MINUTES
EMERGENCY MEDICAL SERVICES
MEDICAL ADVISORY BOARD MEETING
OCTOBER 2, 2002 – 4:00P.M.

MEMBERS PRESENT

Allen Marino, M.D., St. Rose Dominican Hosp.
Blain Claypool, Valley Hosp.
Chief Randy Howell, Henderson Fire Dept.
David Watson, M.D., Sunrise Hosp.
Donald Kwalick, M.D., Clark County Health District
Donald Reisch, M.D., Desert Springs Hosp.
E. P. Homansky, M.D., Valley Hosp.
Frank Pape, D.O., Summerlin Hospital
Jeff Davidson, M.D., Chairman, Valley Hosp.
John J. Fildes, M.D., University Medical Center
Karen Laauwe, M.D., Lake Mead Hosp.
Michael Zbiegien, M.D., Sunrise Hosp.
Philis Beilfuss, R.N., North Las Vegas Fire Dept.
Richard Henderson, M.D., St. Rose DeLima
Timothy Vanduzer, M.D., Mountain View Hosp.
Todd Jaynes, Mesquite Fire & Rescue
William Harrington, M.D., University Medical Center

MEMBERS ABSENT

Asst. Chief Mike Myers, Las Vegas Fire & Rescue
Chief Steve Hanson, Clark County Fire Dept.
David Daitch, D.O., Boulder City Hosp.
Jon Kingma, Boulder City Fire
Pam Turner, R.N. Valley Hospital Medical Center
Pete Carlo, Southwest Ambulance
Steven Peterson, American Medical Response

ALTERNATES

Brian Rogers, Southwest Ambulance
Ed Matteson, Clark County Fire Department
Gerry Hart, American Medical Response
Sandy Young, R.N. Las Vegas Fire & Rescue
Virginia DeLeon, R.N., St. Rose Dominican Hosp.

CCHD STAFF PRESENT

David Slattery, M.D., Quality Assurance
Jane Shunney, R.N., Asst. to the Chief Health Officer
Jennifer Carter, Administrative Secretary
Joseph Heck, D.O., EMS Operations Medical Director
Mary Ellen Britt, R.N., QI Coordinator
Michael MacQuarrie, EMS Field Rep./Instructor
Rory Chetelat, EMS Manager
Shannon Randolph, Sr. Administrative Clerk

PUBLIC ATTENDANCE

Alice Conroy, Sunrise Hospital
Ahmed Salaludhin,
Chris Nollette, PhD, CCSN
Joe Calise, R.N., Summerlin Hospital
Kathy Kopka, Sunrise Hospital
Nancy Cassell, CCSN
Sam Wilson, Specialized Medical Services
Scott Rolfe, UMC
Shelly Cochran, Chayra Communications
Syd Selitzky, HFD
Tom Geraci D.O., Mesquite Fire & Rescue

I. CONSENT AGENDA:

A. Minutes Medical Advisory Board Meeting September 4, 2002

Chairman Davidson asked for a motion to approve the September MAB minutes. A motion was made, seconded and passed unanimously.

II. REPORT/DISCUSSION/POSSIBLE ACTION:

Chairman Davidson introduced new MAB members and new EMS Staff. Dr. Bill Harrington will be the FAB representative, replacing Dr. Jeff Greenlee. Dr. Frank Pape will be the representative from Summerlin Hospital, and is replacing Dr. Nicholas Han. November 6, 2002 will be Dr. Karen Lauuwe's last MAB meeting. She is moving to Florida. There will be a new representative from the Lake Mead facility who will be introduced at the November MAB meeting. A new chairman will be appointed to the Education Committee.

New EMS staff were introduced; Rory Chetelat, EMS Manager and Michael MacQuarrie, EMS Field Representative/Instructor.

A. Review of BLS/ILS Protocols and ALS Protocols

Chairman Davidson reported the Procedure/Protocol Committee passed three motions:

1. Algorithmic assessment based guidelines to be added to toolbox protocols
2. Pediatric age for protocols to be 12 years old with weight appropriate to age for assessment
3. Pediatric protocols will be separate from the Adult protocols and the treatment guidelines protocols will remain the same

After brief discussions Chairman Davidson called for a motion to endorse the recommendations from the Procedure/Protocol Committee. Motion was seconded and carried unanimously.

B. Helicopter Medical Advisory Committee Report

Dr. Zbiegien reported the Helicopter Medical Advisory Committee determined it does not appear to be a problem with inappropriate use of helicopter transport. The committee decided to collect and review data starting October through December on rural ambulance transports to determine how many patients could have benefited from helicopter transport. In January the committee will meet to develop guidelines based on the data.

A question was raised, would the committee look at the helicopter transports for pediatrics that weren't necessary.

Dr. Zbiegien replied Mercy Air currently tracks those transports.

Dr. Slattery commented the committee was charged with developing guidelines for rural providers to determine when to launch a helicopter and when not to. The committee questioned how to fix something, not knowing for sure there is a problem. Some rural providers are unable to provide ALS level of care. Sometimes that is enough to necessitate a helicopter being in that service. The purpose of providing the "Mercy Air Criteria for Appropriateness of Aeromedical Transport" checklist was to help the committee in its goal of developing guidelines for the proper utilization of helicopters versus ground transport.

Dr. Fildes stated the committee also discussed measuring transports that are over triaged as well as capturing under triaged transports. Unless there is a fixed number of over triaged cases, cases that would have required aero medical transport are likely to be missed. For example with the trauma field triage criteria, which are meant to be interpreted broadly and not for aero medical transport alone, it is a national expectation to over triage 25% of cases to keep under triage at 2% or lower. So there is sliding window. If over triage is at zero then under triage is probably great and as a principle that needs to be grappled with.

Missy Greenlee, Mercy Air, explained that the "Mercy Air Criteria for Appropriateness of Aeromedical Transport" checklist that was handed out at the Procedure/Protocol Committee meeting is a national standard by the American Association of Medical Transport. It would be the same thing as Standardizing Joint Commission. Mercy Air's internal QA, is a simple process. It involves one person (Missy Greenlee) conducting a 24-hour follow-up with the hospital the patient was transported to, and a final diagnosis. In the past four years there has been no indication of high volume discharges under 24-hours.

Chairman Davidson commented that the MAB would like to be certain that ground transport is used when it can be, so that the air ambulance is available, and no one is at undue risk, i.e., air is more dangerous than ground.

The Procedure/Protocol committee has determined that there isn't any data available to support the utilization of helicopters versus ground transport. The committee is planning to collect data for the next 3 months and review it, at which time they will begin to develop guidelines for the proper utilization of helicopters versus ground transport.

C. Reappointment of Chairman to Procedure/Protocol Committee

Chairman Davidson nominated Dr. David Watson as the Chairman for the Procedure/Protocol Committee and Dr. Watson accepted the position.

D. Reappointment of Chairman to Priority Dispatch Task Force

Chairman Davidson commented that since the Priority Dispatch Task Force is not a committee and it doesn't meet regularly, he would table the reappointment of the chairman. The Ambulance Oversight Committee (AOC) is meeting October 9 so it would be a week before they receive the information submitted to them by the MAB from last month. He suggested that if anyone is interested in chairing the committee to let him know otherwise he will nominate someone.

A question was raised, should there be a 30-day delay on the Priority Dispatch Task Force bringing information to the MAB from the AOC in November, to December.

Chairman Davidson announced that there would be at least five members from the MAB who will not be able to attend the November meeting as it conflicts with a national meeting that many individuals attend. He said he would rather have Priority Dispatch provide the information from the AOC at the December meeting, as there are a lot of issues that the transport agencies would want to go over and he feels the issue would be rushed at the November meeting. He will appoint someone to chair the Priority Dispatch Committee within the week.

E. Pilot Project: Mesquite

Todd Jaynes referred to the handout, which summarized the two proposals from Mesquite Fire & Rescue (MF&R). The first proposal was a request to transport to Mesquite Medical Associates (MMA). Transporting to MMA would reduce the current forty-mile ambulance trip for patients who could be treated at the clinic.

Concerns were raised regarding the staffing of MMA. The clinic is often staffed with a physician's assistant (PA) when a medical physician is not on duty.

Dr. Kwalick commented that he is supportive of MF&R's request as a pilot project. Dr. Geraci, Medical Director of MF&R and Dr. Empey, Medical Director of MMA are both supportive and assuming responsibility for the pilot project.

Kathy Kopka from Sunrise commented that she worked with MMA when they had PAs in the clinic. Dr. Empey's response time when the PAs call him is 10 - 15 minutes. There is an 800 number provided as a resource for the physicians and the PAs call in immediately. MMA has a good relationship with Mercy Air for transporting patients out of there.

Dr. Geraci said MMA is an exceptionally capable clinic. Mesquite Fire & Rescue could transport just when there is doctor on duty. The idea is to take the very low acuity patients to the clinic with 100% QA. He will provide QA reports to the MAB on a monthly basis.

A motion was made to endorse the pilot project with Mesquite with monthly reports with 100% QA and a physician telemetry only for the first six months. Motion was seconded and passed unanimously.

Discussions took place regarding Mesquite Fire & Rescue's second proposal for expansion of the Interfacility Transfer Protocol. MF&R requested the ability to transport patients who are started on intravenous Nitroglycerin, Heprin, and antibiotics by MMA who then require transfer to a facility in the urban area.

Concerns were raised as to whether there was Lovenox at the clinic because most IV antibiotics can be administered in 15 minutes or less. A comment from the board was Lovenox should probably be used instead of Heprin because with Lovenox a drip is not needed. And a patient requiring Nitroglycerin drips would need a helicopter.

A motion was made to table the request from Mesquite Fire & Rescue, to transport patients who are started on Intravenous Nitroglycerin, Heparin, and antibiotics by MMA who then require transfer to a facility in the urban area, until a further report can be presented at the November MAB meeting. Motion was seconded and passed unanimously.

III. INFORMATIONAL ITEMS/DISCUSSION ONLY

A. ED Nurse Managers Report

Virginia DeLeon reported the ED Nurse Managers met September 27 at St. Rose Medical Center. Violence in the emergency department was discussed at length, as there has been an increase of violence with patients and visitors. The nurse managers looked at the current Nevada Revised Statute on assault and battery. There is a concern that the statute essentially applies to police officers, fire fighters, employees of the school district, taxi cab drivers, and transit operators, but it doesn't address health care workers. They are going to lobby that to get support in changing that terminology to add health care workers as a protected class. Southwest Ambulance voiced concerns about the upcoming winter and the turnover of Critical Care Transport (CCT) ambulances.

Dr. Marino commented that because of the Nurse Practice Act a nurse cannot turn over their patient to a paramedic who is sitting in the hall observing patients. It is considered a lower level of care. So most nurses when they are not handling CCT calls are helping out in the 911 system. The nurse managers were asked to support the idea of having their charge nurse sign these charts so the CCT units can get back on the street quicker. The nurse managers graciously supported the idea.

Virginia continued to report that Don Parker with Las Vegas Fire Department gave a report, which addressed concerns regarding disaster communications. There is an action plan being developed to enhance communications during a disaster for a teleconference back up system where all hospitals and EMS agencies can communicate with each other.

Dr. Riesch announced that the Neonatal Unit at Desert Springs Hospital is closed as of Tuesday, October 1. They were a level 2 Neonatal Unit and are now a level 1, with level 3 being the highest level of care and level 1 being the lowest level of care. This in effect makes it so that they can only take very few pregnant women, except for expected vaginal deliveries between 36 - 40 weeks. Any deliveries earlier than 36 weeks will be stabilized and transported out to a higher-level Neonatal unit. Transporting services may want to consider transporting to a facility that has levels 2 or 3 if the delivery is premature or if there are any high risk factors, which includes no prenatal care.

Hospitals that have level 3 neonatal care are UMC, Sunrise, and Valley.

Brian Rogers requested clarification of closure for neonatal patients.

Chairman Davidson commented that obstetrical patients are never to be diverted. Everyone should use common sense in getting the correct level of patient care to the appropriate facilities.

Comments were made that patient choice is always considered first. Obstetrical patients, by statute, should be transported to the emergency room at the hospital of their choice. Transport to Labor and Delivery is provided as a courtesy by the ambulance service.

B. QA Report

Dr. Slattery reported the QA committee is starting to look at clinical performance measures of the EMS system; looking at specific measures of quality for EMS systems universally. In the past three months the committee has narrowed it down to six clinical performance measures:

- Bystander CPR and AED rate
- Critical trauma intervals
  - Time from 911 activation to arrival at trauma center
  - Time from 911 activation to scene departure
- Out-of-hospital non-traumatic cardiac arrest ROSC rate
- Time to first defibrillation
- Out-of-hospital pain relief
- Nontransport
  - Proportion of total calls
  - Proportion of nontransports that result in subsequent hospitalization.

The committee members formed three groups to look at Bystander CPR and AED rate, Critical trauma intervals, and Out-of-hospital non-traumatic cardiac arrest ROSC rate. The committee is finalizing the CPI (Chronic Public Inebriate) and Intracranial Bleed projects. The results will be ready by December 2002. There will be a Clinical Case Review Tuesday, October 15 at 10:00 a.m. in the Clemens room. Dr. Slattery encouraged all providers, physicians, and nurses to attend.

IV. PUBLIC APPEARANCE/CITIZEN PARTICIPATION

No Response

V. ADJOURNMENT

As there was no further business, Chairman Davidson called for a motion to adjourn. The motion was seconded and passed unanimously to adjourn at 5:11 P.M.