MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DIVISION OF COMMUNITY HEALTH

MEDICAL ADVISORY BOARD MEETING

August 06, 2014 – 11:00 A.M.

MEMBERS PRESENT

E.P. Homansky, MD, Chairman, AMR
K. Alexander Malone, MD, North Las Vegas Fire
Dale Carrison, DO, Clark County Fire Department
Chief Guy Nelson, North Las Vegas Fire
Rick Resnick, EMT-P, Mesquite Fire & Rescue
Chief Robert Horton, Las Vegas Fire & Rescue
Brandon Hunter, EMT-P, MedicWest Ambulance
Tressa Naik, MD, Henderson Fire Department
David Slattery, MD, Las Vegas Fire & Rescue
Bryan Bledsoe, DO, MWA (via phone)
Eric Dievendorf, AMR (Alt)
Chief Troy Tuke, Clark County Fire Dept.
Chief Scott Vivier, Henderson Fire Department
Abby Hudema, RN, RTAB Representative (Alt)

MEMBERS ABSENT

Chief Kevin Nicholson, Boulder City Fire Dept
Jarrod Johnson, DO, Mesquite Fire & Rescue
Melinda Case, RN, RTAB Chairman
Tony Greenway, EMT-P, American Medical Response

SNHD STAFF PRESENT

Mary Ellen Britt, EMSTS Manager
John Hammond, EMSTS Supervisor
Rae Pettie, EMS Program/Project Coordinator
Jeff Quinn, Sr. Public Health Preparedness Planner
Heather Anderson-Frank, Associate Attorney
Christian Young, MD, EMSTS Medical Director
Gerry Julian, EMS Field Representative
Judy Tabat, Recording Secretary
Annette Bradley, Attorney

PUBLIC ATTENDANCE

Frank Simone, North Las Vegas Fire Dept
Clem Strumillo, Community Ambulance
Steve Krebs, MD, UMC
Mark Calabrese, CCFD
Mike Barnum, MD, AMR
Jim McAllister, LVMS
Chad Fitzhugh, Mercy Air
Dorita Sondereker, Southern Hills Hospital
Sarah McCrea, LVF&R
Glen Simpson, MWA
Leonel Paradis, LVAPEC
Jim Holtz, Valley Hospital
James Kimsey, Iron Eagle
August Corrales, JTM
Steve Johnson, MedicWest
Sam Scheller, Guardian Elite
Jason Driggards, AMR
Barb Stolfus, TriState CareFlight
Daniel Llamas, HCA
Chris Stachyra, MWA
Keith Jones, Sundance Safety
Dineen McSwain, UMC
Lester Hernandez, MWA/LVAPEC
Rick Schuster, TriState CareFlight
Cody Wedewer, MWA
Jennifer Wyatt, Local 1908

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The Medical Advisory Board convened in Conference Room 2 at The Southern Nevada Health District on Wednesday, August 06, 2014. Chairman E.P. Homansky, MD called the meeting to order at 11:00 a.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. Chairman Homansky asked if anyone wished to address the Board 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.

A. Approve Minutes/Medical Advisory Board Meeting: June 04, 2014

B. Referral of Discussion of Proposed Revisions to District Procedure for EMS-RN Training & Endorsement to the Education Committee

C. Referral of Discussion of Proposed Revisions to District Procedure for AEMT/EMT-Intermediate Recertification to the Education Committee

D. Referral of Discussion of Proposed Revisions to District Procedure for Paramedic/EMT-Paramedic Recertification to the Education Committee

E. Referral of Discussion of Proposed Revisions to District Procedure for AEMT/EMT-Intermediate Refresher Course to the Education Committee

F. Referral of Discussion of Proposed Revisions to District Procedure for Paramedic/EMT-Paramedic Refresher Course to the Education Committee

G. Referral of Discussion of Proposed Revision to District Procedure for Paramedic/EMT-P (CC) Training & Endorsement to the Education Committee

Chairman Homansky asked for a motion to approve the Consent Agenda. *Motion made by Member Naik, seconded by Member Nelson and carried unanimously.*

III. REPORT/DISCUSSION/POSSIBLE ACTION

A. Committee Report: Drug/Device/Protocol Committee (DDP) 08/06/2014

- Review of the Official Special Event Medical Inventory
- Discussion on Code 3 Returns for Cardiac Arrest Incidents

Dr. Barnum stated that the DDP Committee met earlier and made two (2) recommendations. The first recommendation was for approval of the Official Special Event Medical Inventory which was accepted and approved by the DDP Committee. The second recommendation was for a letter of support from the MAB in regard to transporting cardiac arrests Code 2 at the provider's discretion which was accepted and approved by Committee. He then turned the discussion over to Troy Tuke.

Mr. Tuke stated from their EMS Committee and talks with other agencies, they have identified a problem that has been ongoing in regard to rapid Code 3 returns back to the hospital with a cardiac arrest patient without a pulse. He stated that there are two protocols in place, the Prehospital Death Determination and Termination of Resuscitation that agencies need to do a better job of educating their crews on because they are not comfortable using them. He added that as a bridge to that education the DDP Committee is requesting a letter of support from the Health District and MAB allowing them to go back Code 2 with a cardiac arrest with no pulse. He added that Dr. Slattery brought up a suggestion to add enabling language to the Emergency Medical Care Protocols in the next protocol rollout defining which actual calls should be going back emergency Code 3 to the hospital. Dr. Slattery added that they don't want to legislate when they do Code 3 returns but just enabling language for our providers to understand that there are very few conditions in which going Code 3 really matters and suggested that the DDP Committee work on that enabling language.

Dr. Homansky asked Dr. Young to make sure that this is taken forward. Dr. Young answered in the affirmative.

The Board approved the actions of the Committee.

Dr. Homansky announced that Dr. Barnum will now be Co-Chair of the DDP Committee going forward.

B. Discussion of Removal of Prehospital Therapeutic Hypothermia from the SNHD Emergency Medical Care Protocols

Dr. Bledsoe stated that part of a maturing EMS system is looking at practices that may no longer have efficacy based on the best knowledge. The initiation of induced therapeutic hypothermia (ITH) was appropriate at the time and based on the best scientific information available. However, since that time, considerable research has come out and been published in fairly high peer journals that shows the prehospital aspect of ITH probably has no effect on outcome. What brought this alive was just the amount of problems they're having keeping the fluids cool in the portable coolers on the ambulances in the Las Vegas environment and that the procedure is infrequently used because of the short transport times. He referred to three (3) studies that were provided in the handouts and stated that they show there is no benefit in terms of outcome for cooling and probably not a good use of their money and resources. He proposed that they remove this from the protocols, or at the least, make it optional for the various providers.

Dr. Slattery presented the Kim Study which he felt was the best definitive highest level evidence for looking at the question of starting ITH in the field or in the emergency department (ED). The results looked at overall mortality and although ITH either in the field or given in the hospital doesn't necessarily impact mortality it does offer the best chance for neurologic recovery following cardiac arrest. He added that this is still a Level 1 recommendation from the American Heart Association (AHA) and when they started ITH it was important to understand that this is just one piece of an entire bundle of care and an aggressive resuscitation bundle for these patients in the first 24 hours is very important. He referred to the CARES registry for the City of Las Vegas and stated that since 2010 when they started doing ITH, 626 of those survived to hospital admission. All patients received this bundle of excellence for post resuscitation care and most of the patients received 2L of iced saline. In the field they rarely get into the second liter by the time they arrive at the hospital so Dr. Bledsoe is correct with regard to short transport times, but it does drive that resuscitation bundle to incur quicker. He stated that from his perspective as Medical Director for Las Vegas Fire & Rescue they will continue doing ITH in the field.

Dr. Bledsoe stated that this is an evolving science and the bundle of care is certainly important but the preponderance of the evidence shows that the prehospital component does not play any role in survival.

Dr. Homansky felt that the most interesting part of that data stated that a third of the patients were in radiographic congestive heart failure (CHF), but possibly not symptomatic CHF and felt that there are very few people with radiographic CHF with normal oxygenation. He added that the Kim data was great, but there is questions and felt that these kinds of discussions are well worth it and appreciated Dr. Bledsoe bringing it forward.

Mr. Corrales voiced concern with regard to the ingestion of pulmonary edema and CHF when he listened to the Kim study. He felt that infusing 2L of saline may be excessive given the short transport times and would suggest limiting that to 1L and then attempting other passive cooling measures. He felt that there is benefit to ITH but noted that the data is still out and suggested they confirm their own study for best practice.

Dr. Bledsoe agreed and stated he would be interested in participating in such a study and suggested running it under an experimental research protocol, and then revisit it at the MAB for consideration.

Mr. Tuke voiced concern with regard to making ITH optional for the various providers and stated he was an advocate of keeping all of the tools the same on all the rigs across all of the agencies.

Dr. Slattery suggested that given the Kim data they should look at changing the protocol to 1L of cold saline and reminded the Board that part of that bundle of care which is initiated in the field is very important and they need to be careful about discontinuing ITH fluids because of the single study.

Dr. Carrison voiced concern that this procedure has been in place for a significant period of time from an evidenced based standpoint and academically they don't know what difference this change has made.

Dr. Slattery explained that the on scene survival before they started ITH was about 20% and after initiation of prehospital ITH it went to 52%. Based on the Utstein survival report it is currently hovering around the 40% range after changing from 3 hospitals to all hospitals for witnessed V-Fib cardiac arrest. For all arrests, it has gone from 1% to 11% survival.

Dr. Bledsoe stated that you can't confirm that ITH is the cause of those numbers without running logistic regression on that data and the CARES registry doesn't look at hypothermia as one of the factors in survival or neurologic outcome. He felt that in Vegas it comes down to CPR, short transport times, and reasonable geographic spacing of the hospitals.

Dr. Homansky felt that when a patient comes in that has been cooled as part of the bundle they do get a higher level of care so there is benefit that they are bringing to these patients.

Member Vivier made a motion to refer this discussion to the Drug/Device/Protocol Committee for further research. Member Tuke seconded and carried unanimously.

Dr. Homansky added that he would like it looked at as how they can drill down and analyze the data locally in terms of best practice.

C. Rollout of the Emergency Medical Care Protocol Educational Program

Mr. Hammond reported that his office developed the core educational components for the protocol rollout and those have been sent to the Educational Coordinator for all the agencies. He advised the Board that he has brought extra copies for anyone who is interested.

D. Discussion of Newly Revised OEMSTS Procedure Manual

Ms. Britt introduced Rae Pettie; the Project Coordinator for the EMS Office who took the lead on this project with the help of other staff members and will discuss the changes to the procedure manual.

Ms. Pettie referred to the Draft EMS Procedure Manual and Summary of Changes in the Board's handouts and stated there was a great deal of housekeeping changes throughout the procedure manual and that they reorganized some of the information to make the document flow better. The rest of the housekeeping changes were made for the purpose of clarification. She proceeded to go through all the changes throughout the manual. She noted that the new procedures listed at the bottom of the Summary of Changes, #1) and #5) are new additions to EMS Regulations, and #2) through #4) are processes that were already in place, but not included in previous iterations.

New Procedures

1) "District Procedure for Endorsement to Administer Immunizations and Dispense Medication (AI/DM) in Response to a Public Health Emergency"
2) "District Procedure for Initial/Renewal of Ambulance Permit"
3) "District Procedure for Authorization/Reauthorization as an EMS Training Center"
4) "District Procedure for Initial/Renewal Designation as an EMS Pediatric Destination Hospital"
5) "District Procedure for Special Event Medical Plan Approval"

E. Discussion of Special Events Medical Plan Approval Process

Ms. Britt stated that they created a Special Event Medical Plan Approval packet which includes a number of supporting documents that are in the Board's packet. The idea is to try to make sure that the applicant is informed as possible at the outset of the process so that they can move through getting those plans approved in a timely manner. The packet of information includes the District Procedure for the Special Event Medical Plan Approval; the Questionnaire, which will help them understand whether or not they are required to submit a medical plan for approval; the Application, the Algorithms; the Special Event Medical Inventory; and then finally the Post-Event Reporting as required by law. She added that this will be provided to each of the business licensing and/or special event departments for each of the political jurisdictions, as well as the fire departments and EMS agencies so that if an individual regardless of which portal they come in through as they enter the process will receive the same information. The Regulations become effective 90 days after they are approved by the Board, which was on June 26th, so we are encouraging individuals who are now approaching to come into compliance with the law that there will be a more concerted effort as we push these packets out to the business licensing folks to make sure that everyone is ready to go when they submit their applications.

F. Discussion of Transfer of Care (TOC)

Mr. Hammond advised the Board that he will now be reporting the TOC quarterly to mirror when he reports to the legislature. For 2nd quarter 2014, System wide, there were 42,858 transports that were in the case definition. Of those, 14,614 exceeded the standard of 35 minutes, increasing the percentage over the first quarter, which was 31.8% out of standard to 34.1% out of standard. The number one reason for the delay given was "none given" which he has instructed to the ED/EMS Regional Leadership Committee that they need to be putting the correct reason so they can track whether there's an actual problem that needs to be fixed. He added that he will continue to send each facilities data to their CEO quarterly.

G. Discussion of Internal Disaster / Mental Health Holds

Mr. Julian reported on the Legal 2000 mental health holds (L2K's) for June and July of this year. He stated that starting on June 27th they had a new format for the hospitals to report their numbers which will include:

1) Total # of L2K's currently housed in your facility
2) # of L2K's occupying space in inpatient area
3) # of L2K's being held in the Emergency Department (ED)
4) # of L2K's awaiting transport to SNAMHS

L2K's	Daily Average	Average In-Patient	Average ED	Awaiting SNAHMS
June 2014	271	142	175	185
July 2014	291	122	175	180

Mr. Julian reported the total hours for internal disaster (ID) for June and July of this year in comparison to 2013.

	June	July
2014	384.62	393
2013	316	190.03

IV. INFORMATIONAL ITEMS/ DISCUSSION ONLY

A. ED/EMS Regional Leadership Committee Update

Ms. McCrea started out the discussion by providing a brief summary of her conversation with Ross & Neil regarding the discrepancy between the emergency departments and their data. One of the reasons for the discrepancy was that Ross & Neil only look at the patients that are waiting to be transferred and not the patients that are still in need of medical care. She added that only accounts for less than 10% of the discrepancy and that most of the discrepancy comes in the patients insurance status and encouraged the hospitals to drill down and do an insurance assessment to see if they qualify for insurances that other facilities might cover. They also asked that the hospitals take the time to try and get those uninsured patients who might be eligible for some of the newer insurances insured. She felt that having these discussions are helpful in identifying where the obstacles are in this process of getting these patients through our system.

Dr. Slattery added that they had also talked about the fundamental problem with psychiatric patients with no medical concerns or issues being brought to the ED's. They want to start the discussion about collaboration in terms of moving towards getting patients that are cleared in the field with very conservative criteria directly to psychiatric hospitals. The second piece of this is the serial public inebriate program which with their partners Westcare has good criteria in terms of receiving those patients when those beds are available. There is an interest in expanding that by addressing those patients that are in a revolving door between jail and the ED and felt there is some work going forward from a community standpoint.

Mr. Holtz stated that the main focus of the meeting was on the TOC and the importance of ED Managers and directors accurately updating the Transfer of Care system so they have good data and on the EMSystem and accurately updating 3 times a day.

B. Committee Report: QI Directors

Dr. Young reported that the QI Directors met prior and had an interesting case presentation from MedicWest Ambulance with some educational opportunities for the field crews, which they will try and compile. There was a request at the last MAB meeting to bring forward as an in-house trial review of the Rollins 7 SmartMask, which is an oxygen delivery device that is FDA approved. AMR will bring that out in a limited term to get some provider feedback and report back to the QI Committee. He added that they discussed ongoing metrics with the transport QA from the City of Las Vegas and also their metrics going forward with the new spinal immobilization protocol which was clearly a change to the way the patients have been managed in the system and hopefully be able to demonstrate that was the right thing decision.

C. Trauma Report

Ms. Hudema reported that the Regional Trauma Advisory Board (RTAB) has two new non-standing members, former Senator Shirley Breeden was appointed as the new general public representative and Dr. Shauna Davis from the Children's Advocacy Alliance was appointed as the new member representing health education and

prevention services. She added that a workgroup consisting of members from both the RTAB and Trauma Medical Audit Committee continues to meet to the make revisions to the trauma system plan. The workgroup is currently focused on those sections related to performance improvement and there is a work session scheduled for August 27th. The Trauma System Advocacy Committee is working on outreach efforts to increase awareness about the Southern Nevada EMS & Trauma System. A twitter account has been created and fact sheets will be developed to inform policymakers about the impact of traumatic injuries in Southern Nevada. The Committee is also working on legislative efforts related to EMS & Trauma System development and funding in Nevada. Senator Joyce Woodhouse has agreed to introduce a bill draft in support of EMS and trauma system activities statewide. Steve Tafoya, the manager of the state EMS office attended both the RTAB and Advocacy meetings and agreed the legislative effort should be a joint initiative. He and Mary Ellen will develop a strategic plan for how much money is needed and how the money will be allocated. She added that representatives of the state trauma registry have been working to get the registry back up and running. The non-trauma hospitals are able to upload data but the trauma centers are still having difficulty. There's a technical glitch and the SNHD Informatics program has offered technical support to work through some of those challenges. Progress reports will be provided as needed.

Ms. Britt stated that previously she had reported to the Board that there was a bill draft that had been submitted to move the EMS program from the State Health Division to the Department of Public Safety and she has since learned that they have withdrawn that bill draft and have confirmed that that will not be going forward.

D. Report on Survey Conducted Regarding Proposed Bill Draft for Paramedics to Initiate Legal 2000 Process

Ms. McCrea apologized for not being able to present the results of the survey but the Governor's office asked that they wait until they've had a chance to act upon the results which should be in about a month. She stated that they had a total of 607 people complete the survey of which 528 came from Southern Nevada and they had a really strong showing from those people that are on the streets performing this particular task and would definitely be affected by the change. She added that when the results are available she will present it to 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. Chairman 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 Board, Chair Homansky called for a motion to adjourn; the motion was made, seconded and passed unanimously to adjourn at 12:14 p.m.