MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

MEDICAL ADVISORY BOARD MEETING

January 2, 2013 – 11:00 A.M.

MEMBERS PRESENT

E.P. Homansky, MD, Chairman, AMR
Richard Henderson, MD, Henderson Fire Department
Jarrod Johnson, DO, Mesquite Fire & Rescue
Chief Scott Fuller, Las Vegas Fire & Rescue
Chief Troy Tuke, Clark County Fire Department
Martin Tull, MedicWest Ambulance
Aaron Harvey, EMT-P, Henderson Fire Dept. (Alt)
David Slattery, MD, Las Vegas Fire & Rescue
Christian Young, MD, Boulder City Fire Dept
Bryan Bledsoe, DO, MedicWest Ambulance
Jeff Buchanan, EMT-P, North Las Vegas Fire Dept
Rick Resnick, EMT-P, Mesquite Fire & Rescue
Tony Greenway, EMT-P, American Medical Response
James Vivone, EMT-P, Boulder City Fire Dept. (Alt)

MEMBERS ABSENT

Chief Kevin Nicholson, Boulder City Fire Dept
Chief Scott Vivier, Henderson Fire Department
Dale Carrison, DO, Clark County Fire Department
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
Eric Dievendorf, EMT-P, AMR
Jim McAllister, EMT-P, LVMS
Gina Schuster, EMT-P, Community Amb.
Donna Miller, Lifeguard International
Abby Hudema, RN, UMC
August Corrales, EMT-P, CSN
Frank Simone, EMT-P, North Las Vegas Fire Dept
Steve Krebs, MD, UMC/St. Rose
Dorita Sondereker, RN, Mercy Air
Gregg Fusto, UMC Trauma
Derek Cox, EMT-P, LVFR
Scott Morris, North Las Vegas Fire Dept
Jim Holtz, Valley Hospital
Evelyn Lundell, UMC
Eileen Davies, Lifeguard International
Chad Fitzhugh, EMT-P, Mercy Air
Gerry Julian, Mercy Air
James McAllister, EMT-P, LVMS
Sam Scheller, EMT-P, Guardian Elite
John Trautwein, MD, Summerlin
Pat Foley, Clark County Fire Dept.
Gail Yedinak, UMC
Steve Johnson, EMT-P, MedicWest

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, January 2, 2013. Chairman E.P. Homansky, MD called the meeting to order at 11:00a.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. Homansky 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 Homansky 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 Homansky 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: November 7, 2012

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

III. REPORT/DISCUSSION/POSSIBLE ACTION

Dr. Homansky opened the discussion by thanking Dr. Slattery for his work as Chairman of the MAB and bringing objectivity to the Board in terms of evidence based para-medicine. He believes that EMS and the collaboration with the emergency departments is truly a remarkable system that does an amazing job and doesn't get enough credit and was glad to be part of it.

A. Committee Report: Pediatric Destination Taskforce 11/15/12

Dr. Trautwein introduced himself along with Dr. Krebs as the Co-Chairs of the Pediatric Destination Taskforce. He advised that back in 2009 there was question as to whether they were meeting the National Standard of Care in the treatment of pediatric patients through the EMS community. There was an initiation of discussions to change the criteria by which it is determined which hospitals could accept pediatric patients and since then there have been several issues that have transpired which prompted a review of that process. He stated that he and Dr. Krebs began a dialog to see what they could do to make sure that the community meets the national standard but at the same time not make it so onerous that other facilities couldn't assist in their own pediatric programs and to ensure there was adequate coverage for Las Vegas. The short term outcome of this was that they felt that the system that was currently in place prior to January of this year did meet both the Academy of Pediatrics and the American College of Emergency Physician guidelines. He added that now that they have a more stable administration within Sunrise, UMC, St. Rose Siena and Summerlin, the four pediatric directors of those hospitals could meet and come up with policies that were fair to everyone and provide an opportunity for growth in the future as well.

Dr. Krebs added that the big concern with the new policies taking place January 1, 2013 was the designation of being board certified/board eligible (BC/BE) specifically in pediatric emergency medicine which could potentially limit the ability to consider qualified physicians. He added that in his last 6 months of reviewing charts at St. Rose and UMC, he hasn't seen very many if any examples of patients being taken to inappropriate facilities or missed triage. He felt that the community has done a great job of bringing children to the appropriate level of care. He stated that he and Dr. Trautwein will continue meeting with Dr. Stocker and Dr. Fisher over the next four to six months to have some formal language in effect by July 2013 that they could present to the committee for review and possible approval.

Mr. Chetelat informed the Board that effective January 1, 2013 there was a clause in the regulations that stated that they had to have 24/7 coverage by a BC/BE physician. During the Pediatric Destination Taskforce it was recommended that the new criteria be suspended through July 1, 2013 to give the four hospitals time to get together and develop language that everybody is comfortable with to bring forward to the MAB. He added that Health District supports this decision since they don't have the expertise in house to make that decision.

Dr. Homansky asked for a motion to extend the pediatric destination criteria that was in place prior to January 1, 2013 to be extended for one year. *Motion made by Member Slattery, seconded by Member Bledsoe and carried unanimously.*

B. Discussion of Proposal to Add an Air Ambulance Seat on the Medical Advisory Board

Mr. Chetelat reported that at the last EMS Regulations Workshop there was discussion regarding adding additional seats to the MAB to include air ambulance services and special event agencies. He added that Donna Miller from Lifeguard International has made a formal request for a seat on the MAB and referred to the copy of letter in the handouts and turned the discussion over to Ms. Miller.

Ms. Miller stated that she is the president of Lifeguard International and also a flight nurse and believes that having someone who is very knowledgeable and experienced in air ambulance services would bring a lot of value to the MAB. Fixed wing air ambulance has very unique challenges that are not common knowledge to hospitals, ground ambulance or fire fighting agencies which involve aviation regulations through the Federal Aviation Administration (FAA), medical authority and accountability through the State of Nevada Division of Health and SNHD EMS regulations. Dr. Henderson stated that he didn't feel that the fixed wing air ambulance is an EMS issue and questioned why the Health District was in charge of the training and inventory.

Mr. Chetelat explained that the Office of EMS & Trauma System (OEMSTS) by authority from the NRS control the inventory and set the standards of training for EMS-RN's that is an impact to her business model. He felt that the primary function of the MAB is on the 911 system and stated that he is opposed to adding additional seats to the MAB in this regard. Dr. Henderson suggested that air medical have their own advisory board under the OEMSTS rather than the MAB which is strictly EMS.

Ms. Miller stated that the main goal of the MAB is to ensure quality of care with patients until they get to the destination of care. While they may not be responding to 911 calls, they transport those patients from one hospital to another and felt that they are part of the EMS system.

Dr. Slattery stated that the air medical system is extremely important for the community and they are part of the EMS system just like the hospitals and the special events crews. The purpose of this board is to take important work that has been done at the committee and subcommittee level where the line share of the work is done and make decisions on it. He felt that her input at that committee level and publically at the MAB would be more valuable than just having a seat on the Board.

Ms. Miller stated that the EMS Regulations state that the MAB means a board appointed by the Health Officer consisting of one Medical Director and one Operations Director for each permitted agency. Mr. Chetelat explained that when the Board was redesigned the idea was that the primary function of the Board is to advise the Health District on the 911 system and that authority ends once that patient crosses the door into an emergency room. The fixed wing air ambulance is picking that patient up after they have been stabilized by a physician or under the physician's direction and control. He added that they are a vital part of the system but no longer really part of the 911 system which is this Board's primary responsibility.

Gerry Julian from Mercy Air suggested that if air medical is not going to a part of the MAB then they definitely need to bring back the Air Medical Task Force and meet more frequently.

Mr. Chetelat agreed and added that one of Ms. Miller's primary concern is some states have virtually no regulation around air ambulance services and because they are interstate they can fly in here and pick up her patients and fly out. He stated that there are issues that need to be fixed and he is more than willing to support Ms. Miller in trying to change some of those loopholes in the NRS.

Dr. Homansky questioned if there was a motion, hearing none he stated that he appreciated the input and will move on.

C. Discussion of Revisions to EMS Regulations

Mr. Chetelat reported that the EMS Regulations Workshop has completed their review of the regulations and they will use this opportunity as the second notice of public workshop. He noted revisions are highlighted with a note on the side; those were comments that were made around certain regulations already discussed. If there was no comment by them that would be mean it was unopposed at the last workshop. He then reviewed some of the major changes and follow-up discussion points from the first workshop.

- Request to keep minimum agency staffing requirements:

  Mr. Chetelat stated that Section 800.130 was removed because according to the Health District's attorney, minimum staffing is considered to be a business decision to be determined by each ambulance operator. The OEMSTS does set the standard of staffing during operation of an ambulance.

Ms. Miller voiced concern that by taking that regulation away you allow for part time air ambulances to come here which opens a lot of issues for the fixed wing air ambulance. She added that instead of arbitrarily setting up a number that each agency has to have she would just state that they need to provide service 24 hours a day, 7 days a week. She referred to EMS Regulation 1300.100 and suggested removing "Rotorwing" to fix that issue. Mr. Chetelat stated that would prevent a part time fixed wing service based out of Clark County that may not always be available but it won't fix the out of state fixed wing that wants to fly in here part time because our authority doesn't stretch over the border. He added that he doesn't have a problem striking "Rotorwing" from that line then it would be inclusive of everybody that they have to have a full time unit.

Motion made by Member Henderson to remove the word "Rotorwing" from EMS Regulation 1300.100, seconded by Member Homansky and carried unanimously.

- Request to drop the requirement for CCT attendants to have three years of field experience down to two years of field experience:

  Mr. Chetelat stated that in response to an EMS agency's request, a recommendation was made to change the years of experience required from three years to two for a paramedic to become a critical care paramedic (CCT). Related to this it was decided to keep the requirement of three years for a paramedic to become an Air Ambulance Attendant and asked the Board for their input. He added that just as a qualifier, CAMTS (Commission on Accreditation of Medical Transport Systems) has now recently moved towards requiring three years experience for an air ambulance paramedic.

  Dr. Morgan noted that it is already established that paramedics flying on an air ambulance in this county fall under Clark County paramedic protocols and there is no additional change in the scope of practice theoretically for those individuals and yet they are allowing individuals with less experience to have an expanded scope of practice as a CCT paramedic on the ground. Dr. Bledsoe agreed and suggested that the air and the ground CCT paramedic experience be the same for consistency.

  Mr. Greenway stated that University of Maryland, Baltimore County (UMBC) is requiring two years to get into their CCT program and from a recruitment and retention perspective on the AMR side they support the two years perspective. He added that looking at the scope of experience a one year paramedic has versus a two year paramedic they show a vast difference, but not as much of a difference between a two year and a three year paramedic.

  Dr. Bledsoe made a motion that there be consistency between and Air Ambulance Paramedic and CCT Paramedic in terms of minimums. Dr. Homansky seconded.

  Mr. Chetelat questioned if that would be for two or three years experience. Dr. Bledsoe stated that all he wanted was consistency.

  Dr. Slattery stated that he supports keeping them consistent at the higher standard of three years or separating out air paramedics and CCT paramedics. He disagreed with lowering the standards across the board he felt that if they are looking for consistency he supports three years.

  Dr. Henderson voiced concern that an advanced practiced CCT paramedic will be in a rig by themselves with less experience then an air paramedic who is in a helicopter with an RN.

  Mr. Chetelat explained that on the other side of that argument the CCT paramedic is picking up a patient from a physician that has already done a certain amount of stabilization where as the flight medic is arriving on a scene of a bus crash in the middle of nowhere and is quickly separated from the nurse because they have to triage numerous patients and making critical decisions without guidance.

  Dorita Sondereker, Clinical Manager for Mercy Air stated that the scope of practice is different for a CCT paramedic versus an air paramedic and felt that the CCT paramedic is more advanced and should have three years experience and that the standard across the United States for an air paramedic is three years.

  Dr. Slattery stated that he would be interested in seeing the data that Mr. Greenway quoted regarding the difference between a two and three year paramedic. He felt that perhaps that three year mark is arbitrarily a mark in the sand and not really sure how well that is based on evidence. He stated that it is difficult to go backwards in terms of dropping the requirements and they really are taking care of critical patients and often they are operating outside of the normal protocols. Sometimes the decision making is probably more of a factor then the actual experience.

Member Bledsoe withdrew his motion.

Dr. Henderson felt it was hard to argue with a national organization.

Mr. Hammond explained that the three year requirement is a new standard from CAMTS that came out in August. He added that they base their data on the projected individual they see in their practice. They found that the three year experience gives them the opportunity to interface with the multiple levels of patients that they may see. He noted that the OEMSTS requires the flight services to be CAMTS certified so if we allow them to hire somebody that has only 2 years experience and they have a CAMTS audit, that Air Attendant will not meet their standards.

Mr. Greenway stated that UMBC who does the majority of CCT training in the US just recently dropped their standard to two years for the ground paramedic and felt that would be helpful for those that are having difficulty recruiting CCT paramedics.

Dr. Slattery stated that his only concern equating CAMTS and UMBC is there could be a different agenda regarding lowering the experience level to two years from the training institute in terms of a decrease in their enrollment and their ability to get people into their classes. There may be an incentive to ask the question that when they get out in the streets does that year of experience matter. Mr. Greenway stated that AMR can support the three years and then have that conversation over this coming year to look at some metrics that objectively look at what is the difference between two and three year experienced paramedic.

Dr. Homansky questioned that if there is no motion the language will remain 3 years experience for both the CCT Paramedic and the Air Ambulance Attendant. Mr. Chetelat answered in the affirmative.

Dr. Homansky stated that hearing no motion he asked Mr. Chetelat to move on.

- Do special purpose permitted agencies need to adhere to the same reporting requirements:

  Mr. Chetelat answered in the affirmative that special purpose permitted agencies need to report to the State, per NRS, NAC and Nevada State Health Division.

- Consideration of adding additional seats to serve on the MAB.

  Mr. Chetelat stated that was discussed in the previous topic but there will more discussion regarding the RTAB seat.

Dr. Bledsoe questioned why they haven't moved forward with the new national standard to the roles of EMT, EMT Advanced, and Paramedic. Mr. Chetelat explained the two years ago when the legislature met, the State tried to bring forward those name changes but due to some political fighting and a change in leadership at the State it didn't get done. Those changes can't be made until the NRS is changed and there is already legislation in place. Pat Irwin the State EMS Director is working closely with the chair of that committee and he doesn't expect any opposition at this point. Dr. Bledsoe questioned that once those changes are made this will be brought back. Mr. Chetelat answered in the affirmative.

- 1300.900 Endorsement to Administer Immunizations, Dispense Medication and Respond to a Public Health Emergency

  Mr. Chetelat stated that this is new language added to our regulations that was pulled from the NAC and NRS to be able to use EMS personnel in the event of a governor declared emergency. EMS personnel with appropriate training could be utilized to provide medication and immunizations in a crisis under the direction of a health officer.

- Advanced Practitioner of Nursing (APN) and Physician Assistant (PA) were added as persons qualified to do physicals.

- Added Regional Trauma Advisory Board (RTAB) chairman or their designee as a member of the MAB.

All other changes relate to housekeeping and clarification of language. Mr. Chetelat expects the regulations to be adopted by the Board of Health in February.

IV. INFORMATIONAL ITEMS/ DISCUSSION ONLY

A. Committee Report: QI Directors

Dr. Young reported that QI Committee met this morning and he stated that he wanted to publically recognize Frank Simone from the North Las Vegas Fire Department, Steve Johnson from MedicWest Ambulance and Abby Hudema from UMC for presenting a very interesting case that hopefully will generate quite a few learning points.

Additional discussions were related to developing an airway metric tool for the EMS system. He added that various agencies have fairly impressive and robust QA procedures already in place to address their airway success rate and intubation skills and with the advent and development of the electronic health records some significant potential is there to just escalate our system in terms of tracking these kinds of metrics on a system wide basis.

B. Trauma Report

Ms. Britt reported that at the next Regional Trauma Advisory Board (RTAB) meeting, they are planning to do a state of the system report to talk about which of the American College of Surgeons recommendations they have accomplished and which ones still need work. In addition they are planning to do benchmark indicators and scoring assessments of the trauma system to lay the foundation for review of the trauma plan and regulations. The Trauma System Advocacy Committee is working on a bill draft resolution to secure funding for the State Trauma Registry which has not been fully operational since 2007. She added that everybody received the "Think Outbreak" card as part of their packet from the Health Districts Office of Epidemiology and stated there are additional copies of those cards to pick up for their staff.

C. Internal Disaster Monthly Report

Tabled

D. ED/EMS Regional Leadership Committee Update

Evelyn from UMC reported that there were no issues during New Years Eve in the emergency departments. She added that one concern brought up in the meeting was an issue with telemetry communication with the providers and it was noted that there is potential for patient care delay as well as a safety matter. It was agreed that the ED Directors will need to do more education on the read back when the providers give a report so all the information given is understood.

Mr. Chetelat thanked Dr. Slattery for all he did to advance the EMS system as Chair of the MAB. He added that he didn't get the vice chair nomination on the agenda for this meeting but asked the members to confer with each other before the next meeting to come up with some recommendations for a vice chair.

Dr. Slattery questioned Ms. Britt if there is anything that this Board can do to support the bill draft to secure funding for the State Trauma Registry. He asked if she could put together a draft letter that each of agencies can put on their letterhead for letters of support. Ms. Britt answered in the affirmative.

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 Homansky 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 Homansky adjourned the meeting at 12:06 p.m.