MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

MEDICAL ADVISORY BOARD MEETING

November 7, 2012 – 11:00 A.M.

MEMBERS PRESENT

David Slattery, MD, Chairman, Las Vegas Fire & Rescue
Richard Henderson, MD, Henderson Fire Department
Eric Anderson, MD, MedicWest Ambulance
Chief Troy Tuke, Clark County Fire Department
Martin Tull, MedicWest Ambulance
Scott Morris, North Las Vegas Fire Dept (Alt)
Scott Fuller, Las Vegas Fire & Rescue
Christian Young, MD, Boulder City Fire Dept
Dale Carrison, DO, Clark County Fire Department
E.P. Homansky, MD, Vice Chairman, AMR
Rick Resnick, EMT-P, Mesquite Fire & Rescue
Tony Greenway, EMT-P, American Medical Response
Chief Scott Vivier, Henderson Fire Department

MEMBERS ABSENT

Chief Kevin Nicholson, Boulder City Fire Dept
Jeff Buchanan, EMT-P, North Las Vegas Fire Dept
Jarrod Johnson, DO, Mesquite Fire & Rescue
K. Alexander Malone, MD, North Las Vegas Fire

SNHD STAFF PRESENT

Rory Chetelat, EMSTS Manager
John Hammond, EMS Field Representative
Patricia Beckwith, EMS Field Representative
Mary Ellen Britt, Regional Trauma Coordinator
Kelly Morgan, MD, EMS Consultant
Judy Tabat, Recording Secretary

PUBLIC ATTENDANCE

Brian Anderson, Community Ambulance
Jim McAllister, EMT-P, LVMS
Gina Schuster, EMT-P, Community Amb.
Abby Hudema, RN, UMC
Jen Renner, RN, Sunrise Hospital
August Corrales, EMT-P, CSN
Frank Simone, EMT-P, North Las Vegas Fire Dept
Richard Martindale, LVAPEC
Richard Main, EMT-P, AMR
Terry Stanley, RN, UMC
Diana Taylor, CCSD
Kathleen Carmona, Valley Health System
Debra Rexford, VHS
Evelyn Lundell, UMC
Derek Cox, EMT-P, LVFR
Pat Foley, Clark County Fire Dept.
Eric Dievendorf, EMT-P, AMR
Larry Johnson, EMT-P, MWA/AMR
Bryan Bledsoe, DO, MedicWest Ambulance
Gerry Julian, Mercy Air
Chris Baker, TriState CareFlight
Mark Calabrese, EMT-P, Mt. View Hospital
Sam Scheller, EMT-P, Guardian Elite
Justin Williams, LVAPEC
Victor Montecerin, EMT-P, MW
August Corrales, EMT-P, CSN
Steve Krebs, MD, UMC
Melody Talbott, RN, UMC
Paul Houghton, LVFR
Dorita Sondereker, RN, Mercy Air
Rebecca Dennon, EMT-P, JTM

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The Medical Advisory Board convened in the Human Resources Training Room #2 of the Ravenholt Public Health Center on Wednesday, November 7, 2012. Chairman David Slattery, MD called the meeting to order at 11:02a.m. The

Affidavit of Posting, Mailing of Agenda, and Public Notice of the Meeting Agenda were executed in accordance with the Nevada Open Meeting Law. Dr. Slattery noted that a quorum was present.

I. PUBLIC COMMENT

Public comment is a period devoted to comments by the general public on items listed on the Agenda. All comments are limited to five (5) minutes. Chair Slattery asked if anyone wished to address the Committee pertaining to items listed on the Agenda. Seeing no one, he closed the Public Comment portion of the meeting.

II. CONSENT AGENDA

Chairman Slattery 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.

Approve Minutes/Medical Advisory Board Meeting: September 5, 2012

Chair Slattery asked for a motion to approve the Consent Agenda. *Motion made by Member Young, seconded by Member Anderson and carried unanimously.*

III. REPORT/DISCUSSION/POSSIBLE ACTION

A. Committee Report: Drug/Device/Protocol Committee (DDP) 11/7/12

1. Review of Alternate Drugs
   a) Hydromorphone (Dilaudid)
   b) Fentanyl (Sublimaze)
   c) Diazepam (Valium)
   d) Ketamine (Ketalar)
   e) Droperidol (Inapsine)
   f) Propofol (Diprivan)

2. Discussion of Integration of Alternative Drugs in the Current BLS/ILS/ALS Protocols

Dr. Morgan referred to the Alternative Drug Protocol packet in the Board handouts and stated each protocol contains dosing, contraindications and lists each protocol that is involved with the medication. She advised that these have been approved by DDP after significant discussion and are ready for review and approval with a go live date of February 1, 2013. Dr. Slattery added that there is a bit of urgency with this item and thanked Dr. Morgan and the DDP Committee for all their hard work.

Dr. Slattery asked for a motion to approve this packet in its entirety. *A Motion was made by Member Tuke to approve the Alternative Medication Protocol packet in its entirety. Member Young seconded. After concerns were brought forward regarding the Propofol(Diprivan) protocol Member Tuke withdrew his motion.*

Dr. Anderson expressed concern regarding respiratory failure with using propofol. Dr. Slattery stated that this Board will review each protocol individually.

Valium: Alternative to Midazolam
A Motion was made by Member Homansky to approve the Diazepam (Valium) Protocol. Member Anderson seconded and carried unanimously.

Dilaudid: Alternative to Morphine
A Motion was made by Member Young to approve the Hydromorphone (Dilaudid) Protocol. Member Anderson seconded and carried unanimously.

Inapsine: Alternative to Zophran.
A Motion was made by Member Henderson to approve the Droperidol (Inapsine) Protocol. Member Homansky seconded and carried unanimously.

Fentanyl: Alternative to Morphine
A Motion was made by Member Henderson to approve the Fentanyl (Sublimaze) Protocol. Member Anderson seconded and carried unanimously.

Ketamine: Alternative to Etomidate

Dr. Morgan questioned the "maintenance of sedation" verbiage under indications in the protocol. Dr. Slattery stated that as a friendly amendment to change it to read "Ketamine is a neuroleptic used for induction prior to intubation."

A Motion was made by Member Anderson to approve the Ketamine (Ketalar) Protocol with the stated change. Member Young seconded and carried unanimously.

Propofol: Alternative to Etomidate

Dr. Young questioned the dosage being administered at 2 minute intervals. Dr. Slattery stated that was the recommendation from the DDP that rather than trying to calculate drip rates in the field to just do intermittent bolus administration for sedation as needed once the patient is intubated.

Dr. Carrison agreed with Dr. Anderson's earlier comments pertaining to respiratory failure and voiced concerns regarding a rapid drop in blood pressure and questioned why this drug is being considered. Dr. Henderson related that this is only as an induction agent for intubation.

Dr. Slattery stated that this is a training issue. Dr. Anderson agreed but feels this medication has additional side effects. He added that you can induce complete anesthesia with this medication where the patient will have no muscle tone and no respiratory drive so it's different from the other medicines that they are handing their crews. He felt that this is the drug of last resort for an agency to use for induction.

Chief Vivier stated that when this drug was originally proposed they recognized the danger but it was during the time when Etomidate wasn't available and Ketamine was not readily available so the situation was if you needed to induce that patient what would be the alternative and Propofol was the 3rd tier alternative.

Dr. Homansky commented that the drug itself states it is only for administration by an anesthesiologist but this is a last choice and no one is better than a paramedic for taking care of the side effects. Dr. Carrison professed that too much emphasis is put on intubation when a medic can bag a patient.

Mr. Chetelat felt that approving an overall protocol doesn't mean and agency is forced to use it. That decision would be up to the agency and their medical director. Dr. Anderson agreed but felt if they are out of Etomidate and you have Ketamine and Propofol, approving this allows them to go right to Propofol. Dr. Slattery respectfully disagreed. He felt a decision can be made in terms of arranging it in tiers and additional education or safety measures to be put in place.

Dr. Slattery called for a motion to approve the Propofol protocol. *A Motion was made by Member Henderson to approve the Propofol (Diprivan) Protocol, Member Homansky seconded and a vote was taken. The motion was opposed by: Clark County Fire Department and MedicWest Ambulance, The motion passed by a 6 to 2 simple majority.*

Dr. Slattery stated that the Propofol Protocol will be moved to DDP Committee for additional discussion and if the Committee decides to bring it back with the decision that it shouldn't be used at all or that it should be used as a 3rd tier medication that specific item can then be voted on at the MAB.

Dr. Morgan discussed how the alternative drugs were integrated into the current protocols. Dr. Slattery commented that it was very clean and it clearly reflects that these are alternative medications and not something that has to be carried concurrently. Dr. Young questioned if the number 1 and 2 should be listed as 1st and 2nd. Dr. Morgan answered in the affirmative and stated they will make sure that when these alternative drugs are listed it corresponds with the order of the tiers that were voted on back in April.

Dr. Slattery called for a motion to approve the format of the integration of the Alternative Drugs. *A Motion was made by Member Young to approve the format of the integration of the Alternative Drugs in the Current BLS/ILS/ALS Protocols. Member Homansky seconded and carried unanimously.*

Dr. Slattery introduced two new members of the Board: Deputy Chief Scott Fuller, Operations Chief for Las Vegas Fire & Rescue and Martin Tull, Operations Director for MedicWest Ambulance.

B. Committee Report: EMS Destination Criteria Committee 10/3/12

1. Review of Existing Destination Protocols
   a) General Patient Care (GPC)
   b) Induced Hypothermia (IH)

c) Pediatric Patient Destination
d) Stroke

2. Discussion of Future Destination Protocol

Dr. Homansky reported that they met with good representation from most of the interested parties and reviewed the destination criteria within those listed protocols.

Dr. Slattery stated that the idea is that this committee will review the destination criteria protocols on an annual basis and bring back recommendations to the MAB. One item that was referred from the MAB was discussion to implement a STEMI center destination protocol to line up with the Mission Lifeline program. There is an Induced Hypothermia (IH) Protocol and the idea was for this Committee to address how to incorporate a STEMI destination within the IH Protocol. Dr. Homansky stated that at the next meeting they will be comparing the benchmarks between the Mission Lifeline program and the criteria for a hospital to become a certified chest pain center to see the differences and what more needs to be done. He added that there were some concerns regarding the new criterion for pediatric patient destination that is going to be in place starting January 1, 2013 so a taskforce will be meeting next week and all the interested parties have been notified. The stoke destination will also be discussed further at the next meeting.

C. Discussion of Draft Trauma Field Triage Criteria Protocol

Mary Ellen Britt referred to the Trauma Field Triage Criteria (TFTC) protocol in their handouts and stated that this protocol was reviewed extensively by the Trauma Procedure Protocol Review Committee (TPPRC) over the course of 7 months and was endorsed at the Regional Trauma Advisory Board (RTAB) at the last meeting. She reviewed all the modifications that were based on the new National Field Triage guidelines that were created by a multidisciplinary committee.

Step 1: Housekeeping changes
GCS scale < 14 changes to 13 or less
Added: "The pediatric patient MUST be transported to a pediatric center for the treatment of trauma".

Step 2: Minor wording changes
Added: "The pediatric patient MUST be transported to a pediatric center for the treatment of trauma".

Step 3: The national guidelines actually removed the 40mph crash. They also removed prolonged extrication and rollover. But the committee decided that in light of the fact that they do not currently have access to the vehicle telemetry data that they use in their criteria that they would retain the 40mph crash criteria and also they wanted to retain the rollover with an unrestrained occupant. They did remove the extrication and prolonged extrication criteria.

Step 4: They then added back Step 4 "Assess special patient or system considerations, such as:"

She added that within the catchment areas, under the St. Rose Siena section, there were minor housekeeping changes: It now states that step 3 and step 4 patients can be transported to Siena and then the other clarification that was made was under UMC. Previously on the map it showed that the area south of McCarran those step 1 & step 2 patients in that area should be transported to UMC but the protocol did not reflect that so we added that language in to describe that geographic area.

Ms. Britt requested that this protocol be included in the February 1, 2013 rollout.

Chief Vivier questioned the fact that Step 1, 2 and 3 all have "MUST" language if the patient meets that criteria but Step 4 does not so he understood that step as a consideration and asked who the crews contact to determine where they go.

Ms. Britt stated that the Committee expected that it was going to be EMS provider judgment much like the other steps so that if the patient met those criteria and needed to be seen in a trauma center they would be transported to the trauma center in the catchment area that they are in. Dr. Carrison agreed.

Dr. Henderson expressed concern with the verbiage in the section "St. Rose Siena Hospital (Level 3 Trauma Center) Catchment Area." He explained that it doesn't say "if you've made the decision to transport" it says "step 3 & 4 are to be transported to St. Rose Siena". Ms. Britt explained that is really intended to define the catchment area once that decision has been made.

After considerable discussion Mr. Greenway suggested changing that first line in the "St. Rose Siena Hospital (Level 3 Trauma Center) Catchment Area" section to read "Trauma calls that meet step 3 or in the providers judgment meet step 4 of the Trauma Field Triage Criteria protocol." The Board agreed.

A Motion was made by Member Homansky to approve the TFTC Protocol with the stated change. Member Vivier seconded and carried unanimously.

D. Discussion of Draft CPAP (Continuous Positive Airway Pressure) Protocol

Mr. Hammond advised the Board that AMR & MedicWest Ambulance previously performed a study as to whether or not the use of CPAP in our system would be effective. At that time the MAB voted to accept their protocol for a roll out but since it came at an off time, it was held until the new protocols were going to be issued. He referred to the 2 different versions in the handouts and stated that one is directly from AMR and the other one is a procedure draft that is in the current protocol format. Changes have been made to the Respiratory Distress protocol and the Pulmonary Edema/CHF protocol to reference this procedure if they meet the indications shown in the CPAP protocol.

Chief Vivier questioned the implementation date for these to be effective. Mr. Hammond answered February 1, 2013.

Mr. Montecerin questioned if there is any mention in the CPAP protocol about end tidal CO_2. Dr. Slattery stated that was a great idea and suggested adding that as an educational box to consider continuous capnography.

A Motion was made by Member Homansky to approve the CPAP Protocol with the stated change. Member Vivier seconded and carried unanimously.

E. Discussion of Draft Behavioral Emergency Protocol

Tabled

F. Discussion of Proposal to Conduct Study of IO (Intraosseous) Use in Conscious Patients to be Referred to the QI Directors Committee

Chief Vivier reference the green packet in the handouts as the IO use in conscious patients study proposal. He stated that they are requesting that the MAB consider this study and refer it to the QI Directors Committee in this format so that the Committee can start this process to allow Henderson Fire Department to study this question. The study question that they are looking to propose is to expand the current use of I/O for patients to those who could be conscious or semiconscious. The process doesn't change but it does require the addition of the anesthetic Lidocaine**.** This would be a non-randomized, prospective observational study to describe the use of IO in the conscious patient for the duration of one year and also the secondary optimum would be to describe adverse affects and complications. They would be looking to start this study at the first of the year and run it for a full 12 month period.

A Motion was made by Member Homansky to accept this study and refer it to the QI Director's Committee. Member Anderson seconded and carried unanimously.

G. Approval of Drug/Device/Protocol Committee Bylaws

Mr. Hammond referred to the attached DDP Bylaws in their handouts and stated most of the Subcommittee's have bylaws that have been mirrored the MAB bylaws and reviewed the modifications.

Article II	Add "If the committee chair is not a MAB member, a MAB liaison needs to be appointed.
Article III, Section 1.	The membership of the DDP Committee shall be composed of volunteer representatives from permitted agencies, Add "Receiving Hospitals" Change Emergency Medical Technicians to Emergency Medical Services Professionals
Article III, Section 3.	Change to read: DDP Committee members shall serve for a 2 year limit with no limitations on reappointment as long as they hold an eligible position in the community.
Article III, Section 5.	Change to read: Each standing member shall have one vote. In the event that the standing member is not available, an agency designee, approved by the DDP Committee Chair shall cast the vote. Article IV, Section 1. Change 2nd sentence to read: The

officers will be appointed by the MAB Chair to serve a two year term from January 1 through December 31st of the second year.

Article X — Add "and approval by the MAB."

Dr. Carrison questioned the last amendment under Article X that reads "Recommendations for changes to these bylaws may be forwarded to the EMSTS Manager by the Chair of the DDP with the consent of the DDP and approval by the MAB. All changes are made under the sole discretion of the EMSTS Manager or their designee" and stated that the last line takes the MAB out of the final decision.

Mr. Chetelat explained the overall structure of all the committees and added that the language is in there to allow the EMSTS Manager or their designee to say that they don't necessarily agree with the MAB's final decision. Then the alternative would be to go to the Board of Health (BOH) to voice your concerns as members of the MAB which is the chain of command setup by the BOH and the regulations that are defined.

Dr. Slattery stated that the MAB does a good job and felt that they should control their bylaws and if it's that big of a disagreement, it should go to the BOH.

Mr. Chetelat recommended striking the language "All changes are made under the sole discretion of the EMSTS Manager or their designee. The Board agreed.

A Motion was made by Member Young to approve the DDP Bylaws with the stated change. Member Anderson seconded and carried unanimously.

H. Discussion of January MAB Meeting Date

The Board agreed to meeting January 2, 2013

IV. INFORMATIONAL ITEMS/ DISCUSSION ONLY

A. Committee Report: QI Directors

Dr. Young reported that the QI Committee has been focusing on some of the recent medications and their dosing. They are pooling some of the efforts of the electronic health records that a lot of the EMS agencies now are coming up on line. They are having some challenges but looking forward to simulate more system wide date to look at some quality metrics.

Dr. Slattery requested that the QI Committee report be brought up to the Report/Discussion/Possible action section of the agenda. Mr. Chetelat stated that because of the protection and confidentially we keep it under informational items only.

B. Trauma Report

Ms. Britt reported that the TPPRC has completed its work on the TFTC protocol and now will be reviewing and revising the trauma plan beginning in February. The Trauma Rehabilitation Committee has met 3 times now and the representatives from the rehabilitation facilities and trauma centers have agreed to exchange information to look at patient outcomes and in addition they are working on creating a resource list of rehabilitation facilities. The Trauma System Advocacy Committee had its first meeting on the 24th of October which included a former legislature and a current legislature and their first objective is to look at a sustainable funding source for the trauma system.

C. Internal Disaster Monthly Report

Mr. Hammond reported that for the month of October the internal disaster report showed only 3 hospitals with internal disasters; Valley Hospital for 13 hours total on October 12th and 13th, UMC for 2.3 hours on October 22nd and St. Rose Siena for a total of 127 hours throughout the month.

D. ED/EMS Regional Leadership Committee Update

Dr. Slattery reported that a representative from Rawson-Neal Psychiatric Hospital discussed some of their policies and took questions from the Committee. The Committee offered an invitation to the medical director from Rawson-Neal to this meeting for further discussion. Dr. Slattery added that the good news is that they are starting

to move in the direction of doing evaluations for medical clearance at their facility and they have extended the hours of their outpatient clinic.

Dr. Homansky advised that there is a screening form that EMS is using up in Reno where a patient who does appear to be medically stable would be taken directly to the psychiatric facility. This procedure started October 1st and there have been no reported problems in the first 30 days of operation. He added that if things go well up there, this procedure will be brought down here. EMS will need to be in serviced and be comfortable with the screen form but Tracey Green's goal is to get 50% of all the medical screening done at Rawson-Neal in the near future.

E. Clark County School District Healthcare Personnel & EMS Interface

Diana Taylor, Director of Health Services for the Clark County School District (CCSD) spoke to the Board regarding the role of school nurses in CCSD and their capabilities they have in school. She reported that she would be willing to provide any kind of presentation to let you know just what their role is and what EMS's expectations are as far as what a school nurse and school staff would do regarding providing care for our students. Dr. Slattery thanked her for coming and felt that it would be a good idea to meet with the EMS Office and come up with some ideas.

Dr. Slattery recognized 2 individuals that have played a big part in the EMS system. Jen Renner, who is moving on to take the director of Southern Hills Emergency Department and Mark Calabrese, who is in charge of the Emergency Department at Mountain View Hospital.

Dr. Slattery stated Dr. Homansky's group, the DMS-EmCare group and the Valley Health System will be hosting a seminar on November 13th at Texas Station that will cover the latest updates in acute MI management and STEMI care from start to finish. Dr. Homansky stated there will be education credits for the paramedics and doctors and everyone is welcome.

Trish Beckwith asked the Board for direction and clarification regarding the changes that have been made to the alternative medication protocols and the education for the rollout that will be due February 1, 2013 since the MAB is not meeting until January 2, 2013. Dr. Henderson stated that all the medications were approved. Dr. Slattery stated that she will have an answer next month for the Propofol. Ms. Beckwith reminded the Board that the agencies need to notify the EMS office when you've completed training on 90% of your personnel. Dr. Slattery informed the Board that they did discuss at the DDP that for those agencies that are currently using alternative medications and trained 90% of their personnel; these protocols are going to be in effective today.

Dr. Slattery announced that he is passing the gavel to Dr. Homansky as the new Chairman of the MAB. He stated that it's been a pleasure and an honor to be in this position and thanked the Board.

V. PUBLIC COMMENT

Public comment is a period devoted to comments by the general public, if any, and discussions of those comments, about matters relevant to the Committee's jurisdiction will be held. No action may be taken upon a matter raised under this item of this Agenda until the matter itself has been specifically include on an agenda as an item upon which may be taken pursuant to NRS 241.020. All comments are limited to five (5) minutes. Chair Slattery asked if anyone wished to address the Committee. Seeing no one, he closed the Public Comment portion of the meeting.

VI. ADJOURNMENT

There being no further business to come before the Committee, Chair Slattery adjourned the meeting at 12:21 p.m.