



**MINUTES**

**EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM**

**PEDIATRIC DESTINATION TASKFORCE**

**December 2, 2009--11:00 A.M.**

**MEMBERS PRESENT**

Michele McKee, MD, Chairman, UMC Hospital  
Mark Calabrese, EMT-P, MedicWest Ambulance  
Nancy Harpin, RN, UMC Hospital  
Debbie Pavlica, RN, St. Rose Siena Hospital  
Frank Pape, DO, Summerlin Hospital (alt)  
Susan Crowder, RN, MountainView Hospital

Ravi Garehgrat, MD, MountainView Hospital  
Josh Hedden, Sunrise Children's Hospital  
Kristine Bruning, RN, Summerlin Hospital  
Allen Marino, MD, MAB Chairman  
Chief Bruce Evans, North Las Vegas Fire Dept

**MEMBERS ABSENT**

Thomas Gowan, MD, Summerlin Hospital

Michael Bachman, MD, Sunrise Children's Hospital

**SNHD STAFF PRESENT**

Joseph J. Heck, DO, Operational Medical Director  
Mary Ellen Britt, Regional Trauma Coordinator  
Trish Beckwith, EMSTS Field Rep  
Lan Lam, Recording Secretary

Rory Chetelat, EMSTS Manager  
John Hammond, EMSTS Field Rep  
Judy Tabat, Administrative Assistant

**PUBLIC ATTENDANCE**

Will Wagon, MountainView Hospital  
Jay Fisher, MD, UMC  
Amy Bochenek, Centennial Hills Hospital  
Robert Freymuller, Summerlin Hospital  
John Higley, EMT-P, Mesquite Fire & Rescue  
Lorelie O'Campo, RN, St. Rose Siena  
Tim Eichholz, EMT-I, CSN  
Alexis Mussi, Sunrise/MountainView Hospital  
David Slattery, MD, Las Vegas Fire & Rescue  
Michael Zbiegien, MD

Kim Dokken, RN, St. Rose Siena  
E.P. Homansky, MD, American Medical Response  
Brian Rogers, EMT-P, Henderson Fire Dept.  
Eric Anderson, MD, FES  
Wade Sears, MD, HCA/FES  
Jennifer Renner, RN, HCA  
Leslie Avery, MD, Sunrise Hospital  
Phuong Lam, St. Rose Siena  
Joseph Richard, EMT-P, Las Vegas Fire & Rescue

**CALL TO ORDER - NOTICE OF POSTING OF AGENDA**

The Pediatric Destination Taskforce convened in the Clemens Conference Room at the Ravenholt Public Health Center at 11:04 a.m. on Wednesday, December 2, 2009. The meeting was called to order by Chairman Michele McKee. She 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 McKee noted that a quorum was present.

## **I. CONSENT AGENDA**

Chairman McKee stated the Consent Agenda consisted of matters to be considered by the Pediatric Destination Taskforce that can be enacted by one motion. Any item may be discussed separately per Taskforce member request. Any exceptions to the Consent Agenda must be stated prior to approval.

### Minutes Pediatric Destination Taskforce Meeting October 7, 2009

Chairman McKee asked for a motion to approve the minutes of the October 7, 2009 Pediatric Destination Taskforce meeting. A motion to accept the minutes was made, seconded and passed unanimously.

## **II. REPORT/DISCUSSION/POSSIBLE ACTION**

### A. Discussion of Taskforce Recommendations and Medical Advisory Board Response

Dr. Marino stated that he had some concerns with the way the recommendation was presented to the MAB. Other destination protocols address the dealings of patients from start to finish; he felt the recommendation from this Taskforce did not include how patients would be dealt with outside the emergency room. Dr. Marino felt that a pediatric intensive care unit (PICU) is an important component that should be considered as it would include a credentialed intensivist along with medical bylaws that specify how long the intensivist has to arrive at the hospital when dealing with critical patients.

Dr. Marino stated that the way the recommendation was presented all pediatric patients would be obliged to go to one of the four pediatric hospitals in the system. He noted that if a parent requests to go to a nearby facility, it should be handled in the usual fashion where the provider would contact the facility for approval to transport. Dr. McKee clarified that the intent was never to supersede the existing protocol.

### B. Review of Previous Discussion of EMSC Tiers in Illinois

Dr. McKee related that a three tiered system was reviewed by the Taskforce when the process began. Following several meetings, a dichotomous decision was made to recommend a single tiered system where a facility either is, or is not a pediatric destination facility. The criteria included:

- 24/7 coverage by a pediatric emergency medicine boarded physician or a pediatric critical care physician
- 80% of pediatric ED nursing staff Emergency Nursing Pediatric Course (ENPC) certified; at least one ENPC certified nurse must be on duty at all times; in addition, PALS certification is required for all nurses.
- QI process to be directed by the pediatric emergency medicine or pediatric critical care physician

### C. Discussion of Current Capabilities within our Locale

Nancy Harpin stated that since the previous MAB meeting, she has looked into the suggestion of adding a PICU as a requirement as they are licensed. Ms. Harpin discovered that the state does not actually license a PICU, rather the facility is licensed as intensive care. The hospital reports it as total number of intensive care beds and then breaks it down. Ms. Harpin sees a benefit to having a PICU but would like to see it as an independent unit with appropriate staff and equipment.

Dr. McKee reported that there was a lot of discussion at the MAB regarding 24/7 coverage by a pediatric emergency medicine or pediatric critical care physician onsite. She does not believe this standard should be compromised as it is already a single tier. Dr. Marino expressed a concern in keeping the criteria rigid since the specialty is difficult to recruit for and he doesn't want to see facilities having to divert as a result of not having coverage. He feels that allowing a board certified physician to cover when a pediatric physician is down is appropriate. Dr. McKee referenced a report published by the Institute of Medicine of the National Academies called *Emergency Care for Children: Growing Pains* which states that pediatric patients need to be cared for specific to their needs and that they're not a part of the general population. She stated that this report also speaks to the capability of facilities in general; referring to staff, equipment, discharge instructions, etc. She stated that making the coverage anything less than 100% would be a mistake. Mr. Chetelat concurred stating that there wouldn't be a point to having a special destination if there wasn't 24/7 coverage. Dr. Marino stated that he would like to avoid having to bypass facilities. Dr. Heck pointed out that although there aren't enough specialty physicians in Las Vegas, stroke and trauma are not allowed to have coverage part of the time; they meet it 100% of the time. He also believes that if there were a commitment to pediatric care, there may be more doctors willing

to work here. It could be the lack of dedication that is deterring physicians from coming to Las Vegas. Dr. Heck stated that the OEMSTS supports Dr. McKee's proposal with the 24/7 coverage; the decision of the PICU will be left to the Taskforce to decide. Dr. Frank Pape disagreed, stating that Summerlin Hospital has made a commitment to their pediatric department but has faced challenges in recruiting. He does not feel there are enough people coming out of the training programs. Dr. Fisher disclosed that there are 1500 boarded physicians in the country with a five percent cushion and 100 released every year nationally. Dr. McKee made a suggestion to go with the recommendation of requiring one of the two pediatric subspecialists and reconvening in approximately six to 12 months to determine whether the facilities were able to meet this goal and the percentage of the time they didn't. She feels that by doing this, an opportunity to add another tier can be reconsidered to expand the catchment area and include more facilities.

Dr. McKee asked the Taskforce to vote on whether or not they'd like to include the PICU to the criteria. At this point in time public comment was made from audience members.

Dr. Wade Sears stated that as long as there is guidance from a pediatric trained physician, this would provide a sufficient level of care. He noted that the second level of care is the most crucial, not the initial.

Dr. Leslie Avery concurred that it is difficult to recruit pediatric subspecialties but stated that they don't ever staff their PICU with a non-board eligible fellowship trained or board certified physician. There are times when they don't have that sort of coverage in which case they'd have the in-house pediatric critical care physician to provide 24/7 back up. Dr. Avery believes critically ill patients do best when they're at larger centers. She agrees with the idea of holding the bar high and meeting the needs of the community. Dr. Avery also pointed out that many pediatric patients are already gravitating towards pediatric facilities so adult ER physicians are not seeing many pediatric patients anymore. As a result, she feels the level of competency in ER physicians could significantly decrease.

Dr. Jay Fisher stated that the system should be looking to progress; therefore, the bar should be set high and the facilities should be given a timeframe to get there.

Dr. Slattery stated that a tiered system would make the most sense but he supports the proposal of starting out with the highest tier and then evolving over time.

Dr. Heck pointed out that even if the protocol is approved, there would be a period of time given to the facilities to meet the criteria.

Robert Freymiller suggested employing an on-call provision to allow facilities to meet the criteria. He noted that JC certified stroke centers don't have a neurologist or neurosurgeon on site; they are contacted by phone when needed. Mr. Freymiller feels the patient should be in good hands for the first 10-20 minutes until one of the specialty physicians call in as there are nurses, ER physicians and physician assistants at the facilities. Dr. McKee disagreed with Mr. Freymiller; she stated there are day to day routine things that happen in a pediatric department that warrant the hands-on person being available as soon as the patient comes through the door.

Will Wagnon questioned the Taskforce as to what their objectives are. Is the objective to expand access points for pediatric care or limit where kids are transported in the valley? He related that when the sickest child is transported, EMS takes them to the closest facility even if they're not a pediatric destination at which point the ER physicians and nurses at that facility are relied upon to stabilize that child and then transfer to the appropriate facility.

#### Discussion of the Future of Pediatric Based Care

Dr. Marino asked if the onsite critical care physician is required to see all children in the ER. Dr. McKee answered no. Dr. Marino further clarified that a general ER physician is the one initially taking charge of the critical care child. Dr. McKee replied that he was correct. Dr. E.P. Homansky asked the Taskforce to come up with a compromise and give the system time before raising the bar. He denoted that it's already a compromise by having a critical care physician that may be upstairs sleeping but isn't called upon unless there was a catastrophe. Dr. Marino stated that having a critical care physician available upstairs asleep and having a critical care physician give instructions to a general ER physician by phone while en route is the same thing.

A motion was made by Dr. Marino to revise the proposal presented as follows (additions italicized):

1. The ED is to have a physician with one of the following subspecialty qualifications onsite 24/7:
  - A) Board Certified/Board Eligible in Pediatric Emergency Medicine (PEM): via either general pediatrics or emergency medicine route
  - B) Board Certified/Board Eligible in Pediatric Critical Care (PCC)

Recommend Physician be Board Certified within 2 years of eligibility. Available within 30 minutes on-site response time
2. Nursing:
  - A) 80% of Pediatric ED nurses to have ENPC (Emergency Nursing Pediatric Course) certification, with at least one ENPC certified nurse present at all times. Two year grace period to obtain this level of certification.
  - B) All nurses should possess PALS (Pediatric Advanced Life Support) certification.
3. QI must be a process managed by either the PEM or PCC subspecialist with routine assessment and processes for improving care.
4. PICU

The motion was approved by: Dr. Ravi Garehgrat, Dr. Pape (alt. for Dr. Thomas Gowan), Mark Calabrese, Debbie Pavlica, Kristine Bruning, and Dr. Marino. The motion was opposed by: Bruce Evans, Nancy Harpin, Susan Crowder, Josh Heddon, and Dr. McKee. The motion passed by a simple majority.

Dr. Marino advised facilities to submit medical bylaws and contracts to the OEMSTS.

### **III. INFORMATIONAL ITEMS/ DISCUSSION ONLY**

None

### **IV. PUBLIC COMMENT**

None

### **V. ADJOURNMENT**

As there was no further business, Chairman McKee called for a motion to adjourn. The motion was seconded and passed unanimously to adjourn at 12:18 p.m.