MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DIVISION OF COMMUNITY HEALTH

MEDICAL ADVISORY BOARD MEETING

December 4, 2013 – 11:00 A.M.

MEMBERS PRESENT

E.P. Homansky, MD, Chairman, AMR
Bryan Bledsoe, DO, MedicWest Ambulance
K. Alexander Malone, MD, North Las Vegas Fire
David Slattery, MD, Las Vegas Fire & Rescue
Chief Thomas Miramontes, Las Vegas Fire & Rescue
Brandon Hunter, EMT-P, MedicWest Ambulance
Tony Greenway, EMT-P, American Medical Response
Tressa Naik, MD, Henderson Fire Department
Dale Carrison, DO, Clark County Fire Department
Jarrod Johnson, DO, Mesquite Fire & Rescue
Chief Troy Tuke, Clark County Fire Dept.
Chief Scott Vivier, Henderson Fire Department
Scott Morris, North Las Vegas Fire Dept (Alt)
Melinda Case, RN, RTAB Representative

MEMBERS ABSENT

Chief Kevin Nicholson, Boulder City Fire Dept
Chief Jeff Buchanan, North Las Vegas Fire Dept
Rick Resnick, EMT-P, Mesquite Fire & Rescue

SNHD STAFF PRESENT

Mary Ellen Britt, EMSTS Manager
John Hammond, EMS Field Representative
Christian Young, MD, EMSTS Medical Director
Judy Tabat, Recording Secretary

PUBLIC ATTENDANCE

Frank Simone, EMT-P, North Las Vegas Fire Dept
Clem Strumillo, EMT-P, Community Amb.
Abby Hudema, RN, UMC
Mark Calabrese, Mountain View Hospital
Dorita Sondereker, RN, Mercy Air
Cole Sondrup, MD, Community Ambulance
Holden Myers, LVAPEC
Israh Tureaud, LVAPEC
Jason Burkhart, MWA
Michael Lipetri, LVAPEC
John McConaughy, LVAPEC
Cathy Jones, VHS
Ed Pisarsky, TSCF
D. French, Sunrise
Gerry Julian, EMT-P, Mercy Air
Steve Johnson, EMT-P, MedicWest
Eric Dievendorf, EMT-P, AMR
August Corrales, EMT-P
Steve Krebs, MD, UMC
Jason Driggards, AMR
Andy Toenniessen, LVAPEC
Robert Yoon, AMR
Maria Teemsma
Jonah Schreiner, LVAPEC
Lauren Williamson, LVAPEC
Barb Stolfus, TSCF
Melody Talbott, RN, UMC

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The Medical Advisory Board convened in Conference Room 2 at The Southern Nevada Health District on Wednesday, December 4, 2013. Chairman E.P. Homansky, MD called the meeting to order at 11:00 a.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 Board 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: October 2, 2013

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

III. REPORT/DISCUSSION/POSSIBLE ACTION

A. Committee Report: Drug/Device/Protocol Committee 11/06/13 & 12/04/13

11/06/2013

1. Review of Operations Protocols
   - Chronic Public Inebriate
   - Communications
   - Documentation
   - Do Not Resuscitate
   - Inter-Facility Transfer
   - Pediatric Patient Destination
   - Prehospital Death Determination
   - Release of Medical Assistance
   - Termination of Resuscitation
   - Transport Destinations
   - Waiting Room Criteria

   Dr. Johnson advised the Board that the DDP Committee has reviewed and approved the Operations Protocols. He added that most of the Operations Protocols were taken out of the General Patient Care (GPC) Protocol and created as separate operations with no significant changes.
   Member Johnson made the motion to accept the Operations protocols as they are written. Seconded by Member Greenway and passed unanimously.

2. Review of Treatment Protocols
   - Adult/Pediatric Tachycardia, Stable
   - Adult/Pediatric Tachycardia, Unstable
   - Adult/Pediatric Ventilation Management
   - Hypothermia/Hyperthermia

   Dr. Johnson reported that these protocols were workshopped in October and brought to the DDP Committee to review last month. He added that for the most part the Committee stayed on task by taking the current protocols and putting them into an algorithmic format without any changes except for the Ventilation Management Protocol where as a Committee they felt a branch point directing to a Failed Airway Protocol needed to be added.

   Chief Tuke questioned if the Ventilation Management Protocol should be approved without the Failed Airway Protocol completed. Dr. Naik felt that shouldn't hold up the process.

   Dr. Slattery questioned the rationale behind the Ventilation Management Protocol.

   Dr. Young stated that currently there is no step progression of the approach to the patient for airway, only a process for intubation. Dr. Carrison stated the pendulum swings back and forth with regard to airway management in the field particularly with intubation. In the past they have had a lot of failed intubations because BVM wasn't being done effectively and felt that having a Ventilation Management Protocol with a failed airway branch point would be effective.

   Dr. Young referred to the Respiratory Distress Protocol which was to establish whether or not the airway and ventilation was adequate. If it was not adequate, the idea was that the Ventilation Management Protocol with a branch point to a Failed Airway Protocol would actually follow an actual deliberate practice and there

was nothing in the current protocols to address that. Dr. Malone felt that starting to talk about ventilation management and having a protocol in place even if it is a fundamental protocol opens the door to future improvements and enhancements.

Dr. Slattery stated that he can certainly see the importance of the BVM and good ventilation practices but was hoping to see something in the protocol about properly ventilating someone using capnography and capnography directed ventilation.

Dr. Bledsoe stated that airway misadventures are uncommon in this system given its size and felt that it is such an important process and something the paramedics don't do often and felt a protocol would be important.

Dr. Homansky asked Dr. Slattery if he was comfortable with moving forward. Dr. Slattery answered in the affirmative.

Member Johnson made a motion to approve the Treatment Protocols as written. Seconded by Member Greenway and passed unanimously.

3. Report from Drug/Device/Protocol Algorithm Workshop for the Development of the Cardiac Arrest Protocol

Dr. Johnson reported that the DDP Workshop was held in November to discuss the development of the Cardiac Arrest Protocols which was then put into algorithmic format and brought back the DDP Committee for review in December.

4. Discussion of a Failed Airway Protocol

Dr. Young stated that since creating a Failed Airway Protocol would go beyond the charge of putting the current protocols into algorithmic format he formally requested the Board task this back to the DDP.
Dr. Homansky asked the Board if that was agreeable. The Board answered in the affirmative.

5. Discussion of Educational Pearls

Dr. Johnson reported that they are nearing the end of putting the protocols in algorithmic format and it was the decision of the Committee that the protocol manual would have the protocol on one side and the education pearls on the right hand side and they were tasking some key educators for their input.

12/04/2013

Review of the Cardiac Arrest Protocol

Dr. Johnson reported that the cardiac arrest protocols were placed in algorithmic format but as a Committee felt that there were changes needed especially on such an important issue so as it stands, it is not ready to be reviewed.

B. Discussion of Spinal Immobilization Protocol

Dr. Bledsoe shared a presentation with the Board and started off the discussion by stating there has been a trend over the last 2 years across the county to eliminate the use of backboards in EMS and asked the MAB to take this under advisement. In most emergency departments and trauma centers, patients with known cervical spine injuries are simply left in cervical collars and placed onto soft beds following imaging. He then gave a history on backboards and research study position papers. He concluded his presentation by stating that there is no evidence that backboards immobilize the spine, they cause pain and make airway management more difficult with a risk of aspiration.

Dr. Carrison agreed and added that this is a start, backboards are causing harm and that is something we are not supposed to be doing. Dr. Malone concurred.

Dr. Homansky asked Dr. Bledsoe if he wanted to send this to committee for review. Dr. Bledsoe stated that he would recommend this go to the DDP Committee to formulate a protocol and then present it back to the MAB.

Dr. Slattery stated selected immobilization has already been adopted and the NEXUS (National Emergency X-Radiography Utilization Study) criteria have been incorporated into our protocols. He added that this study was presented at the AMSP (Association of Medical Services Providers) Board last year and one of the reasons they don't have a position statement yet is because there is not a lot of evidence for those patients already with trauma and neurological deficits. He stated that this will be a challenge for the DDP because he feels that for 90% of the patients a collar would be just fine, but it's those patients with deficits that will be a challenge. He asked Dr. Bledsoe if he had any insight from other systems on this issue.

Dr. Bledsoe stated that in 5 years at UMC he has never put a patient back on a board and they have seen some pretty horrible fractures. Dr. Slattery stated that this is not about movement in a hospital environment it's about an out of hospital environment.

Dr. Homansky stated that this has been a good discussion and will refer this to the DDP Committee for review and thanked Dr. Bledsoe for bringing it forward.

C. Discussion of Healthcare Facility Capabilities Regarding Pediatric Patient Destination Criteria

Dr. Krebs reported that last year the Pediatric Destination Taskforce which he and Dr. Trautwein are co-chairs met last year to discuss the language that was going to change on January 1, 2013 which was set forth by previous taskforces. At the time the motive was to try and encourage more recruitment of pediatric emergency room trained physicians in the area so it was going to be a little more restrictive to very selective physician coverage approved for a pediatric destination center in the EMS system. The reality of the new policy taking place was the designation of being board certified/board eligible (BC/BE) specifically in pediatric emergency medicine limited the ability to consider qualified physicians and it was difficult to recruit Pediatric Emergency Room (ER) trained physicians. They were tasked last year to come up with language that would be more appropriate and through their first meeting last year as well as multiple meetings including Dr. Trautwein, Dr. Fisher representing UMC, and Dr. Stocker representing Sunrise and crossing over with St. Rose he referred to the "Proposed Language for Pediatric Destination Criteria" handout which is the language that they are presenting for consideration to be a pediatric destination center.

Dr. Trautwein stated that the criteria would be that in order for a facility to be a pediatric destination they had to provide the following:

1. Provide 24/7 in-house coverage for the Emergency Room with one of the following:
   a. BC/BE Pediatric Emergency Medicine Physician
   b. BC/BE Emergency Medicine Physician
   c. BC/BE General Pediatrician, at the discretion of the Medical Director of the individual facility.
2. Have a Pediatric Intensive Care Unit that provides 24/7 coverage with a BC/BE Pediatric Critical Care Specialist (PCC) available on site within 30 minutes, by contract.
3. Provide nursing services;
   a. 80% of pediatric ED nurses must have ENPC certification
   b. At least one ENPC nurse must be present at all times
   c. All pediatric ED nurses shall have PALS
4. Have a Medical Director who is BC/BE in Pediatric Emergency Medicine
5. Quality improvement must be conducted by the Medical Director or PCC physician or their designee
6. OEMSTS will audit for compliance

Dr. Trautwein added that one of the other things that they did add was the medical director of the facility did need to be a fellowship trained in pediatric emergency medicine again recognizing that there is a benefit in having that expertise and establishing that as kind of standard for each facility.

Dr. Slattery questioned the proposed language in 1c stating that a BC/BE General Pediatrician at the discretion of the Medical Director of the individual facility could provide coverage for the Emergency Room. He added that they are redirecting EMS traffic to hospitals that they consider pediatric emergency centers and felt that the practice of emergency medicine in general pediatrics is very different and didn't understand the rationale. Dr. Bledsoe stated that the issue is there are just not enough pediatric emergency medicine physicians. Dr. Carrison also voiced concern on general pediatricians working in pediatric emergency rooms. Dr. Trautwein stated that 3 if not all 4 facilities currently operate that way.

Dr. Carrison felt that the term "Medical Director of the Individual Facility" seemed vague because the medical director of the facility is not necessarily someone who has any expertise in pediatric emergency medicine.

Dr. Homansky questioned if they meant pediatric medical director. Dr. Trautwein answered in the affirmative and stated that refers back to #4 that the medical director is BC/BE in pediatric emergency medicine. Dr. Carrison stated that needed to be clarified in 1c of the proposed language.

Dr. Slattery stated that his objection is in principle and he understood the logistics but emergency medicine saw this very similar pattern 10-15 years ago and you either believe or you don't that they should be BC/BE in a

fellowship trained pediatric ED or emergency medicine (EM). A residency in pediatrics is not the same as doing a residency in pediatrics and then a fellowship in pediatrics emergency medicine or emergency medicine and fellowship in pediatric EM.

Chief Vivier questioned that by not adopting this language, would it create an access issue for the current pediatric facilities.

Dr. Krebs stated the discussion they had during the last meeting is they do feel they are still elevating the standard of care and that the directors of the pediatric emergency departments felt very strongly that they wanted to continue that path which would be very restrictive and very selective about those applications that they entertained. At this point the supply and demand is not such where they can have that language at the cost of shutting doors in departments and redirecting kids.

Dr. Naik felt that having a list of qualifications that the pediatric medical directors would expect from those general pediatricians would make the board feel more comfortable.

Member Naik made a motion to have the Pediatric Medical Directors come up with a list of criteria that are reasonable standards across the country of what they would look at in allowing a general pediatrician Member Carrison seconded it for discussion.

Dr. Malone felt that would policing individual facilities and stated that the onerous is on those facilities and their credentialing.

Dr. Carrison questioned if this proposed language did not get passed who would get shut down. Dr. Krebs stated that possibly 3 facilities. Dr. Carrison stated that the point is not to shut anybody down, the point is to establish criteria so we provide the best care to our pediatric patients.

Member Naik withdrew her motion.

Member Johnson made a motion to accept the proposed criteria with the change of "at the discretion of the medical director of the pediatric emergency department", Member Malone seconded and carried unanimously.

Dr. Slattery felt it was helpful to hear that this was part of an incremental plan of ultimately getting to the point where everyone is BC/BE in pediatric EM and/or EM. He asked if all the medical directors at each of the pediatric hospitals are all pediatric EM trained and certified. Both Dr. Krebs and Dr. Trautwein answered in the affirmative.

D. Discussion of Extending the Duration of the Temporary District Procedure for Managing Drug Shortages

Ms. Britt reported that the Temporary District Procedure for Managing Drug Shortages will be expiring on January 1, 2014 or until the persistent national drug shortages of formulary drugs have abated and asked that the Board consider extending the duration of this Procedure.

Dr. Johnson questioned the need to have duration and suggested taking out the word temporary and identifying that they are using alternate drugs within the protocol only until the others are available.

Member Naik made the motion to extend the District Procedure for Managing Drug Shortages with no time limitations, seconded by Member Tuke and carried unanimously.

IV. INFORMATIONAL ITEMS/ DISCUSSION ONLY

A. Serial Public Inebriate Program Presentation

Dr. Slattery shared a presentation on the Serial Inebriate Program (SIP). He added that there are a lot of problems in our system right now that they need to all collaboratively tackle. The SIP program modeled after San Diego was developed in partnership with law enforcement, emergency medical services, hospitals, and the courts. SIP provides an effective solution to the unsuccessful "revolving door" practices commonly used to deal with the chronic homeless alcoholics. These individuals are desperately in need of treatment and aside from the human toll, they also cost our communities' emergency services and hospitals millions of dollars each year. SIP takes individuals who have been picked up for being "intoxicated in public" five times and are consequently considered and labeled as a serial public inebriates. These individuals would then get offered forced sobriety by going to a treatment center in lieu of jail time needed to achieve long-term recovery and financial stability. In San Diego they have a medical clinical that would be their new medical home for all issues including medical, psychiatric needs as well as getting them integrated back into society so they have a place to live and get a job. San Diego has seen a 50% decrease in their emergency services and an increased reduction in recidivism rate.

B. Committee Report: QI Directors

Dr. Young reported that they are going to start to distill some of the lessons from the case studies presented at the QI Directors meeting and distribute them so the crews in the streets could start benefiting from these cases. He felt that it would not be that difficult to scrub that data and just get the learning points out there. He added that the Committee is increasing their attention towards trauma field triage criteria and trying to collate that data and find out where the trauma patients are going. He added that Dr. Slattery has been good enough to volunteer the services of the First Pass software to start looking and scrubbing some of the first watch data. The next QI Director Committee meeting will be in February.

C. Trauma Report

Ms. Britt reported that the Regional Trauma Advisory Board (RTAB) requested that they create a taskforce to begin looking at all the plans in the system. They had their first taskforce meeting and went over the Trauma Performance Improvement Plan and those suggested changes will be brought back to the Trauma Medical Advisory Committee (TMAC) for review and then back to the RTAB. The next meeting of the RTAB is January 15, 2014.

D. Internal Disaster/Transfer of Care Monthly Reports

Mr. Hammond reported that October and November 2013 saw an 88% decrease in internal disasters from a high of almost 3400 hours for a month to 421 hours.
He reported that transfer of care is still a challenge. 60% of all drop-offs are less than 30 minutes with 80% of drop-offs within 40 minutes.
Dr. Slattery asked if they could add a report about the mental health holds to this report.
Mr. Hammond answered in the affirmative.

Abby Hudema stated that the ED/EMS Regional Leadership Committee met just prior to this meeting and reported the following discussions:

- 800 MHz radio testing issues continue and stated that the Fire Alarm Office is working with the County Emergency Management Group to make sure that not only is all the equipment working which it seems to be but also that those calls are being answered.
- ED Nurse Managers - There are a lot of changes in the Valley so it was decided that Health District will collate a list as a live document on the Health District website.
- Mental Health - The State is saying that they are seeing improvement which isn't what is being reported from the ED's. They are going to continue to reach out to the mental health community to have a representative attend their meetings more regularly.
- New Years Eve - It is reported that they are well staffed at this point.

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 thanked everybody for the great level of care that is provided to the citizens of Clark County and wished everyone happy holidays. He called for a motion to adjourn; the motion was made, seconded and passed unanimously to adjourn at 12:22 p.m.