MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

MEDICAL ADVISORY BOARD MEETING

May 1, 2013 – 11:00 A.M.

MEMBERS PRESENT

E.P. Homansky, MD, Chairman, AMR
Richard Henderson, MD, Henderson Fire Department
Dale Carrison, DO, Clark County Fire Department
Jarrod Johnson, DO, Mesquite Fire & Rescue
Rick Resnick, EMT-P, Mesquite Fire & Rescue
Martin Tull, MedicWest Ambulance
Chief Troy Tuke, Clark County Fire Dept.
Gregg Fusto, RN, RTAB Representative
David Slattery, MD, Las Vegas Fire & Rescue
Christian Young, MD, Boulder City Fire Dept
Eric Anderson, MD, MedicWest Ambulance
Chief Jeff Buchanan, North Las Vegas Fire Dept
Derek Cox, EMT-P, Las Vegas Fire & Rescue (Alt)
Tony Greenway, EMT-P, American Medical Response
Chief Scott Vivier, Henderson Fire Department

MEMBERS ABSENT

Chief Kevin Nicholson, Boulder City Fire Dept
Chief Thomas Miramontes, Las Vegas Fire & Rescue
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
Mary Ellen Britt, Regional Trauma Coordinator
Kelly Morgan, MD, EMS Consultant
Judy Tabat, Recording Secretary

PUBLIC ATTENDANCE

Brian Anderson, Community Ambulance
Gina Schuster, EMT-P, Community Amb.
Abby Hudema, RN, UMC
August Corrales, EMT-P, CSN
Larry Johnson, EMT-P, AMR/MWA
Eric Dievendorf, EMT-P, AMR
Gerry Julian, EMT-P, Mercy Air
Sarah McCrea, EMT-P, LVF&R
Richard Main, EMT-P, AMR
Elad Bicer, MD
Steve Krebs, MD, UMC
Monica Manig, EMT-P, HFD
Chuck Gebhart, EMT-I, BCFD
Dayna Blake, RN, TSCF
Melinda Case, RN, Sunrise Hospital
Brian Foster, CSN
Grey Martin, CSN
Mike Flannery, LVFR
Ryan Spradling, MWA
Brian Rogers, EMT-P, Community Amb.
Scott Morris, North Las Vegas Fire Dept
Victor Montecerin, EMT-P, MWA
Frank Simone, EMT-P, North Las Vegas Fire Dept
Daniel Llamas, HCA
Sam Scheller, EMT-P, Guardian Elite
Steve Johnson, EMT-P, MWA
Jim McAllister, EMT-P, LVMS
Steve Herrin, LVF&R
Tricia Klein, EMT-P, LVAPEC
Sarah Derleth, EMT-P, Community Amb.
Syd Selitzky, EMT-P, HFD
Paul Stepaniuk, EMT-P, HFD
Dorita Sondereker, RN, Mercy Air
Paul Houghton, Las Vegas Fire & Rescue
Chris Gentry, LVAPEC
Jacob Stamer, CSN/MWA
Troy Wayne, CSN
Daniel Schuster, CSN
Steve Patraw, Boundtree
Debra Releford, VHS

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The Medical Advisory Board convened in Conference Room 2/2A at The Southern Nevada Health District on Wednesday, May 1, 2013. Chairman E.P. Homansky, MD called the meeting to order at 11:01a.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. Homansky 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. Chairman Homansky 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 Homansky 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: March 6, 2013

Chairman Homansky asked for a motion to approve the Consent Agenda. *Motion made by Member Young, seconded by Member Johnson and carried unanimously.*

Chairman Homansky opened the meeting by welcoming Gregg Fusto, Trauma Program Manager at UMC and Regional Trauma Advisory Board (RTAB) Chairman as a new voting member of the Medical Advisory Board (MAB).

III. REPORT/DISCUSSION/POSSIBLE ACTION

A. Discussion of July MAB Meeting Date

The Board agreed to change the date of the next MAB meeting date to July 10, 2013 due to the Fourth of July holiday.

B. Committee Report: Priority Dispatch Task Force 05/01/13

Medical Priority Dispatch System (MPDS) ProQa Version 12.2 Upgrade

a) Breathing Detector Diagnostic Tool (Agonal Breathing)
b) Case Entry Question 3
c) Card #7: Burns (Scalds)/Explosion (Blast)
d) Card #9: Cardiac or Respiratory Arrest/Death
e) Card #12: Convulsions/Seizures
f) Card #28: Stroke (CVA)/Transient Ischemic Attack (TIA)
g) Protocols Y_A, Y_B and Y_C
h) Protocol F

Member Tuke reported that The National Academies of Emergency Medical Dispatch released the newest version of the ProQA MPDS (Medical priority Dispatch System) to version 12.2. He added that Steve Herrin from the Fire Alarm Office (FAO) did a great job of updating the Task Force on all of the protocol and EMD changes to the cards of the dispatch center and stated that the Priority Dispatch Task Force approved all the changes except for 4 items that required additional discussion.

Card #12: Convulsions/Seizures - it was recommended that the dispatchers stay on line with the person that says they might be going into seizures. The Task Force recommended that this needs further review and suggested they hold out on approving this protocol to get an idea how many of those Alpha calls turn into a Code 3 return.

Card #28: Stroke (CVA) Transient Ischemic Attack (TIA) - this protocol is now advocating that the dispatchers obtain phone numbers from the caller to provide that information to a stroke center. Since the dispatcher does not decide where the patient is transported and that the crews give telemetry to the stroke center that they are transporting to the Task Force did not see the need for the dispatcher to call the stroke center. The Board Agreed.

Protocols Y_A, Y_B and Y_C, directs the dispatcher to have bystanders remove a trach for somebody that is having difficulty breathing. The Task Force unanimously agreed and felt that should be left to the providers to determine if there is an actual airway or trach problem. The Board agreed.

Protocol F, Instruction 39 has to do with manipulation and massaging of the breast of the mom if the baby is unable to begin to breast feed and so there some language issues there that we had them take back that we are going to hold and work on some language to bring back to the MAB.

Member Tuke made a motion to approve the recommended changes from the National Academies of Emergency Medical Dispatch as stated with the exception of Card 12 and Protocol F to be brought back after further review. Seconded by Member Carrison and passed unanimously.

C. Discussion of the Protocol Development Project

Dr. Morgan referred to the binder that was given to each agency which included proposed protocols, current protocols, hand written notes and explained the timeline on how this project progressed. She added that there is an electronic version of this manual in a Drop Box site and provided the link.

Member Slattery advised the Board that a small group met at the Health District in April to talk about the process and the frustrations. The group included himself, Dr. Young, Mary Ellen Britt, Rory Chetelat, John Hammond, Trish Beckwith and Dr. Morgan. He stated that making the transition from one protocol format to another format didn't translate 100% of the time so changes were made in the process with medications and steps that became exponential and keeping track of the moving parts became a problem. One of the decisions that came out of that meeting was to redefine their mission to primarily make the change from the old format to the new algorithmic format. Secondarily they discussed the process for adding new protocols and new medications. He reasserted that the process for adding any new protocol or new medication comes to the MAB first and then this Board will direct the DDP. The last item was that there is a great deal of discussion and work that occurs at the subcommittee level and when it gets brought to the Board level some of those discussions that have already been resolved are being brought up by members who were not at the subcommittee or didn't get that communication. He emphasized the importance for this Board to be informed at what happens at the subcommittee level that is going to impact the decision they are making. This Board does reserve the right to discuss any issue that is concerning even though it was addressed before and it is the Chair's prerogative to stop that discussion if it was discussed and unanimously agreed upon at the committee level and that person just wasn't there. Member Slattery then turned the meeting over to Dr. Morgan.

Dr. Morgan referred to the Table of Contents and stated there is a comparison of the current and proposed treatment protocols. She noted that everything that is listed in a blue font is a new treatment protocol and everything that is in black font is a current protocol. She added that she has kept everything in alphabetical order but potentially moving forward she would like to see it laid out in an A (Airway), B (Breathing) .C (Circulation), D (Disability), E (Everything else) format.

Member Vivier questioned if they had the results of the survey. Member Slattery stated that in looking at the table of contents he counted 31 new protocols and felt that it might be helpful to go through the survey results to see which ones they are going to make a decision to direct the DDP to go forward with.

Dr. Morgan advised the Board that a survey monkey went out to the 18 voting members of the MAB and they received 11 responses and reviewed the results of the survey where the consensus was "yes" to add a new protocol.

Chest Pain

Dr. Morgan explained the reason she created the Chest Pain Protocol because there are other causes of chest pain and there was no option in the Acute Coronary Syndrome (ACS) Protocol to not give aspirin. Member Slattery stated he needed more information and suggested adding this to the current ACS protocol rather that a brand new separate chest pain protocol. She then asked if they want more protocols that are simplified or the same number of protocols that have more information on them. Member Johnson stated that one of the limitations in going to an algorithmic format is you run out of space quickly. The design initially was for a book that they could lay open with educational pearls on one side that doesn't mess up the algorithm flow and have your actual algorithm on the other side.

Member Young questioned if the suggestion would be to have a chest pain protocol with an exit route that would go to ACS. Dr. Morgan answered in the affirmative. Member Slattery stated that they need to do as much work

as possible to get the protocols as simple as possible so that the decision points on the algorithm lead to a change of management. After a brief discussion Chairman Homansky stated that the consensus was adding the Chest Pain Protocol with one of the exit routes going to ACS.

Member Tuke expressed the fact that the first thing that needs to get done is to get all of the current protocols as they are written in the new format, see what they look like and get them out to the field people for their input. Member Slattery agreed that they need input from the field; but felt at the same time, they made a decision over a year ago that they are moving with this format change. He felt that they will not go back on that unless the Board changes that decision.

Dr. Morgan went through the Table of Contents to inform the Board which protocols are already done and which ones she is currently working on. Chairman Homansky questioned which protocols the survey monkey had consensus on. Dr. Morgan stated that following treatment protocols were voted on to move forward:

Chest Pain had 45%
Drowning had 54%
Hypothermia / Heat Illness 60%
Neonatal Resuscitation 70%
Pain Management 63%
Seizure 54%

Member Anderson made the motion to move forward and develop protocols in the new format for Chest Pain, Drowning, Hypothermia/Heat Illness, Neonatal Resuscitation, Pain Management and Seizure, seconded by Member Slattery and carried unanimously.

Member Young questioned if there was a consensus on those that didn't need to be added as a protocol. Dr. Morgan stated that the following treatment protocols were voted not to add as a protocol:

The Broselow Tape 50%
Amputation 40%
Dental Emergencies 60%
Dystonic Reactions 40%
Febrile Illness 50%
Hanging 40%
Ocular Emergencies 45.5%
Pediatric Destination Criteria (currently in Operations) 50%
START Triage 54.5%
TFTC (currently in Operations) 50%
Severe Head Trauma

Member Young made the motion to exclude at this time from further development of new protocols the following suggested protocols: Amputation, Broselow Tape, Dental Emergencies, Dystonic Reactions, Febrile Illness, Hanging, Ocular Emergencies, Severe Head Trauma. Seconded by Member Slattery and carried unanimously.

Member Slattery questioned why Pediatric Destination and START Triage were not considered in the motion. Dr. Morgan stated that those are procedures.

Member Young amended his previous motion to include Pediatric Destination Criteria and START Triage as not required, seconded by Member Anderson and carried unanimously.

Dr. Morgan stated that there are a handful of protocols where people were in the middle and needed more information or suggested that they should be added to one of the existing protocols.

- Airway Obstruction – Decided to add to Airway Protocol
- Assault – Decided to add to TFTC
- Carbon Monoxide – Decided to add to Smoke Inhalation / Altered Mental Status / Overdose
- Extremity and Crush - add to General Trauma Protocol and education
- Failed Ventilation Management - Dr. Morgan stated that there was a push from DDP to go from airway management to ventilation management taking the stress off of just securing an airway to being able to ventilate a patient. Member Young felt that if they have an airway, a good and adequate and well thought out airway algorithm, they could include failed ventilation and airway obstruction.
- Diabetic Emergencies - Member Young felt that this needs to be addressed in other protocols as an alert box but not enough to warrant its own protocol.
- Severe Head Trauma – Decided to add to Trauma

Dr. Morgan stated she is combining the (6) Cardiac Dysrhythmia protocols into (3) Cardiac Dysrhythmia protocol; Pulseless, Bradycardia and Tachycardia. Member Johnson questioned if they will be folded into the (3) at the next DDP meeting. Dr. Morgan answered in the affirmative.

Member Slattery questioned if it would be prudent to reference ACLS except where they as a Board disagree with ACLS to simplify those protocols. He felt that there are little things that they disagree on but for the most part they all agree on ACLS. Dr. Morgan added that they expect their providers to keep those cards and those are the standards they are being held to with the exception of those couple of changes. She stated that she didn't have a problem with referencing ACLS.

Dr. Morgan referenced her list of proposed procedures and the survey results:

- Basic Airway Maneuvers – Dr. Morgan stated that they list Endotrachial Intubation, Needle Cricothyroidotomy and Supraglottic Airway as procedures but there is nothing on basic airway maneuvers and looking at how the procedure is lined out it tells you nothing about how to actually do them. Member Slattery felt that Member Young's comment of a robust airway protocol is probably the answer which would incorporate all of those.

  Member Young stated he would send it back to the committee to work on developing Airway Protocol and if for some reason there is too much and the recommendation is to go back to the Board stating they need a separate protocol they will address it at that point.
- Hemorrhage control: Dr. Morgan stated that the only reason she brought this up is there is some question about trying to encourage tourniquet use. Member Slattery stated that tourniquets are currently covered in the protocols. Dr. Morgan stated that it just says pressure or tourniquet and this came up previously with regard to the Swat medics. Member Carrison stated that everybody should be carrying and using them because in Boston it was clearly evident the primary reason for death in IED's is desanguation from amputation and the only solution to that is a tourniquet. They work and they are proven and once they are on you leave them on until you get to the trauma center. He added that it is not a complicated protocol, its education, it's a device that you carry and you are educated about how to use that device.
- In-line Nebulizers - Decided not to add
- Mechanical Ventilator - Decided not to add
- Meconium Aspirator - Dr. Morgan stated that the Meconium Aspirator is the only item on the survey regarding procedures where the consensus was they wanted more information. She stated that the reason she brought this up is because this is a device that every unit is required to carry and she felt that most people don't know how to use. It is one of those required pieces of equipment that is not referenced anywhere. Member Slattery stated it would be appropriate to put into obstetrical emergencies. Dr. Morgan added that it was approved in neonatal resuscitation as well and she will add it to the education of the neonatal resuscitation.
- Orogastric Tube Placement - Decided not to add
- Splinting - Dr. Morgan stated that nobody thought they needed to add splinting as a treatment protocol and the reason she brought that up was to make sure people are using Sager and traction splints appropriately and there is no guidance anywhere for that procedure.

  Chairman Homansky stated that the procedure should be referenced in the protocol that would use that procedure. Member Fusto stated that splinting is not listed under Shock or General Trauma. He added that the tourniquet isn't under the general trauma or shock protocol either. Dr. Morgan agreed and stated that is why she listed them separately. Member Fusto questioned if it would be easier to put it under general trauma and shock instead of making it a separate one. Dr. Morgan stated she reference hemorrhage control under General Trauma.

  Member Slattery stated that on the splinting issue he felt they didn't need a separate protocol; in his experience their providers do a great job and guaranteed they know how to put on a Sager Splint. He noted that if Dr. Morgan's perception is that it is not being done then he suggested looking at the evidence and numbers to see if they need a protocol.

Dr. Morgan wrapped up her discussion by stating her goal is all the protocols should be ready for the June DDP meeting and that she has people on board to do the education pages.

Member Carrison questioned how Droperidol was added to the Seizure protocol for the excited delirium patient. He added that he wasn't aware that they ever decided that Droperidol would be used for excited delirium and asked that this discussion be added to the agenda for the next meeting. Chairman Homansky assured Member Carrison that they will put that on the agenda.

IV. INFORMATIONAL ITEMS/ DISCUSSION ONLY

A. Committee Report: QI Directors

Dr. Young reported that the main discussion point at the meeting was standardized reporting for airway information. They are going to start looking at tracking an airway metric card which will be brought forward at the next meeting and hopefully roll out shortly thereafter. His goal is that every tube that gets placed will have some sort of metric so they can follow problems, look for trends and identify areas for education.

B. Trauma Report

Ms. Britt reported that they conducted the trauma self assessment on the 17th of April and thanked those that participated. She added that they had a total of 52 people attend that session and she is the process of finalizing that report and will make sure this Board receives a copy when it is published. The 2nd item to report is on Senate bill 205 which is the bill draft that is currently being considered by the Senate Finance Committee to fund the State Trauma Registry which has not been functional since 2007. The bill passed out of the Health & Human Services Committee and she thanked those who took the time to write a letter of support, and stated that they sincerely appreciate that effort and will keep them posted as it moves thru the legislature.

C. Internal Disaster Monthly Report

Mr. Hammond reported improved numbers for March and April.

D. ED/EMS Regional Leadership Committee Update

Dr. Homansky reported the main discussion point of the meeting was psych holds and how they are distributed. He added that anyone who reads the paper knows the difficulties that Ross & Neal are going through right now; their staffing has been cut including their mobile units so they are out in your facility into the hospitals less often. The positive points are that they are going to try and get their medical director to the next meeting. He stressed that it is imperative that each hospital update their EMSystem on psych holds every 12 hours and there will be more discussion on that at the next meeting. Dr. Homansky stated that this Committee is a good avenue for those discussions and asked Ms. Britt to contact Jim Holtz to see if he would like to move their meeting in July to the 10th.

Medical Advisory Board Service Recognition:

Rory Chetelat – Chairman Homansky announced the retirement of Rory Chetelat and acknowledged him as being instrumental in allowing this Board to be more effective and thanked him for all that he's done. Ms. Britt thanked him for his superb leadership during his service and noted he will be missed.

Richard Henderson, MD – Member Vivier recognized Dr. Henderson for his service to the MAB and EMS Community. He added that he has brought innovation to this community that is immeasurable and will always be known as a provider's advocate.

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. Chairman Homansky 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 Homansky adjourned the meeting at 12:31 a.m.