CLARK COUNTY HEALTH DISTRICT

MINUTES
EMERGENCY MEDICAL SERVICES
MEDICAL ADVISORY BOARD MEETING
MARCH 1, 2006 – 11:00A.M.

MEMBERS PRESENT

Richard Henderson, M.D., Chairman, Henderson Fire
Philis Beilfuss, R.N., North Las Vegas Fire Dept
E. P. Homansky, M.D., American Medical Response
Tim Crowley, EMT-P, Las Vegas Fire & Rescue (Alt.)
Allen Marino, M.D., NLVFD and Medicwest Ambulance
Lawrence Pellegrini, D.O., Las Vegas Fire & Rescue
Dale Carrison, D.O., Mercy Air and Clark County Fire Dept.
David Daitch, D.O., Boulder City Hospital
Rory Chetelat, M.A., EMT-P, EMS Manager, CCHD
Gerry Hart, American Medical Response (Alt.)
Trent Jenkins, EMT-P, Clark County Fire Department (Alt.)
Brian Rogers, EMT-P, Medicwest Ambulance
Brian Fladhammer, Mercy Air Service, Inc
Chief David Petersen, Mesquite Fire & Rescue
Scott Vivier, EMT-P, Henderson Fire Department (Alt.)
Thomas Geraci, D.O., Mesquite Fire & Rescue

MEMBERS ABSENT

Chief Mike Myers, Las Vegas Fire & Rescue
Kurt Williams, American Medical Response
Russ Cameron, EMT-P, Clark County Fire Department
Randy Howell, EMT-P, Henderson Fire Department
Jon Kingma, EMT-P, Boulder City Fire Department

CCHD STAFF PRESENT

Joseph J. Heck, D.O., Operational Medical Dir.
Judy Tabat, Administrative Assistant
Lawrence Sands, D.O., Dir. Of CHS
Trish Beckwith, Field Representative
Mary Ellen Britt, R.N., Quality Improvement Coordinator
Moana Hanawahine-Yamamoto, Recording Secretary
David E. Slattery, M.D., Asst. EMS Medical Director
Jane Shunney, Asst. to Chief Health Officer

PUBLIC ATTENDANCE

Jo Ellen Hannom, R.N., Clark County Fire Department
Roy Carroll, American Medical Response
Deb Dailey, EMT-P, Medicwest Ambulance
David Nehrbass, American Medical Response
Jeramy Hardonstce, Community College of S. Nevada
Larry Johnson, EMT-P, Medicwest Ambulance
Davette Shea, R.N., Southern Hills Hospital
Sandy Young, R.N., Las Vegas Fire & Rescue
Donna Fitzpatrick, R.N., Las Vegas Fire & Rescue
John Higley, EMT-P, Mesquite Fire & Rescue
Dominick Shannon, Community College of S. Nevada
Rob Nichols, EMT-P, American Medical Response
Greg Fusto, University Medical Center
Steve Patraw, EMT-P, Medicwest Ambulance
Derek Cox, EMT-P, Las Vegas Fire & Rescue
Jerry Newman, Specialized Medical Services
Don Abshier, EMT-P, Clark County Fire Department
Chris Fitch, Community College of S. Nevada
Steven Kramer, American Medical Response
Kevin Lanler, Community College of S. Nevada
Robbie Pettingill, Community College of S. Nevada
Shannon Long, Henderson Fire Department
Julie Siemers, R.N., Mercy Air Services Inc.
John Martinolich, EMT-P, Las Vegas Fire & Rescue
Rod Hackwith, EMT-P, Community College of S. Nevada
Tricia Klein, EMT-P, American Medical Response
Dennis Smith, American Medical Response

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The Medical Advisory Board convened in the Clemens Room at the Ravenholt Public Health Center at 11:04 a.m. on Wednesday, March 1, 2006. The meeting was called to order by Chairman Richard Henderson. He 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 Henderson noted that a quorum was present.

I. CONSENT AGENDA

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

A. Minutes Medical Advisory Board Meeting February 1, 2006

B. Discussion of Revision to BLS/ILS/ALS Protocols due to changes in AHA Guidelines to be referred to Procedure/Protocol Committee

II. REPORT/DISCUSSION/POSSIBLE ACTION

A. Procedure/Protocol Committee

1. Discussion to Revise the 20 minute Protocol

Dr. Heck stated that one of items discussed during a task force meeting to reduce emergency department offload times was to take out the verbiage that says 20 minutes and make it become the practice to take the patient directly to the waiting room if they meet the criteria. In section H. Disposition of the "General Patient Care Protocol" the way it was initially worded was there would be a 20 minute period in which the crew would have to keep the patient on their gurney to allow the hospital to find an appropriate bed. What we found is the patient was taken to the waiting room anyway so the proposed change to that language under #7 is take out the 20 minutes and say upon arrival in the ED the patient meeting the criteria will be placed in a hospital waiting room or other appropriate location. In addition to that change adding to letter "f" under #7 *and verbal notification to hospital personnel* so the crew would not roll in and put somebody in the waiting room and not notify appropriate hospital personnel that they've placed a patient in the waiting room.

Dr. Carrison voiced his concern for hospital liability with regard to patients with a saline lock who were given phenergan and/or morphine and put in a waiting room. Since there's no control over anybody in the waiting room what happens if they pass out. Whose responsibility is it if the patient walks out?

Dr. Henderson stated they've included a disclaimer (Patient Information Sheet) that the patient would sign and if the patient refuses, the EMS crew will remove the saline lock.

Dr. Homansky stated he appreciated what Dr. Carrison was saying, but with the constraints our system is under, we need to be doing things like this.

Dr. Daitch voiced concern about giving pain medication just before dropping off the patient in the waiting room and felt that medics should not give medication if there is a short transport time.

Dr. Heck stated that this protocol has been in place for over a year and we have not had any adverse reactions reported from somebody receiving phenergan or morphine and being placed out in the waiting room. We do have some history behind it now. Mr. Chetelat added that the QA Committee is going to do a 100% review on these cases with UMC once we get the IRB approval.

Tim Crowley asked who we are protecting with the Patient Information Sheet, the hospital, patient or Health District. Dr. Slattery stated that it provides some level of protection for everyone. Mr. Crowley then asked where the form goes after it's signed.

Dr. Heck felt that the form should be signed and attached to the PCR that's being left with the hospital and since it's going to be utilized for this protocol it should be given to every patient regardless if they have a saline lock or not because there is more information on this sheet then just about the saline lock. We could add verbiage to "f" under #7 reflecting this page as well.

Dr. Homansky made the motion to approve the changes in #7 of the General Patient Care Protocol, section H. Disposition as evidenced on the handout along with using the witness form that will be given to be part of the permanent record and that there is also 100% review of these by the QI Committee going forward with report back to the MAB. The motion was seconded and passed by a 5-4 vote.

2. Discussion on Guidelines for C-Spining

Dr. Heck stated that another issue discussed by the task force was whether or not a majority of our patients require c-spining when they are involved in a minor trauma realizing this prevents patients from going to a waiting room plus subjects individuals to undue pain and hardship while they are waiting in a hospital hallway for their cervical spine to be cleared. Several protocols from other jurisdictions were reviewed and we came up with a conglomerate of those based on what we thought would be a good starting point for discussion.

Dr. Henderson stated that this is the Nexus criteria plus a little safety net.

Dr. Carrison suggested that under intoxication to make it clear that it's drug and alcohol. Dr. Heck stated that he'll add drug and/or alcohol intoxication.

Dr. Slattery suggested that under neuro exam changing it from focal deficit to any numbness and weakness and under spinal exam, pain upon range of motion.

Dr. Pellegrini added that the paramedics do a good job understanding minor MVA and the he has nothing but confidence that they can handle this protocol.

Dr. Marino made a motion to approve the Spinal Immobilization protocol with the changes discussed. The motion was seconded and carried unanimously.

Dr. Heck stated that the EMS office will put out an implementation date and education requirements.

3. Discussion on Patient Choice being the Highest Priority

Mr. Chetelat stated that the Health District strongly felt that stable patients should continue to be transported to their choice of hospitals and the task force decided it was not necessary to revise the General Patient Care Protocol.

B. Discussion on Bypassing a Facility on Internal Disaster

Dr. Heck stated previously we had that if a hospital declares an internal disaster that facility would be bypassed for all patients, but that has proven to be somewhat of a problem in facilities using internal disaster as another form of divert. If a hospital is declaring internal disaster for physical plant issues i.e. fire, flood, power failure that hospital would be bypassed for all patients, but if the internal disaster is due to patient overload, then patients in cardiac arrest or critically unstable should be transported to the hospital despite the declaration of an internal disaster.

Mr. Crowley felt that his can lead to interesting conversations between dispatchers and agencies as to why the hospital is on internal disaster.

Dr. Marino felt this is just recreating divert. Unless that hospital is closing down themselves to elective surgeries we're almost endorsing them pulling that card on a regular basis.

Dr. Heck stated that all these points are extremely valid and part of the issue is that we let the hospitals define internal disaster and there is no obligation for the EMS agency to accept that definition. Hospitals are using a very broad language under JCAHO which says that anything that creates an environment in which is unsafe to provide patient care and they are saying patient overload is creating that environment. He also stated that it is within the purview of this Board to make the recommendation that for EMS, internal disaster means physical plant issues.

Dr. Homansky commented that this issue should go to a subcommittee with some input from the hospitals before we make this decision. Dr. Slattery agreed stating that we don't have the authority to make decisions on what happens inside of the hospitals and we need to define how we're going to recognize internal disaster from a public health safety point of view and maybe put out a public service announcement to let the community be aware.

Mr. Chetelat added that it is going to be difficult for this body to work with the hospitals to make that definition. He felt we can inform them of where we're headed and involve them in the process but we need to determine what's in the best interest of EMS patients that are critically unstable.

Dr. Heck stated that the concept of a PSA has been discussed and if the Board wants to make that recommendation we can bring it back to discuss. He added that we can take #8 and delete the second sentence and then say that if you declare an internal disaster we will bypass you then as a recommendation have the Health District facilitate a PSA. Mr. Chetelat explained that it would require 100% reporting in advance of an internal disaster which doesn't happen.

Dr. Carrison felt that this committee was not addressing this the right way and that they need to go to the hospital that is on internal disaster all the time and sit down with their administration and explain the problem and present our solution.

Davette Shea didn't feel that any of the nurse managers would have a problem with accepting a critically ill or arresting patient during an internal disaster.

Dr. Heck offered another amended version which would be that if a hospital declares an internal disaster that facility is to be bypassed for all patients except for those patients in cardiac arrest or critically unstable. Dr. Pelligrini stated deleting #8 and just keep #1 would accomplish this. Dr. Henderson stated that he would like a public broadcast to be added to that amended version.

Dr. Slattery voiced concern over the fact that we are taking the sickest, unstable patient to a facility for whatever reason has declared itself internal disaster. He felt that this committee is making the assumption that they are going on internal disaster inappropriately. Dr. Henderson explained that it is not an assumption looking at the history. Dr. Marino agreed and added it doesn't mean that once they get stabilized we don't transfer them somewhere else.

Dr. Marino made a motion that if a hospital declares an internal disaster that facility is to be bypassed for all patients except for those patients in cardiac arrest or critically unstable and consider a PSA. The motion was seconded and carried unanimously.

III. INFORMATIONAL ITEMS/DISCUSSION ONLY

A. Quality Improvement Meeting Update

Dr. Slattery advised that the committee examined the QA tool that will review the patient transfer to ED waiting room on arrival protocol. It will take place at the University Medical Center, Sunrise and St. Rose's hospitals. The records for all of the patients falling under the patient transfer to ED waiting room on arrival protocol will be reviewed by the QI committee and reported by to the Medical Advisory Board. Dr. Slattery also stated that there will be a revised draft to the prehospital death determination protocol to be considered next month.

B. Trauma System Development Update

Mr. Chetelat noted that the Clark County Health District has changed its name to the Southern Nevada Health District. The trauma system plan has been approved by the Board of Health. The standardization of trauma telemetries has been referred back to the Regional Trauma Advisory Board for further discussion.

C. Roll out for Narcotic Resupply Process

Mr. Chetelat reiterated the importance of the EMS providers developing their own narcotic resupply procedure. In December 2005, a deadline of 120 days was given.

Mr. Chetelat noted that the Procedure/Protocol meeting scheduled after the MAB was cancelled.

IV. PUBLIC APPEARANCE/CITIZEN PARTICIPATION

Dr. Carrison mentioned that the University Medical Center has received a three year approval for Emergency Medicine Residency. They will have eight residents starting the first week of July.

V. ADJOURNMENT

As there was no further business, Chairman Henderson called for a motion to adjourn. The motion was seconded and passed unanimously to adjourn at 12:00 p.m.