MINUTES
EMERGENCY MEDICAL SERVICES
MEDICAL ADVISORY BOARD MEETING
JANUARY 3, 2001--6:00 P.M.

MEMBERS PRESENT

Jeff Davidson, M.D., Chairman.
Philis Beilfuss, R.N.
Jeff Greenlee, D.O.
Deputy Chief Ken Riddle
Donald Reisch, M.D.
E. P. Homansky, M.D.
Richard Henderson, M.D.
Michael Zbiegien, M.D., Alternate
Michael Walsh, FAB Representative
Donald Kwalick, M.D.
Brian Rogers
Division Chief Randy Howell
David Watson, M.D., Alternate
Deputy Chief Steve Hanson
Pam Turner, R.N.
David Daitch, D.O.
Karen Laauwe, M.D.
David Slattery, M.D.
Allen Marino, M.D.

MEMBERS ABSENT

John Fildes, M.D.
Marc Abramow, M.D.

CCHD STAFF PRESENT

Jane Shunney, R.N.
Mary Ellen Britt, R.N.
Ellen Wilfong, Recording Secretary
LaRue Scull
Kelly Quinn
Jean Folk

PUBLIC ATTENDANCE

NAME	ASSOCIATED WITH
Candice Kidd	Westcare
Chris Cox	Westcare
Rick Wilber	Flight for Life
Todd Jaynes	Mesquite Fire & Rescue
Jim Kindel	Mesquite Fire & Rescue
Mary Levy, R.N.	UMC Paramedic Program
Pete Carlo	Southwest Ambulance
Aaron Harvey	Henderson Fire Department
Tim Gardner	Henderson Fire Department
Virginia Deleon, R.N.	St. Rose Dominican Hospital
Nancy Cassell	Community College of So. NV
Henry Clinton	Las Vegas Fire & Rescue
Derek Cox	American Medical Response
Karla Hilts, R.N.	Lake Mead Hospital Med Center
Scott Rolfe, R.N.	University Medical Center
Patti Glavan, R.N.	Boulder City Hospital
Scott Johnson	Las Vegas Fire & Rescue
Joelle Babula	Las Vegas Review-Journal
Sandy Young, R.N.	Las Vegas Fire & Rescue
Alice Conroy, R.N.	Sunrise Hospital Medical Center

Margaret Williams, R.N.	Mountain View Hospital
Kathy Kopka, R.N.	Sunrise Hospital Medical Center
Ken Thompson, R.N.	Sunrise Hospital Medical Center
Trace Skeen	American Medical Response
Nancy Harland, R.N.	Sunrise Hospital Medical Center
Brad Goss, R.N.	STEALTH
Jacqueline Taylor	University Medical Center
Joe Calise, R.N.	Summerlin Hospital
Jon Kingma	Boulder City Fire Department
Anthony Jennings, D.O.	University Medical Center-CCT
Davette Shea, R.N.	University Medical Center-QC
Chris Parker	American Medical Response

CALL TO ORDER-NOTICE OF POSTING OF AGENDA

The EMS Medical Advisory Board convened at 6:04 p.m., on Wednesday, January 3, 2001 in the Clemens Conference Room at the Otto H. Ravenholt, M.D. Public Health Center. The meeting was called to order by Chairman Jeff Davidson, M.D. He stated 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. Davidson noted that a quorum was present.

I. CONSENT AGENDA

A motion for Board approval of the following items on the Consent Agenda was made, seconded, and carried unanimously.

A. Minutes Medical Advisory Board Meeting December 6, 2000

B. Referral to Drug Committee:

a. Proposed Deletion of Diazepam (Valium) from Official Paramedic Drug Inventory

b. Proposed Revisions to ACLS Dysrhythmia, Procedure and Drug Protocols

II. REPORT/DISCUSSION/POSSIBLE ACTION

A. Draft Revised Midazolam (Versed) Drug Protocol

Dr. Laauwe referenced the revised draft Midazolam (Versed) drug protocol included in the MAB packets. She stated the pediatric and adult doses were separated to provide easier reading. Dr. Daitch made a motion for Medical Advisory Board endorsement of the revised draft Midazolam (Versed) drug protocol. The motion was seconded by Dr. Slattery. Dr. Davidson called for discussion on the motion. Brian Rogers stated E.D. physicians should be made aware they cannot refuse to write replacement prescriptions for Midazolam, especially now that it is to be used for seizures. He said AMR ambulance crews have problems getting replacement Midazolam prescriptions from some E.D. physicians, as they are reluctant to let paramedics use the drug. He suggested the Medical Advisory Board write a letter to all the emergency departments regarding this issue. He felt that if the revised protocol allows paramedics to give Midazolam for specified seizure indications without a physician's order, it is the E.D. doctor's responsibility to write a replacement prescription when the drug is used. Chief Riddle remarked that hospitals providing telemetry communications must restock ambulance medications so as to be in

compliance with Clark County Health District EMS Regulations. Dr. Davidson said he had no problem with the MAB writing a letter to the ED's. Dr. Greenlee suggested including EMS Regulations section 1300.200 in the letter. (EMS Regulations Section 1300.200 states "Any hospital which provides telemetry orders to Ambulance Attendants, Air Ambulance Attendants, and Firefighter Attendants shall comply with the provisions set forth in subsections I through VII." Subsection VII reads, "Provide for the restocking of expended medical supplies including medications and IV fluids that have been recommended by the Medical Advisory Board, reviewed by the Facilities Advisory Board and directed by the Health Officer, unless prohibited by State or Federal law.")

Dr. Zbiegien, his colleagues at Sunrise Hospital's Pediatric Emergency Department, and Pediatric E.D. physicians at UMC, have discussed the prehospital use of Midazolam for pediatric seizures and recommended some changes to the draft protocol. They are as follows:

1. Telemetry physician's orders needed for all pediatric intubation, sedation, and seizure patients.

2. <u>Intubation/sedation prior to cardioversion</u>
   IV - 0.1 mg/kg titrate to effect. Maximum single dose: 5 mg. Must be given slowly over a period of 3-5 minutes. Allow at least 5 minutes before repeating dose to fully evaluate sedative effect. Maximum total dose: 10 mg.

   <u>Seizures</u>
   IV - 0.1 mg/kg titrate to effect. Maximum single dose: 5 mg. Must be given slowly over a period of 3-5 minutes. Allow at least 5 minutes before repeating dose to fully evaluate effect on seizure activity. Maximum total dose: 10 mg.

   IM - 0.2 mg/kg. Maximum single dose: 7 mg. May not be repeated. Care must be taken to verify that the needle is not in a vessel prior to injection.

Dr. Zbiegien explained the reason for changing the IM dose from a maximum of 10 mg. to 7 mg. is based on recommendations from Dr. Chamberlain, in Washington, D.C., who is a proponent of using IM Midazolam for pediatric seizure patients. The dose should be 0.1 to 0.2 mg/kg depending upon whether the patient is taking other medications such as Erythromycin which increases the serum levels of Midazolam. Also, IV Midazolam should be given no faster than 3-5 minutes as it can cause seizures in neonates and small babies if given too rapidly.

<u>After much discussion among the Board members regarding the new pediatric dosage information brought forward by Dr. Zbiegien, Dr. Daitch withdrew his motion for MAB approval of the draft revised Midazolam (Versed) drug protocol.</u>

Dr. Davidson felt it was acceptable to vote on the adult section of the protocol, but requested Dr. Zbiegien and his pediatric colleagues present their final recommendations as soon as possible to the Drug Committee so that the entire Midazolam protocol, with all revisions, can be presented to the Medical Advisory Board for endorsement. Dr. Marino remarked that the current draft revisions to the Midazolam protocol, as presented in the MAB packets, are based on San Diego County, California's protocol endorsed by the local EMSC program. He suggested Dr. Zbiegien and his colleagues talk with pediatric E.D. physicians in San Diego who follow this protocol. He offered to help them get in touch with the San Diego group.

Dr. Daitch then made a motion for MAB approval of just the adult sections (no pediatric language) of the draft revised Midazolam (Versed) drug protocol. The motion was seconded and a vote was taken. The motion did not carry.

The Board decided to wait until next month to vote on the entire Midazolam protocol to allow time for Dr. Zbiegien's recommendations for the pediatric sections to be included in the revised draft. LaRue Scull stated that all materials for presentation at the February 7th Medical Advisory Board meeting must be submitted to the EMS office no later than the 15th of January.

B. Education Committee Report

Draft EMS Procedure for Chronic Public Inebriate Protocol

Dr. Laauwe referenced the draft Chronic Public Inebriate (CPI) protocol included in the MAB packets. She noted that an algorithm for handling CPI patients was printed on the back of the document. She stated the top box on the algorithm did not reproduce well when photocopied and should read "911 Call." She commented that the Education Committee members approved the draft protocol and they recommend its endorsement by the MAB.

The MAB members suggested several changes to the draft CPI protocol:

1. Change the order of the algorithm so that the "Assessment" box comes before the "CPI Protocol Initiated" box.

2. Replace "Westcare" with "approved alcohol and drug abuse facility" wherever shown in the algorithm.

Chief Riddle made a motion for Medical Advisory Board endorsement of the draft EMS Procedure for Chronic Public Inebriate Protocol with the above-suggested changes. The motion was seconded by Dr. Reisch and was unanimously carried.

Brian Rogers asked who will do the CPI educational program for the prehospital providers? He wanted to make sure that everyone receives the same training. Davette Shea replied that the Westcare staff are willing to help develop the educational component of the protocol so that all agencies get the same information and training. The MAB agreed that the protocol not go into effect until all provider agencies have received the training.

C. Facilities Advisory Board 01/03/01 Meeting

Mr. Walsh reported the Facilities Advisory Board discussed the Department of Health and Human Services' Office of Inspector General (OIG) opinion on ambulance restocking. The OIG proposed an anti-kickback statute "safe harbor" that would protect certain arrangements involving hospitals that restock drugs and medical supplies without charge for ambulance services transporting emergency patients to hospitals. An informational packet regarding the OIG opinion via news releases and the *Federal Register* was given to each FAB member for review in preparation for discussion at the next meeting. Mr. Walsh questioned whether hospitals replenishing ambulance supplies on an out-patient basis would jeopardize their in-patient pharmacy licenses. He stated he will have Summerlin Hospital's pharmacy director investigate this issue and will report back to the FAB. He noted that Dr. Carlos Brandenburg, Ph.D., Administrator, State of Nevada, Division of Mental Health and Development Services, will be coming to a 1:00 p.m. meeting in the Clemens Room at the District Health Center on January 24th to receive input regarding mental health concerns which affect all hospitals and transport agencies in Clark County. He extended an invitation to attend to all interested parties.

Blue Ribbon Committee Report

Mr. Walsh stated the Blue Ribbon Committee held its final meeting on December 7th and submitted the following recommendations to the Facilities Advisory Board:

1. Divert categories would be modified to delete Critical Care and Emergency Department categories. An open/closed model would replace the current system. The proposal would exclude pediatric, NICU, burn and trauma divert categories. The recommendation was approved by the FAB with one member opposed.

2. For purposes of divert, the county would be divided into three geographical regions and only one hospital within a region would be allowed to go on divert at any one time. There was much debate about which hospitals should be in each region. The item was not voted on by the FAB and was deferred until after the Divert Task Force meeting.

3. Support of the Standard of Practice that all community emergency departments adopt the policy that allows for local emergency department decisions to activate the one hour "closed" divert status based on certain specified circumstances or conditions. The recommendation was approved by the FAB.

4. Hospitals will continue to research best practice models for patient flow. The recommendations will be reported on an ongoing basis to the FAB.

D. Divert Task Force Report

Blue Ribbon Committee Recommendations

Dr. Davidson stated the EMS Subcommittee of the Blue Ribbon Committee was tasked with investigating alternatives to improve the divert system from a prehospital standpoint. They researched methods used in other big cities and also looked at

local transport data from January 2000 through September 2000. As a result of this study, the Subcommittee recommended creation of a regional divert system:

Region A.	Mountain View Hospital Summerlin Hospital Valley Hospital University Medical Center
Region B.	Sunrise Hospital Desert Springs Hospital Lake Mead Hospital
Region C.	St. Rose Dominican Hospital- Rose de Lima Campus St. Rose Dominican Hospital-Siena Campus

Dr. Davidson and Sandy Young gave a presentation at the Divert Task Force meeting regarding the proposed regional divert system. He and Ms. Young repeated the presentation for the MAB members and audience.

Ms. Young explained the two issues considered when they began development of the proposed plan for regional divert: (1) the number of patients hospitals receive, and (2) the number of calls to which emergency units must respond. She commented that recent internal best practice changes taking place in the hospitals have helped decrease the amount of time facilities go on divert, and somewhat reduced the waiting time for ambulance crews to offload patients at emergency departments. The remaining problem is trying to keep response units geographically based. (Fire stations are geographically placed based on call volume.) Without some type of regional designation for hospitals and response units, ambulances have to travel across the valley to facilities that are not on divert. This takes them out of their assigned areas and they are not able to respond as quickly to new emergency calls.

Ms. Young referenced a map of the Las Vegas valley that was divided into one-mile squares. She explained that the transport data collected was extracted from Fire Alarm Office (FAO) records. Hospitals were grouped together according to bed size, resources, capability, etc. The hospital groupings were placed into three different zones with a 5-mile radius as a boundary. She stated that the red-to-orange shaded areas on the map, which constitute a 25-30 mile radius, received the majority of emergency calls. In the 9-month time period studied, there were more than 2000 responses to calls in these areas. AMR statistics indicate its ambulances transport approximately 160 patients per day out of this core area to various hospitals. The yellow areas on the map represented 100-250 emergency call responses during 9-month period. The zones were designed to allow a hospital to draw patients from more than one zone, thus providing double coverage in the core area. Also, a response unit cannot be diverted from its designated area. The green areas on the map indicated planned areas for expansion of services as the community grows. Current fire station locations were indicated in black on the map.

Dr. Davidson commented that the proposed regional divert plan was being presented to the Medical Advisory Board as an "information only" item at this time. It will be presented for endorsement at the February meeting, if there is interest among the Board members to do so. He stated there was strong interest by the Blue Ribbon Committee as well as the Divert Task Force in having a regional divert plan. His research of large U.S. cities showed the majority use the open/closed hospital policy as well as designated zones for hospitals and emergency response units. The procedure for the proposed regional divert would be as follows:

1. Hospital ED's report their divert status to a central dispatch (to be designated).

2. Hospital ED's have one hour of divert unless no other ED in their region requests divert; in that case, they may request additional hours (one at a time).

3. In Region A, if a second hospital ED requests divert, the two ED's will rotate one hour of divert at a time.

4. In Region A, if three or four ED's request divert, the four ED's will rotate one hour of divert at a time.

5. In Region B, if two or three ED's request divert, then the three ED's will rotate one hour of divert at a time.

6. In Region C, if both ED's request divert, then the two ED's will rotate one hour of divert at a time.

ED divert would be the only category of divert. A hospital on ED divert would be deemed closed and no patients would be transported to that facility (the exceptions being OB/GYN, NICU, burns, trauma, CAT Scan patients). Dr. Davidson stated the regional divert procedure forces most hospitals to stay open instead of closing due to divert as is currently being done. He felt the program outlined above is a way to divert and rotate facilities while allowing emergency response vehicles to remain in their assigned areas.

Dr. Davidson stressed that the regional divert plan and open/closed policy are only proposals--they are not engraved in stone. No action will be taken if there is no interest in going forward with them. Philis Beilfuss commented that nothing major has been done in the last 15 years to deal with the divert problem. This proposal is one possible solution. We can try it, if it doesn't work, we can look at developing something else. Brian Rogers concurred with Ms. Beilfuss' statement saying the plan would leave more hospitals open. Dr. Davidson said the proposal can be fine tuned and changed as needed. The idea is to unload the system, not to stop the system, and keep hospitals open.

Dr. Homansky made a motion that the regional divert plan and the open/closed policy be placed on the next Divert Task Force meeting agenda for discussion and to be

forwarded to the Medical Advisory Board for possible action at the February 7, 2001 meeting. The motion was seconded by Dr. Laauwe and unanimously carried.

E. Equipment Committee Report

Dr. Greenlee reported the Equipment Committee discussed a proposal to make the pulse oximeter mandatory equipment on the Official Ambulance and Firefighting Agency Inventory. As prehospital administration of Versed requires use of a pulse oximeter to determine the patient's oxygenation status, the Committee felt the device should be mandatory ALS ambulance equipment. The Committee members also reviewed and updated the Official Ambulance and Firefighting Agency Inventory. They suggested making pacemakers mandatory instead of optional, adding a V-VAC-type hand-powered suction device as an optional item, and adding a pediatric CO_2 detection device. Dr. Greenlee stated the proposal for the addition of the pulse oximeter as a mandatory item and the revised Official Ambulance and Firefighting Agency Inventory will be presented at the February MAB meeting for endorsement.

F. STEALTH ASSESSMENTS Program For The Mentally Ill

Brad Goss, R.N., BSN presented an overview of the STEALTH ASSESSMENTS program which provides mental health screenings, assessments, triage and disposition of patients in crisis. Patients range in age from 4 to 100+ years old and have deficits in the categories of depression, substance abuse, psychosis, adjustment and life stressors. To initiate the program, STEALTH staff would be telephoned by police dispatch or emergency department personnel and then drive to the site and assess the patient within 30 minutes. Staff would have the option of calling a psychiatrist to make the final decision on disposition. After the patient is assessed for mental health safety, staff then makes recommendations and helps arrange for disposition. Staff will leave results of the assessment, when appropriate, and then will report the status of the patient's disposition to the medical personnel or police at the scene. Staff will also contact accepting facilities with a courtesy call.

Mr. Goss and Sheila Osterhuber, M.A. are the founders of STEALTH ASSESSMENTS. With the closing of Charter Hospital, they felt there was a need for another mental health rapid crisis assessment team to be formed and thus created the STEALTH program. Their management team consists of individuals with 30-35 years experience in the mental health field including patient assessment and care as well as supervising professionals that deliver that care. Their goal is to provide mental health and chemically addicted patients in the Las Vegas area with a comprehensive evaluation and recommendation for safe follow-up. They feel this will provide police, EMS agencies, and hospital emergency departments with quick and accurate disposition of mental health patients without compromising their resources. Mr. Goss stated STEALTH ASSESSMENTS is seeking Medical Advisory Board endorsement of their program to aid them in pursuit of funding from the City, the County, and area hospitals.

Dr. Davidson asked how STEALTH ASSESSMENTS would impact Montevista's crisis team? Mr. Goss stated that Montevista would take all private pay patients and STEALTH would take all Metro calls, indigent and self-pay patients. Dr. Davidson felt the MAB could endorse the concept of another crisis team but should not be involved

in trying to influence potential funding sources. Dr. Henderson made a motion for Medical Advisory Board recognition of the need for additional field assessment resources whether from private or public sources. The motion was seconded and carried unanimously.

III. INFORMATIONAL ITEMS/DISCUSSION ONLY

Hospital Divert Statistics

Dr. Davidson noted that the hospital divert statistics for the month of December were included in the MAB packets.

IV. PUBLIC APPEARANCE/CITIZEN PARTICIPATION

No response.

V. ADJOURNMENT

As there was no further business, Dr. Davidson called for a motion to adjourn. A motion was made, seconded, and unanimously carried to adjourn the meeting at 7:25 p.m.