



MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DIVISION OF COMMUNITY HEALTH

MEDICAL ADVISORY BOARD (MAB) MEETING

October 3, 2018 – 9:00 A.M.

MEMBERS PRESENT

Tressa Naik, MD, HFD (Chair)
Jim Kindel, BCFD
Chelsea Monge, CA
Jason Driggars, AMR
David Slattery, MD, LVFR
Chief Shawn Tobler, MFR
Chief Lisa Price, NLVFR
John Fildes, MD, RTAB Representative
Mike Holtz, MD, CCFD

Karen Dalmaso-Hughey, AMR
Troy Tuke, CCFD
Chief Kim Moore, HFD
Chief Jon Stevenson, LVFR
Stephen Johnson, MWA
Matthew Horbal, MD, MCFD
K. Alexander Malone, MD, NLVFR
David Slattery, MD, LVFR (via phone)

MEMBERS ABSENT

Sam Scheller, GEMS
Logan Sondrup, MD, CA
Jeff Davidson, MD, MWA
Jorge Gonzalez, MCFD

Daniel Rollins, MD, BCFD
Scott Scherr, MD, GEMS
Jarrod Johnson, DO, MFR

SNHD STAFF PRESENT

Christian Young, MD, EMSTS Medical Director
Laura Palmer, EMSTS Supervisor

John Hammond, EMSTS Manager
Rae Pettie, Recording Secretary

PUBLIC ATTENDANCE

Melanie Robison, AMR
Cameron Seisan, CA
Frank Simone, NLVFD

Carl Bottorf, AirMed
James McAllister, LVMS
August Corrales, UMC

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The Medical Advisory Board convened in the Red Rock Trails Conference Room at the Southern Nevada Health District on Wednesday, October 3, 2018. Dr. Tressa Naik called the meeting to order at 9:00 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. Naik 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. Chairperson Naik asked if anyone wished to address the Board pertaining to items listed on the Agenda. Seeing no one she closed the Public Comment portion of the meeting.

II. CONSENT AGENDA

Dr. Naik 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: August 1, 2018

Dr. Naik asked for a motion to approve the August 1, 2018 minutes of the Medical Advisory Board. *A motion was made by Chief Moore and seconded by Dr. Barnum to approve the minutes as written. The motion carried unanimously.*

B. Discussion of Possible Protocol Development for the Use of Intravenous Acetaminophen for Referral to DDP

Mr. Calabrese stated CCFD is in the process of researching the use of IV Acetaminophen for pain. There have been good results in the hospital setting for its use as an alternative to narcotics. It is his understanding that it is not currently being used in the prehospital setting throughout the country. Dr. Barnum noted that Acetaminophen is very expensive. Mr. Calabrese replied that CCFD was given a quote of \$22 per dose. Dr. Naik noted that HFD was quoted \$40 to \$50 per dose. She stated that they are also looking at alternatives, such as Toradol. They are currently able to obtain it for \$12 per dose if they buy in mass quantities.

A motion was made by Dr. Barnum to refer the use of Intravenous Acetaminophen and other potential non-opioid pain treatment to the Drug/Device/Protocol Committee for further discussion. The motion was seconded by Dr. Holtz and carried unanimously.

C. Discussion of Possible Protocol Development of Mass Casualty Incident for Referral to the Drug/ Device/ Protocol Committee

Chief Moore stated that the fire departments are currently working with the hospitals on a rewrite of the 2012 plan.

A motion was made by Dr. Barnum to refer the possible protocol development for Mass Casualty Incidents to the Drug/Device/Protocol Committee for further discussion. The motion was seconded by Dr. Johnson and carried unanimously.

III. CHIEF HEALTH OFFICE REPORT

No report was given.

IV. REPORT/DISCUSSION/POSSIBLE ACTION

A. Review/Discuss the Following Protocols

1. Prehospital Death Determination (PDD)
2. Vascular Access
3. Addition of 2% Lidocaine to the Formulary

Prehospital Death Determination (PDD)

Dr. Slattery referred the Committee to the draft PDD protocol and stated the medical component works well but, in his view, it still needs work from an operational standpoint. He suggested they refer the discussion to both the QI Directors (QI) and Drug/Device/Protocol (DDP) Committees to be further vetted. Dr. Barnum stated the QI meeting is a closed meeting where they can review cases in a protected environment prior to taking it back to the DDP. They will walk those cases through the protocol to see how they would have been handled because there is a fear that we will have situations where either inappropriate patients were being resuscitated or not resuscitated. Dr. Slattery agreed that they need to have complete consensus about their decision.

A motion was made by Dr. Barnum to refer the draft Prehospital Death Determination protocol to the QI Directors Committee and the Drug/Device/Protocol Committee for further discussion. The motion was seconded by Chief Moore and carried unanimously.

Mr. Simone asked what type of cases need to be brought to the QI meeting. Dr. Slattery stated he would send something out to them through the QA portal.

Vascular Access Protocol

Dr. Barnum referred the Committee to the draft Vascular Access protocol. He stated the revisions relate to expanding IO access beyond the unconscious, unresponsive patients.

A motion was made by Dr. Barnum to approve the revisions made to the draft Vascular Access protocol. The motion was seconded by Mr. Simone and carried unanimously.

Discussion ensued about the addition of 2% Lidocaine to the formulary. Dr. Barnum stated there are supply problems with obtaining the medication. He suggested they approve it and have the DDP work on additional alternatives to provide the patient some pain relief before fluids and medications are administered.

A motion was made by Dr. Barnum to approve 2% Lidocaine as an agent, and to refer the agenda item to the DDP to work on additional alternatives for pain relief. The motion was seconded by Mr. Johnson and carried unanimously.

Dr. Naik asked why we chose 2% Lidocaine instead of 1%. Dr. Fildes stated the failure of local anesthetics is inadequate waiting time for its onset of action as opposed to its concentration; with that as a principle, there may be other alternatives. He suggested they contact one of the anesthesiologists in an effort to create a longer list.

B. Committee Report: Drug/Device/Protocol Committee

Dr. Barnum stated everything that occurred in the DDP meeting was previously discussed in Agenda Item A. "Review/Discuss the Following Protocols."

C. Committee Report: Education Committee

Mr. Simone reported the Committee discussed multiple topics, one of which included a proposed change to the clinical components of the paramedic education program. An additional meeting was scheduled for October 12th to continue the discussion.

The Committee also talked about a procedural change to add Fire Instructor I certification as an alternative pre-requisite in the District Procedure for EMS Instructor I endorsement to mirror the pre-requisite of allowing Fire Instructor II certification for EMS Instructor II endorsement. The revision will be depicted in the next iteration of the EMS Procedure Manual.

Mr. Simone noted there was considerable discussion about the Master EMS Instructor entrance requirements. There are currently ten Master EMS Instructors who are endorsed to put on train-the-trainer courses. There is a gross deficiency in the valley and the agencies need assistance. They also proposed a portfolio requirement for the individual to demonstrate consistent educational standards. The Committee agreed to continue the discussion at the October 12th meeting.

The final agenda item discussed was to allow EMTs to be endorsed as EMS Instructors. Since EMS Regulations currently allow only AEMTs and Paramedics to be endorsed as EMS Instructors they agreed to table the discussion until the next regulations workshop.

D. OEMSTS 3rd Quarter 2018 Reports

1. Transfer of Care Report

Mr. Julian reported that the Transfer of Care statistics have not been prepared and will be provided at the next regularly scheduled meeting.

2. Internal Disaster 3rd Quarter Report

	July	August	September
2017	1.42	2.0	2.17
2018	0.83	0.41	0.05

3. Mental Health Holds 1st Quarter Report

	Total L2Ks 2018/2017	Inpatient 2018/2017	Emergency Dept. 2018/2017	Awaiting SNAMHS 2018/2017
July	264/250	130/106	138/144	136/106
August	280/251	137/112	143/139	114/124
September	251/221	117/100	137/122	128/109

Dr. Naik asked if there was an update on how the process of taking patients who meet the legal hold criteria directly to an emergency room (ER). Chief Stevenson replied that the subject has been very warmly received by Metro. Having a licensed clinical social worker on the unit who is trained in de-escalation techniques has diverted approximately 40% of the patients that would have otherwise been legally formed. This includes patients who agree to go see a mental health professional. However, they have unearthed a larger discussion that needs to take place regarding the challenges of Medicaid reimbursement. One of the providers will not reimburse the mental health facility for the assessment and stabilization of the patients that are medically cleared to be taken to a mental health facility. Their direct guidance is the patient needs to go to the ER no matter what.

Chief Stevenson noted that the CRT (Crisis Response Team) has been successful in a way they hadn't imagined. There is good patient satisfaction and they have heard excellent anecdotal incidents with individual patients. Metro has liked the program so much that they are working hard to find a way to replicate another version of it in the county area to expand it further. They arranged for a meeting with a couple of the County Commissioners. They are also trying to bring in additional stakeholders.

Dr. Young stated that one of the potential points of heartburn was that if a patient was not medically cleared in the ER and brought straight to a mental health facility that we were going to uncover a rash of thyrotoxicosis and sepsis found in those patients. He asked if there have been any fallouts, anecdotally or otherwise, from a medical clearance standpoint, not financial. Chief Stevenson responded there has not been. Their protocol is a model of the draft protocol that Dr. Slattery helped to develop. The protocol is conservative. There is three days of training just to review the mimics of psychiatric events. They have not uncovered any medical issues. Psychologically, more often than not, they have found L2Ks being applied inappropriately for things like dementia, drug abuse or intoxication. When it was pointed out to law enforcement officers they responded that they didn't recognize it and weren't sure what to call it.

Mr. Driggers stated AMR has seen about 650 patients since they started in April. There is a field algorithm to screen the patient and divert them to a mental health facility. As soon as they can get past the barrier with Medicaid, the payor, he feels a lot of other facilities in the valley are going to be eager to participate. Dr. Naik asked if Dr. Iser could be an advocate and talk to the Medicaid group. Dr. Young responded that he thought he would. He suggested they bring the data to a QI Directors meeting to vet it through the QA process. Obtaining data that ultimately will be a little more compelling may prompt a change in state law. Dr. Barnum agreed that they will need a lot of support. Medically cleared patients need to be taken to the psychiatric facility for the services they provide. It's not appropriate to put an undue burden on the emergency system.

Mr. Simone related that many of the payors follow the Nevada State Medicare and Medicaid payment plan. They can approach an amendment to the state plan. Mr. Driggers noted there are about five or six different HMOs out there as well. Dr. Young stated that we received backing from some of the community paramedicine initiatives,

such as REMSA's pilot program. Maybe there is a way to spin this as a community paramedicine initiative and obtain some funding that way.

Chief Stevenson stated there are underlying deeper issues that exist. He explained that Medicaid funding falls into two buckets for payment. One of them is a medical bucket, the other one is a mental health bucket. There is a cap to expenditures from the Medicaid bucket, but there is no cap to expenditures from the medical bucket. The challenge is that when a patient comes in with a mental health complaint and they get funneled to the medical side, they use up the medical dollars. The mental health dollars are untouched, and at the end of the year, the managed Medicaid apparently gets to keep whatever is not spent from the mental health bucket. The cynical version wonders if that's not incentivizing these mental health patients being channeled over to the medical bucket. It doesn't make any difference if they're in a psychiatric facility or the ER for three days if it's coming out of the medical bucket. The more charitable explanation may be that they know the floodgates would be opened and whatever mental health dollars there were to begin with, there wouldn't be enough so there needs to be some vetting of the system to make sure those funds don't get drawn down. He stated it will require some state oversight and direction to be able to make the Medicaid rules apply more effectively for the patient. It's a deeper problem and we will need a lot of agency partners to make the necessary changes. Dr. Fildes stated that the patients they're caring for are the canaries in the coal mine. The problem won't be solved at that level. It will require a much higher level of regulatory change to level the playing field for mental health.

In response to a question about the CRT, Chief Stevenson related that the patients come through the 911 system. The algorithm generates either a 25 Alpha or 25 Bravo psychiatric call. The CRT unit responds on an ALS unit with a licensed clinical social worker who assesses both the patient's physical and mental health. From there they make the determination as to whether or not the patient is appropriate for an ER or to be taken to Desert Parkway. Once they're taken to Desert Parkway the expectation is that they be stabilized. Desert Parkway either arranges for out-patient services, or if nothing else, just intake and stabilization. LVFR's licensed clinical social worker comes from the Southern Nevada CHIPs. They follow up with the patient within three days of contact to ensure there is an appropriate referral for services that are necessary. LVFR tries to ensure there is some connectivity with services as often as possible.

Dr. Naik thanked everyone for their input. She stated this is just the tip of the iceberg, and they should all get behind it. It would be a great advantage to the hospitals, fire departments and EMS to get the process started.

V. INFORMATIONAL ITEMS/ DISCUSSION ONLY

A. ED/EMS Regional Leadership Committee Update

Mr. Calabrese reported the Committee talked about which hospitals have submitted their information to become a STEMI center. They spent the remainder of the meeting clarifying the type of feedback they wanted for STEMIs. They want to make it consistent and he is hopeful they are ready to move forward soon. He stated that future issues will be stroke feedback and sepsis alerts, including prehospital sepsis.

B. Airway Management Task Force Update

Dr. Slattery reported the agencies attended a demonstration of the QuickTrach at the simulation lab. Everyone appeared comfortable with the device and it was a successful lab.

VI. 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 included on an agenda as an item upon which action may be taken pursuant to NRS 241.020. All comments are limited to five (5) minutes. Dr. Naik asked if anyone wished to address the Board.

Mr. Calabrese introduced Dr. Mike Holtz as one of CCFD's new co-medical directors. He stated their other medical director is Dr. Scott Scheer.

Mr. Cox reported that LVFR implemented a triage tag drill in collaboration with AMR and MW for Life is Beautiful (LIB). All transports out of LIB were tagged using the S.T.A.R.T. Triage with RPM methodology

(Respirations, Perfusion, Mental Status). They reviewed the RPM retrospectively and identified some strengths and weaknesses. In the future LVFR will be trying to partner up with the rest of the valley to implement some type of Triage Tuesday. One within the city, and then maybe expand it to the entire system so everyone is comfortable with them. They are interested in how the triage tags will work once the patient reaches the hospital. And an important piece is how to reconcile the patients.

VII. ADJOURNMENT

A motion was made by Dr. Johnson to adjourn the meeting. The motion was seconded by Mr. Simone and carried unanimously.