MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

MEDICAL ADVISORY BOARD MEETING

September 5, 2012 – 11:00 A.M.

MEMBERS PRESENT

David Slattery, MD, Chairman, Las Vegas Fire & Rescue
Richard Henderson, MD, Henderson Fire Department
Eric Anderson, MD, MedicWest Ambulance
Dale Carrison, DO, Clark County Fire Department
Pat Foley, EMT-P, Clark County Fire Dept (Alt)
Frank Simone, EMT-P, North Las Vegas Fire Dept (Alt)
Mark Calabrese, EMT-P, MedicWest Ambulance
Christian Young, MD, Boulder City Fire Dept
Jarrod Johnson, DO, Mesquite Fire & Rescue
E.P. Homansky, MD, Vice Chairman, AMR
Rick Resnick, EMT-P, Mesquite Fire & Rescue
Tony Greenway, EMT-P, American Medical Response
Chief Scott Vivier, Henderson Fire Department

MEMBERS ABSENT

Chief Kevin Nicholson, Boulder City Fire Dept
Jeff Buchanan, EMT-P, North Las Vegas Fire Dept
Chief Thomas Miramontes, Las Vegas Fire & Rescue
Chief Troy Tuke, Clark County Fire Department
K. Alexander Malone, MD, North Las Vegas Fire

SNHD STAFF PRESENT

Rory Chetelat, EMSTS Manager
John Hammond, EMS Field Representative
Patricia Beckwith, EMS Field Representative
Michelle Nath, EMS Project/Program Coordinator
Mary Ellen Britt, Regional Trauma Coordinator
Kelly Morgan, MD, EMS Consultant
Judy Tabat, Recording Secretary

PUBLIC ATTENDANCE

Brian Anderson, Community Ambulance
Jim McAllister, EMT-P, LVMS
Paul Stepaniuk, EMT-P, HFD
Gina Schuster, EMT-P, Community Amb.
Steve Johnson, EMT-P, MWA
Jen Renner, RN, Sunrise Hospital
August Corrales, EMT-P, CSN
Sarah McAllister, EMT-P, LVMS
Larry Johnson, EMT-P, MWA/AMR
Aaron Harvey, EMT-P, HFD
Scott Morris, EMT-I, NLVFD
Abby Hudema, RN, UMC
Greg Fusto, RN, UMC
Jo Ellen Hannom, RN, CCFD

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The Medical Advisory Board convened in Classrooms # 1 and # 2 at American Medical Response – Las Vegas on Wednesday, September 5, 2012. Chairman David Slattery, MD called the meeting to order at 11:02a.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. Slattery 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. Chair Slattery asked if anyone wished to address the Committee pertaining to items listed on the Agenda. Seeing no one, he closed the Public Comment portion of the meeting.

II. CONSENT AGENDA

Chairman Slattery 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.

Approve Minutes/Medical Advisory Board Meeting: August 1, 2012

Chair Slattery asked for a motion to approve the Consent Agenda. *Motion made by Member Homansky, seconded by Member Anderson and carried unanimously.*

III. REPORT/DISCUSSION/POSSIBLE ACTION

A. Committee Report: Drug/Device/Protocol (DDP) Committee 09-05-12

1. Review of Selected Protocols

Medical	**Trauma**
Shock (Adult/Pediatric)	General Multisystem Trauma
Drowning (Adult/Pediatric)	Traumatic Brain Injury
Smoke Inhalation (Adult/Pediatric)	Extremity Trauma/Crush Syndrome
Overdose (Adult/Pediatric)	Amputation
Cardiac Arrest (Adult/Pediatric)	Assault/Abuse
OB/GYN Emergencies	Hanging
Tachycardia (Adult/Pediatric)	

2. Review of the Research on the Following Drugs
   - Solu-Medrol
   - Atrovent
   - Ketamine

Dr. Johnson reported that they have 4 protocols to bring forward that have been approved by the Drug/Device/Protocol Committee (DDP). Dr. Johnson referred to the Drowning Protocol and stated that Dr. Morgan had collaborated with Dr. Semsprott who is a 3rd year resident at UMC and an international expert on drowning. Along with the emphasis on ventilation it was also noted that if the patient is breathing on their own, they recommended a non-rebreather (NRB) at 15-lpm, and if they are not, positive pressure ventilation with a Bag Valve Mask (BVM) was recommended and she will put those in as caveats. The DDP Committee suggested the following revisions:

- Add a box to include traditional CPR
- Add NRB at 15-lpm
- Move capnography up with 12 lead EKG as a paramedic skill

Dr. Slattery questioned if there was discussion regarding CPAP in cases of refractory hypoxemia. Dr. Johnson noted that there was no discussion on refractory hypoxemia and suggested addressing that more from an educational standpoint.

A Motion was made by Member Johnson to approve the Adult Drowning Protocol with stated changes. Member Henderson seconded and carried unanimously.

Dr. Johnson stated that the Pediatric Drowning Protocol is the same as the Adult Drowning except without CPAP and with the same revisions as the Drowning Protocol.

A Motion was made by Member Johnson to approve the Pediatric Drowning Protocol with stated changes. Member Anderson seconded and carried unanimously.

Dr. Johnson referred to the Shock Protocol and reported the following revisions made by the DDP.

- Add "Alternative" to the "Appropriate treatment protocols as indicated" box
- Add oxygen / NRB at 15 lpm
- Change titrate to SBP > 90 mmHg
- Change NS Bolus 1000 ml to 500 ml in the Non-trauma box.
- Add capnography to the cardiac monitor box.

Dr. Carrison informed the Board that new studies indicate that Levophed was preferred over Dopamine or Dobutamine and suggested this be considered. Dr. Slattery felt that was a great point and that may be looked at by the DDP during the review of the formulary.

Dr. Slattery questioned the NS Bolus 500 ml for hypotension and no radial pulse under Trauma related and asked why kind of science that was based on. Dr. Morgan stated that was a change based on trauma recommendations in terms of permissive hypotension. She related that the better indicator of the hypotension rather than just the number on the monitor was to also include radial pulse. The DDP Committee talked about potentially using them in combination with a systolic < 80 so you have 2 indicators as opposed to just 1. Dr. Slattery stated that he didn't know the evidence behind the radial pulse and felt it was going backwards. He asked if the DDP reviewed any literature on the radial pulse issue. Dr. Morgan stated that they did not but she will ask Dr. Johnson for the literature that he pulled for that recommendation. Dr. Johnson added that there was a brief discussion on the reliability of a palpable radial pulse because it is a subjective skill from one person to the next so as Dr. Morgan mentioned talked about possibly indicating 2 parameters there, the systolic less than 80 or palpable pulse. Dr. Slattery stated that he didn't want to delay the process but with the understanding that if there isn't any evidence after it has been reviewed, that section of this protocol will be changed.

A Motion was made by Member Johnson to approve the Shock Protocol with stated changes and agreement to present radial pulse evidence . Member Anderson seconded and carried unanimously.

Dr Johnson reported the same housekeeping changes for the Pediatric Shock Protocol adding that the blood pressure parameter on the non-trauma related was changed to titrate to SBP greater 70 + 2x the age up to 10 years old.

A Motion was made by Member Johnson to approve the Shock Protocol with stated changes and agreement to present radial pulse evidence . Member Anderson seconded and carried unanimously.

Dr. Johnson asked the Board to refer to the trauma protocols in the handouts and explained that they were recommendations made by one of the trauma fellows at UMC. Dr. Johnson reported that these were not ready for approval; the idea was to look over their recommendations and see if the DDP agrees with the major recommendations and branch points with using GCS as an indicator, the permissive hypotension based on radial pulse, using BVM if you can maintain adequate oxygen saturations and the reverse trendelenberg which is a change from anything that has been done before. Some of the DDP suggestions include:

- Opposed to the repeat doses based on transport time on the General Multisystem Trauma, it should be based on the Pain Management Protocol. *(comment made by Dr. Henderson)*
- Does there need to be a separate protocol on each of the trauma scenarios. *(comment made by Dr. Johnson)*
- Recommended to remove the Assault and Abuse Protocol *(comment made by Ms. Britt)*
- Maintain O_2 saturation should be 94% to be consistent with current protocols *(comment made by Mr. Simone)*
- Change penetrating chest wound with suspected tension pneumothorax to suspected tension pneumothorax. *(Comments made by Dr. Johnson, Mr. Corrales, Mr. Simone)*
- Change GCS ≤ 8 to GCS < 8 *(comment made by Ms. Britt)*
- Change name from multisystem to general trauma protocol *(comment made by Mr. Simone)*

- Change soaked kerlix to moisten trauma dressing *(comment made by Mr. Cox)*
- Change 3-side gauze to occlusive dressing *(comment made by Mr. Cox)*
- Add a caveat under Palpable Radial Pulse with SBP < 80 with or without a pulse and make it a 2 tiered requirement. *(comment made by Dr. Morgan)*

Dr. Slattery started the discussion by saying that this will be too difficult to do all at once and suggested this go back to the DDP to look at each of those step points and the evidence to support those one by one. He added that if there are huge gaps in the current protocols then those need to be addressed in terms of how to incorporate what they have already identified into those current protocols. He felt that most of it is consistent with what is already being done. He thanked the DDP for bringing it forward and will continue to watch as it develops.

B. Committee Report: Education Committee 9/5/12

1. Approval of Education Committee Bylaws
2. Election of New Chairperson and Vice Chairperson
3. Development of Educational Component for New Protocols
4. Development of New EMS Instructor Exam

Chief Vivier reported that the Education Committee met earlier and there was 4 items of action that were taken. Under the approval of education bylaws, there was discussion and suggested changes were made and turned the discussion over to Dr. Slattery

Dr. Slattery informed the Committee that from an historical standpoint the Medical Advisory Board (MAB) Chairperson picks the chairperson for each of the sub committees and in the past it has always been a MAB board member. Working with Dr. Homansky, they felt it was restrictive to open up the chairperson position to only board members so to facilitate that they needed the ability to have this committee chair take action at the board level and procedurally to do that they needed to assign a board liaison. In the situation when the committee chair is appointed by the MAB chairperson and is not a board member, he or she would also have to appoint a board liaison to that committee and that board liaison would be the one that would take the action at the board level and bring forth motions. Dr. Slattery recommended the following changes:

Article II	Add "If the committee chair is not a MAB member, a MAB liaison needs to be appointed. (And that liaison would bring forth any motions from that committee)
Article III, Section 1.	The membership of the Education Committee shall be composed of volunteer representatives from permitted agencies, Add "Receiving Hospitals" Change Emergency Medical Technicians to Emergency Medical Services Professionals (the idea is just to be inclusive of the education of hospital representatives also)
Article III, Section 3.	Change to read: Education Committee members shall serve for a 2 year limit with no limitations on reappointment as long as they hold an eligible position in the community. (So the chair will be appointed by the MAB every 2 years and they can be reappointed infinitely)
Article III, Section 5.	Change to read: Each standing member shall have one vote. In the event that the standing member is not available, an agency designee, approved by the Education Committee Chair shall cast the vote. (So we didn't' want to assign alternatives, again allowing an agencies designee to cast that vote and it will just have to be ran by the chair)
Article IV, Section 1.	Change 2nd sentence to read: The officers will be appointed by the MAB Chair to serve a two year term from January 1 through December 31st of the second year. (To reflect the MAB change)
Article X	Add "and approval by the MAB." And that just reflects that process that we do right now.

A Motion was made by Member Carrison to approve the Education Committee Bylaws with stated changes. Member Vivier seconded and carried unanimously.

Dr. Slattery announced that August Corrales has been selected as the new Chair of the Education Committee and Jo Ellen Hannom from CCFD accepted the vice chair position and congratulated them both. He thanked Chief Vivier and the Education Committee for all their excellent work.

Chief Vivier reported that there were 6 alternative medications that were approved and the education for those medications has been developed by a workgroup of the Education Committee and submitted to the Office of Emergency Medical Services & Trauma System (OEMSTS) to be disseminated out to all the agencies.

Next item discussed was the development of a new EMS instructor exam. The current exam had some deficiencies and identified gaps so the Education Committee voted to develop a workgroup to revise the instructor exam and anybody interested to be a part of that workgroup was to submit an interest email to the OEMSTS at ems@snhdmail.org attention Trish Beckwith.

Finally, under information items there was discussion regarding the anticipated changes to the roles of EMT, EMT Advanced, and Paramedic and how those changes to their scope are going to be affected in education. That would be a priority of the Education Committee to ensure that when those go into effect they are prepared to support that with education, regulation and protocols.

C. Progress Report: Airway Management Task Force

Tabled

IV. INFORMATIONAL ITEMS/ DISCUSSION ONLY

A. Update on EMS Drug Shortage

Mr. Chetelat advised the Board that the letter from Dr. Coleman went out stating that the Health District is standing by their deadline of November to stop the use of expired drugs. He added that he has tried to reach out to the State with no luck to see what they are doing on that process. He thanked everybody who has participated on the Drug Shortage Workgroup for all their hard work.

B. Internal Disaster Monthly Report

Tabled

C. ED/EMS Regional Leadership Committee Update

Ms. Britt reported that in general the ED/EMS Regional discussed their EMS offload time and their activities in each of the facilities. Dr. Homansky asked the Board for their consideration to move this Committee meeting directly before the MAB. He felt that both meeting would get better attendance and the communication between the nurses and this Board would be increased. The ED/EMS Regional Leadership Committee has decided to meet every other month so the next one would be in November. Mr. Chetelat felt that it was worth considering and added that when the meetings are transitioned over to the new Health District location, they could hold concurrent meetings in separate rooms and since his staff doesn't provide support to the Leadership Committee it wouldn't be a burden. Dr. Slattery stated that he understood that this wasn't officially agendized but asked if anybody was opposed to trying to get the ED/EMS meeting closer to the MAB. The Board agreed.

V. 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 include on an agenda as an item upon which may be taken pursuant to NRS 241.020. All comments are limited to five (5) minutes. Chair Slattery asked if anyone wished to address the Committee. Seeing no one, he closed the Public Comment portion of the meeting.

VI. ADJOURNMENT

There being no further business to come before the Committee, Chair Slattery adjourned the meeting at 11:43 a.m.