alpha responses from Card 28.*
- *Educational Deficiencies – Mandate (2) two hours of stroke education to be included in the emergency medical dispatcher continuing medical education required for recertification.*
- *Pre-arrival instructions – No recommendations*
- *Outcome measurement – Review 20 calls annually where Card 28 was activated at the Emergency Medical Dispatch (EMD) QA/QI meetings. Findings should be reported to QA/QI Committee for review.*

***Objective 1B**: Develop recommendations for improving the management of potential stroke victims during the time period from 911 call to EMS arrival.*

No recommendations.

***Objective 1C**: Determine educational needs of EMS providers in Southern Nevada in terms of:*

- *Identification of acute stroke*
- *Performance of appropriate history, exam, diagnostic tests and documentation as it is related to prehospital stroke care*

Develop a video to appropriately educate Clark County EMS providers on prehospital stroke care.

***Objective 1D**: Determine which stroke scale will be used by all EMS providers in Southern Nevada.*

Recommend the use of Cincinnati Stroke Scale and re-evaluate the system at a later date.

***Objective 1E**: Draft prehospital stroke care management protocol (to exclude destination criteria).*

Created draft Acute Cerebral Vascular Accident protocol

***Objective 2A**: Determine the quality measures and measurement tool that will be used for assessing initial and continuous EMS receiving hospital designation.*

Primary criteria would be certification as a Primary Stroke Center by the Joint Commission (JC). The measurement tool used will be measures outlined by the JC.

***Objective 2B**: Determine the performance and quality measures and measurement tool that will be used to assess prehospital stroke care, decision-making, and protocol compliance.*

Follow the treatment protocol "Acute Cerebral Vascular Accident" (STROKE). The established standards in prehospital stroke care are as follows: maintain airway, breathing and circulation; identification of stroke signs and symptoms (Cincinnati stroke scale); rapid initiation of transport (10 minute scene time); establishment of last known well time; supplemental oxygen for patients with hypoxemia; checking blood glucose level; avoidance of administration of glucose containing fluids (unless patient is hypoglycemic); and delivery of patients to receiving centers capable of rapidly caring for acute stroke. These quality measures will be reported quarterly at the SNHD QA meeting.

***Objective 2C**: Determine triggers and process for performing peer review for EMS providers.*

Important Data Collection Points - EMS

1. Was the Cincinnati stroke scale completed? (Preferably within first five minutes on scene)
2. Were mimics identified? (Hypoglycemia, postictal, Bell's Palsy, etc...)
3. Was a time identified when stroke symptoms started?
4. Was contact information obtained (family member)?
5. Was hospital notified of incoming stroke patient?
6. Were arrival, scene, departure and hospital times documented? (Target 10 minute scene time)
7. Were protocol variations documented?
8. Patient taken to appropriate facility?

***Objective 2D**: Determine process and triggers for performing peer review for stroke receiving hospitals.*

Important Data Collection Points – Hospital

Percentage of patients that arrive by EMS.
Percentage of patients with prior notification of arrival.
Percentage of patients arriving after 3 hours but before 6 hours.
Code 100 activation percentage vs. EMS perceived Code 100.
Number/percentage of patients receiving t-PA.
Accuracy in identification of stroke (review of D/C ICD-9 code compared with initial EMS interpretation).
Symptomatic ICB from AIS receiving t-PA/ discharge percentages

***Objective 2E**: Work with the SNHD Office of EMS & Trauma System to provide a proposed budget to the Executive Committee for stroke system data collection, clerical and statistical support, and quality assurance and oversight activities.*

A budget was proposed and approved. Rory Chetelat stated that the health district will hold a workshop to include the community to discuss how fees will be assessed.

***Objective 3A**: Invite all hospitals in Southern Nevada to participate in the assessment process.*

All hospitals were invited to participate in the assessment process.

***Objective 3B**: Assess each of the hospitals in Southern Nevada regarding their readiness for stroke care management.*

Amelia Hoban provided a list of hospitals and outlined their capabilities.

***Objective 3C**: Make recommendations to the Executive Committee regarding criteria of the above listed hospital resources, facility commitment, and any additional requirements determined by the Taskforce to be eligible for designation as a Stroke Receiving Hospital for the EMS System in Southern Nevada.*

All patients experiencing stroke symptoms within Clark County should be transported to the nearest JC certified primary stroke center. These centers must provide the Clark County Health District with a current copy of their JC certification. For patients experiencing stroke symptoms outside a 50 mile radius from a JC Stroke Center, the licensee providing emergency medical care shall call and consider transport to the nearest receiving facility. If the receiving facility is not certified as a stroke center they must have a transfer agreement in place with a stroke center of the highest possible JC certification.

***Objective 3D**: Design process for keeping information obtained from 3B current for continuous system decision-making.*

The 10 JC data measures were presented for review (see attached).

A motion to accept all the Stroke System Executive Committee's recommendations was made, seconded and passed unanimously.

Dr. John Henner stated that Southern Hills and MountainView Hospitals are scheduled to become accredited shortly; he asked what the process would be to become a designated stroke center. Mr. Chetelat stated as soon as a facility becomes accredited, notify the health district and once the information is verified with JC, they would be eligible to receive stroke patients.

B. Report from Pediatric Destination Taskforce

Dr. Michele McKee noted that the following recommendation was passed unanimously by the Committee:

A single tier system with the following minimum recommendations: an ER that has a physician onsite 24/7 that is either board eligible or board certified in pediatric emergency medicine or pediatric critical care with special notation that the pediatric ER physician may have gone through either a PEDS residency or an emergency medicine residency and then gone on to a pediatric emergency medicine fellowship. If they are a relatively new graduate, they will need to be board certified within two years or establish eligibility. For nursing standards, it is recommended 80% of pediatric ER nurses be certified in an Emergency Nursing Pediatric Course. There is a two year period to attain that level of compliance. All nurses should be certified in Pediatric Advanced Life Support (PALS) and the QI process must be directed by the pediatric emergency medicine or pediatric critical care specialist at the facility.

Chief Mike Myers asked if there is a governing body for pediatric patients like the JC for stroke patients. Dr. McKee stated there is not. There was concern expressed by Board members that it would be difficult to verify a hospital's compliance with the above recommendations. Dr. Marino suggested the requirement for a Pediatric Intensive Care Unit (PICU) because they are state licensed. This would provide an objective way to identify which facilities qualify to be a pediatric destination.

Dr. Malone noted that a year ago the MAB requested they seek expert opinion. As a result, the Pediatric Destination Taskforce was formed. It was decided that the Taskforce would develop the appropriate model. The MAB has been presented with the expert opinion and consensus of the Taskforce. Dr. Malone stated that he supports Dr. McKee's recommendation as presented.

After considerable discussion, a motion was made for the Pediatric Destination Taskforce to meet again with the recommendation that the option of a PICU be reviewed. The motion was seconded and passed unanimously.

C. Biennial Appointment of Medical Advisory Board Meeting Chairman

A motion was made to nominate Dr. Allen Marino for a second term. The motion was seconded and passed unanimously.

Chief Myers noted that in the future, he would like to see medical directors from each agency get the opportunity to chair the Board as it would be beneficial to hear different viewpoints.

III. INFORMATIONAL ITEMS/ DISCUSSION ONLY

A. Report on Conclusion of AirTraq Airway Device

Chief Scott Vivier presented a summary of the AirTraq Pilot Program conducted by Henderson Fire Department. He stated the focus of the study was prehospital endotracheal intubation. Studies in the past have shown that this procedure requires constant practice in order to maintain proficiency as under-practiced providers may cause serious complications. Utilizing the AirTraq showed a 72% success rate per attempt. Overall, the study was a success.

IV. PUBLIC COMMENT

None

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 12:07 p.m.

Ten Joint Commission Data Measures

STK-1 Deep Vein Thrombosis Prophylaxis
Patients with an ischemic stroke or a hemorrhagic stroke and who are non-ambulatory should start receiving DVT prophylaxis by end of hospital day two.

STK-2 Discharged on Antithrombotic Therapy
Patients with an ischemic stroke prescribed antithrombotic therapy at discharge.

STK-3 Patients with Atrial Fibrillation Receiving Anticoagulation
Patients with an ischemic stroke with atrial fibrillation discharged on anticoagulation therapy.

STK-4 Thrombolytic Therapy Administered
Acute ischemic stroke patients who arrive at the hospital within 120 minutes (2 hours) of time last known well and for whom IV t-PA was initiated at this hospital within 180 minutes (3 hours) of time last known well.

STK-5 Antithrombotic Therapy Administered By End of Hospital Day Two
Patients with ischemic stroke who receive antithrombotic therapy by the end of hospital day two.

STK-6 Discharged on Cholesterol Reducing Medication
Ischemic stroke patients with LDL >100, LDL not measured, or on cholesterol-reducer prior to admission, who are discharged on cholesterol reducing drugs.

STK-7 Dysphagia Screening
Patients with an ischemic or hemorrhagic stroke who undergo screening for dysphagia with a simple valid bedside testing protocol before being given any food, fluids, or medication by mouth.

STK-8 Stroke Education
Patients with an ischemic or hemorrhagic stroke or their caregivers who were given education or education materials during the hospital stay addressing **all** of the following: personal risk factors for stroke, warning signs for stroke, activation of emergency medical system, need for follow-up after discharge, and medications prescribed.

STK-9 Smoking Cessation/Advice/Counseling
Patients with ischemic or hemorrhagic stroke with a history of smoking cigarettes, who are, or whose caregivers are, given smoking cessation advice or counseling during hospital stay. For the purposes of this measure, a smoker is defined as someone who has smoked cigarettes anytime during the year prior to hospital arrival.

STK-10 Assessed for Rehabilitation
Patients with ischemic or hemorrhagic stroke who ere assessed for rehabilitation services.

(Copied from Joint Commission Disease Specific Stroke Binder)

Get With Guidelines measures STK-1, 2, 3, 4, 5, 6, and 9 for patients listed above as well as patients with a transient ischemic attack.