MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DIVISION OF COMMUNITY HEALTH

MEDICAL ADVISORY BOARD (MAB) MEETING

March 2, 2022 – 11:00 A.M.

MEMBERS PRESENT

Mike Barnum, MD, AMR (Chairman)
Jessica Leduc, DO, HFD
Chief Jennifer Wyatt, CCFD
Nathan Root, HFD
Douglas Fraser, MD, RTAB Rep.
Chief Scott Phillips, LVFR
Samuel Scheller, GEMS
Mike Holtz, MD, CCFD
David Slattery, MD, LVFR
Chief Frank Simone, NLVFD
Chief Shawn Tobler, MFR
Jessica Goldstein, AMR
Kelly Morgan, MD, NLVFD
Evan Befus, MWA

MEMBERS ABSENT

Jeff Davidson, MD, MWA
Nigel Walton, BCFD
Scott Scherr, MD, GEMS
Ryan Hodnick, DO, Moapa
Chief Kim Moore, HFD
Chief Stephen Neel, MVFD
Nate Jenson, DO, MFR
David Obert, DO, CA
Daniel Rollins, MD, BCFD

SNHD STAFF PRESENT

John Hammond, EMSTS Manager
Christian Young, MD, EMSTS Medical Director
Edward Winder, Associate Counsel
Laura Palmer, EMSTS Supervisor
Chad Kingsley, EMSTS Regional Trauma Coordinator

PUBLIC ATTENDANCE

Samantha McKee
Logan Larson
Lisa Rogge
Daniel Shinn
Brett Olbur
Jeremy Kilburn
Kat Fivelstad, MD
Faith Lewis
Jim McAllister
Ethan Van Muyden
John Recicar
Sandra McMurry
Ryan Young
Paul Stepaniuk
Maya Holmes
Amanda Kelley
Daniel Llamas

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

Dr. Mike Barnum called the meeting to order at 11:04 a.m. and stated the Affidavit of Posting was posted in accordance with the Nevada Open Meeting Law. All Board members joined the meeting via teleconference and the roll call was administered by Laura Palmer, EMSTS Supervisor, who noted that a quorum was present.

I. FIRST PUBLIC COMMENT

Members of the public are allowed to speak on Action items after the Committee's discussion and prior to their vote. Each speaker will be given five (5) minutes to address the Committee on the pending topic. No person may yield his or her time to another person. In those situations where large groups of people desire to address the Committee on the same matter, the Chair may request that those groups select only one or two speakers from the group to address the Committee on behalf of the group. Once the action item is closed, no additional public comment will be accepted. Chairman Barnum 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

Dr. Barnum stated the Consent Agenda consists 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: December 1, 2021

A motion was made by Chief Simone, seconded by Dr. Morgan, and carried unanimously to approve the Consent Agenda as written.

III. CHIEF HEALTH OFFICE REPORT

Mr. Hammond informed the Board that Mike O'Callaghan Military Medical Center was approved as a Level III Trauma Center by the Board of Health. The American College of Surgeons will schedule a consultation visit once they start to receive trauma patients. A protocol has been developed that defines their catchment area, which is anything east of Pecos, and when Pecos hits the I-15, anything east of I-15, and anything north of Lake Mead. Mr. Hammond noted that he will be sending out the amended TFTC Protocol so the agencies can begin training their EMS providers.

IV. REPORT/DISCUSSION/ACTION

A. Discussion of BiPap Pilot Program

Mr. Root stated Henderson Fire Department (HFD) was fortunate to receive Zoll Z Vent Transport Ventilators as part of the grant for the Covid response. They submitted paperwork for a proposed pilot study to utilize BiPap for non-invasive positive pressure ventilation. In only one case a patient that was placed on PiPap in the field progressed to an intubation. To date, they have compiled data from 39 cases; 92% of those patients had a positive outcome. Only three patients who were delivered to a hospital progressed to an intubation. In two of the cases, the continuity of care ended when the patients were delivered to the hospital and the ER physician immediately intubated the patient. One of those patients was intubated almost six hours after HFD's care; the other patient was intubated almost nine days after admission. Mr. Root noted that the patients are turning around in such a special way in a very uncontrolled environment. The best part is they can control the comfort of these patients en route to the hospital. In addition, they are also seeing a little less cardiac pre-load and after-load effects for CHF patients when used in conjunction with high dose Nitro and getting the blood pressures to come down a little bit more, and at a steadier rate.

Mr. Root stated the pilot paperwork was delivered to the OEMSTS and HFD is revisiting the training aspect. The proposal is to include BiPap in the CPAP protocol and change the name of the protocol from "continuous positive airway pressure" to "non-invasive." So the agencies would have the option to either use CPAP or BiPap, and if you have the ability to do both, the provider in the field could make the judgment of starting one and progressing to the other, or leading with one and staying with that one. The indications/contraindications for both remain the same, so the procedures would be aligned.

Mr. Scheller stated he is in favor of BiPap, but his concern is the significant cost that will be incurred, especially for the smaller agencies. He asked whether the long-term goal is to put ventilators on all ALS vehicles and change the scope of practice to allow for paramedics to use the full setting on the ventilator. Mr. Hammond stated that ventilators have been on the equipment list as an optional item for years. He is okay to redefine the current CPAP protocol and add another potential pathway for a non-invasive airway. He is not okay with creating disparity because of one agency's ability/inability to purchase the equipment. If there is a similarity between the two that causes no benefit or risk of one over the other, than he's okay with each agency using the equipment they have.

Mr. Hammond noted that he would like to see more than just a month's worth of data. It was agreed the protocol outline would be referred to DDP and HFD will continue the pilot study to collect more data.

Mr. Root related that crews are currently calling in for orders to use BiPap from the physician at the hospital the patient is being transported. No physician has denied the request, and HFD is requesting a standing order during the pilot. Mr. Hammond stated that although frustrating, they will need to continue to call for orders because it is a pilot protocol. Several doctors responded that they would not have a problem with a standing order for BiPap from a safety standpoint. Mr. Hammond stated that the way the pilot was presented included calling for orders, and he wants to protect the crews and agencies from potential issues down the road. After much discussion, it was agreed that HFD will seek approval from the physician groups at their destination hospitals for a standing order. They will communicate that directly to the District, and the District will let them know when all the components are in place so that they can modify the pilot project proposal.

A motion was made to refer the CPAP protocol to the Drug/Device/Protocol Committee to approve a name change to Non-Invasive Positive Pressure Ventilations protocol. The motion was seconded by Dr. Slattery and carried unanimously.

B. Committee Report: Education Committee (03/02/2022)

Chief Simone reported the Education Committee approved the draft bylaws that included a restructure of the membership. Nominations were received and the following individuals were approved to serve as standing members:

Three representatives from Public EMS providers:	Chief Frank Simone Nathan Root Chris Racine
Three representatives from Private EMS providers:	Bud Adams Chris Stachyra
One representative from Fixed-Wing EMS providers:	Ryan Fraser
One representative from Rotor-Wing EMS providers:	Krystal French
One representative from each Paramedic Educational Program:	Braiden Green Susie Kochevar Matthew Dryden
One representative from EMT/AEMT Initial Education Training Program not otherwise affiliated with an agency or Paramedic Educational Program:	Deb Dailey

Dr. Barnum reported that the second agenda item discussed was the pit crew approach concept for pre-assignment of roles in cardiac arrest. It was agreed that the educational component needs to reconcile the team roles to address both a single and dual agency response. The Committee approved the addition of the following pearl for inclusion in the cardiac arrest protocols:

"Pre-assignment of Pit Crew Roles is recommended. When not possible tasks can be assigned by order of arrival.

1 or 1st at patient side – Airway
2 or 2nd at patient side – Compressions
3 or 3rd at patient side – IV/IO Access, Med Administration
4 or 4th at patient side – Measure, Monitor/AED Placement
5 or 5th at patient side – Family Liaison/History Gathering"

Dr. Barnum reported that the Committee also discussed the SNHD Mentorship Program, the preceptor program for paramedic students. In response to concerns brought up by several educators in the system, the Committee will work on amending the definition of a "critical patient" and subsequently what constitutes a critical call.

C. Committee Report: Drug/Device/Protocol (DDP) Committee (03/02/2022)

Dr. Holtz reported the Committee approved the pit crew approach concept to address cardiac arrests in Clark County. They also discussed draft revisions to the pediatric cardiac arrest protocol that would adjust the order of treatment. It was agreed to table the discussion until the next meeting.

Dr. Holtz reported the Committee also discussed issues related to EMS providers when they are in remote and wilderness situations. Clarifying language will be added to the Termination of Resuscitation protocol and be brought back for discussion at next month's meeting.

V. INFORMATIONAL ITEMS/ DISCUSSION ONLY

Dr. Barnum expressed sadness with the untimely death of Dr. Matthew Horbal. He recognized his contributions to the Medical Advisory Board, DDP Committee and the Clark County EMS community.

Dr. Slattery welcomed Scott Phillips as the Assistant Chief for Las Vegas Fire & Rescue. He stated Mr. Phillips brings a wealth of experience as a firefighter/paramedic, as well as an exceptional EMS Supervisor for the system. He noted he has always been a leader in every position held at LVFR, and he is looking forward to his leadership serving on the Board. Dr. Slattery also thanked Battalion Chief Joe Richard for his past service on the Board.

Dr. Barnum reminded everyone that swimming pool and hot car season is quickly approaching so this is the time to start implementing their plans to address these issues.

A. ED/EMS Regional Leadership Committee Update

Jessica Goldstein reported the Committee heard a presentation from Jessica Wallace about AHA's policy statement on STEMIs. They were also introduced to Spring Valley's new cardiac and stroke coordinators.

Ms. Goldstein reported the Committee discussed the need to continually message the crews about the importance of early alerts to ensure best care and timely response from the cath lab and cardiology team. The same was discussed to address stroke care. The Committee also discussed the need to ensure that the crews obtain pertinent personal information on scene.

B. QI Directors Committee Update

Dr. Young reported the Committee continued their discussion on the Termination of Resuscitation and Prehospital Death Determination protocols, which is now a standing agenda item.

C. Emerging Trends

Dr. Young stated there has been discussion among the trauma center medical directors about the re-routing of hanging cases. In looking at these patients through a trauma lens, as soon as they are altered, as frequently happens in cardiac arrests, that pretty much routes them to a Step 1 or Step 2 trauma center just because they're in extremis. Most of these people are succumbing to injuries that are not necessarily traumatic. The cases are mostly cerebral hypoxia, pulmonary vascular congestion, and a run of medical codes. Followed by those not succumbing to their injuries, followed by forensics evaluations for strangulations, as well as toxicology evaluations, and therapeutic hypothermia after the codes. The discussion was the best location for these patients is just the closest emergency department capable of handling a cardiac arrest. They don't need to bypass multiple hospitals to get to a trauma center as there is really nothing specifically done for these cases at the trauma centers. The exception is if there is an element of penetrating trauma to the neck. That, of course, changes things and now shifts the lens through a trauma case and thus to the TFTC protocol and TFTC routing. In looking at these cases, it is extremely rare where there is an actual C-spine fracture. These are not hangings in the sense of the classic judicial hanging where you have an appropriately placed knot where someone is falling greater than their body height resulting in their death. These are mostly asphyxiation type injuries. They are working with the EMS liaisons throughout the different health care systems to slowly change that behavior, which will be discussed in the Education and DDP committees in the future.

Dr. Fraser, trauma director at UMC, stated they would like to stop the trend of automatically taking these patients to a trauma center and get them to the appropriate facility. He stated less than 5% of any of the hangings they have been are truly asphyxiation. If later they are found to have a blunt cerebral vascular injury in their carotid, or an airway issue, they can always be transferred to a trauma center for those higher level of care issues, but it is a rare occurrence. He noted the sooner they can get that information out to the EMS providers

to start delivering this subset of patients to the nearest non-trauma center, the better.

VI. SECOND PUBLIC COMMENT

Members of the public are allowed to speak on Action items after the Committee's discussion and prior to their vote. Each speaker will be given five (5) minutes to address the Committee on the pending topic. No person may yield his or her time to another person. In those situations where large groups of people desire to address the Committee on the same matter, the Chair may request that those groups select only one or two speakers from the group to address the Committee on behalf of the group. Once the action item is closed, no additional public comment will be accepted. Chairman Barnum asked if anyone wished to address the Board pertaining to items listed on the Agenda. Seeing no one, he closed the Second Public Comment portion of the meeting.

VII. ADJOURNMENT

There being no further business, the meeting was adjourned at 11:55 a.m.