MINUTES
EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM
DIVISION OF COMMUNITY HEALTH
MEDICAL ADVISORY BOARD MEETING
June 03, 2015 – 11:00 A.M.

MEMBERS PRESENT
Dale Carrison, DO, Chairman, CCFD
Eric Anderson, MD, MedicWest Ambulance
Tressa Naik, MD, Henderson Fire Department
Kim Dokken, RN, RTAB Representative
Chief Scott Vivier, Henderson Fire Department
Chief Lisa Price, North Las Vegas Fire
Tony Greenway, EMT-P, American Medical Response
Chief Robert Horton, Las Vegas Fire & Rescue
David Slattery, MD, LVF&R (via phone)
E.P. Homansky, MD, AMR
Jarrod Johnson, DO, Mesquite Fire & Rescue
Chief Rick Resnick, Mesquite Fire & Rescue
Troy Tuke, Clark County Fire Dept.
Chief Chuck Gebhart, Boulder City Fire Dept.
Brandon Hunter, EMT-P, MedicWest Ambulance

MEMBERS ABSENT
Chief Kevin Nicholson, Boulder City Fire Dept
K. Alexander Malone, MD, North Las Vegas Fire

SNHD STAFF PRESENT
Mary Ellen Britt, EMSTS Manager
Gerald Julian, EMS Field Rep
Joseph P. Iser, MD, Chief Health Officer
Dawn Nielsen, Legal Intern
Christian Young, MD, EMSTS Medical Director
Judy Tabat, Recording Secretary
Heather Anderson-Frank, Associate Attorney

PUBLIC ATTENDANCE
Steve Johnson, MedicWest
Chad Fitzhugh, Mercy Air
Dineen McSwain, UMC
Jim McAllister, LVMS
Frank Simone, NLVFD
Cole Sondrup, MD, Community Amb.
Mark Calabrese, CCFD
Ed Pisarsky, TSCF
Sarah McCrea, LVFR
Cathy Jones, VHS
Steven Moore, LVRJ
Donna Miller, LG
Damon Schilling, AMR
Mike Barnum, MD, AMR
Chris Stachyra, Mercy Air
Ryan Bezemer, Community Amb.
Daniel Llamas, HCA
Glen Simpson, MWA
Monica Manig, HFD
Rod Sholty, LG
Henry Kokoszka, HFD
Barb Stolfus, TSCF
Steve Krebs, MD, UMC
Donald Gibson, HFD
Derek Cox, LVFR

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, June 03, 2015. Chairman Dale Carrison, DO called the meeting to order at 11:01 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. Chairman Carrison 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 Carrison 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 Carrison 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: April 01, 2015

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

III. CHIEF HEALTH OFFICE REPORT

Dr. Iser addressed the Board to give an update on the current 2015 legislative issues:

SB314: Revises the composition and duties of health districts in certain larger counties.
- Removed alternates on the Board of Health
- Removes 3 people from the Board: Physician, Environmental Representative and a nurse and puts them into an advisory board capacity.
- There would be a change in structure of the Health District
  - District Health Officer which no longer needs to be a physician
  - Chief Medical Officer who would report to the District Health Officer

This bill is still on the Governor’s desk and is awaiting signature.

SB 189: Amends NRS 450B to require the Division of Public and Behavioral Health to maintain the state trauma registry. This bill failed to make it out of the assembly. He stated that in the interim they will work with Senator Woodhouse to look at another funding mechanism.

AB 158: Amends NRS 450B to authorize any public or private entity where allergens capable of causing anaphylaxis are present to obtain an order for an epinephrine auto-injector to be kept on-site and administered to a person reasonably believed to be experiencing anaphylaxis by an appropriately trained agent of the entity, a family member or health care provider. This bill passed.

AB 305: Amends NRS 450B to allow a permitted ambulance service or fire-fighting agency to provide community paramedicine services with licensed attendants who have been endorsed to provide the services. This bill passed.

AB 308: Amends NRS 450B to exempt cities, towns or townships whose population is less than 25,000 from needing to comply with the current requirements for special event medical coverage. This bill passed.

SB 327: Amends NRS 450B to require minimum staffing of two attendants on an air ambulance and specifies the qualifications of the air ambulance attendants. It also requires an air ambulance that receives a patient in Clark County to be permitted in Clark County. This bill passed.

IV. REPORT/DISCUSSION/POSSIBLE ACTION

A. Committee Report: Education Committee (05/12/2015)

1. Discussion of Psychiatric Patient Destination Training

   Mr. Simone reported that an Education Workshop was held prior to the Committee meeting and it was decided at that workshop to make the education for the psychiatric patient destination a training video and they are in a process of developing those vignettes. The workshop will meet again on June 17th to review the scenarios that mimic psychiatric events. He added that the one thing they want to do is have all the medical components and education ready, so when they do designate those facilities, everything will be in place.

   Dr. Carrison questioned what facilities have agreed to accept these patients. Dr. Slattery stated that this is an item for discussion later on the agenda and asked if the Board wanted to address at this time. Chairman Carrison felt it would be appropriate.

   Dr. Slattery stated they he had a stakeholder meeting with the psychiatric mental health facilities on April 29th. All facilities that provide mental health care were invited, and they had a decent representation of those
facilities. The whole purpose of that meeting was to share with them the vision where they are able to take patients from the field, have the paramedics screen them, and bring them directly to a mental health facility. They also shared with them the screening criteria that was set up by the Health District and approved by this Board and the criteria the mental health facilities would have to meet before they could transport to them. There were a few obstacles and challenges from the facilities. One of the obstacles was having the ability to do a medical clearance exam 24/7 and that some of them simply don’t have the infrastructure in place to be able to receive EMS traffic. He added that there are current restrictions on all medical health facilities in terms of dealing with getting approval prior to admission so that is another obstacle for some of the facilities. He stated that to answer how many of the facilities would be able to this, WestCare felt they were in a position to be able to provide this care when they open up their new facility. Dr. Slattery added that he feels that this is a good protocol, and if they are even able to move a small number of patients from the field directly to the mental health facilities it would be a success.

Dr. Slattery added that one issue that was brought up by some of the mental health facilities was regarding getting a call from psychiatrists or primary care physicians wanting to transport their patient to a mental health facility directly. They were dialing 3-1-1 then that call transferred to the 9-1-1 call center which generated a call through the FAO, and then fire trucks and private ambulances showed up with lights and sirens. When that happens, they follow a SNHD destination protocol, which is a transport to an emergency department. Mr. Greenway stated that he met with those facilities and clarified that when patients were not experiencing emergencies and had been medically cleared by physicians, they can call private ambulance companies directly, not using the 3-1-1 line, but by using the 702-384-3400 line, which is the direct line to the non-emergent dispatch center for AMR.

Dr. Slattery stated there is no action needed at this time; he just wanted to update the board. He stated that they started with a protocol, developing a consensus, and then approved that protocol, and now Mr. Simone and the Education Committee are doing a wonderful job developing education. The QA Committee is working on the quality assurance metrics, and they will turn all of that on when the facilities are ready.

2. Discussion of Cervical Stabilization Training Video

Dr. Young reported that the Cervical Stabilization Protocol was approved during the last protocol rollout and put into place. Dr. Bledsoe and Scott Diel put out a companion video that included some examples and vignettes on how this protocol will be implemented. The Education Committee reviewed that video and there were some suggestions made. Those suggestions were brought that back to Scott Diel and Dr. Bledsoe to incorporate into the video. He expected the video to be done in the next week or so and will send it out to everyone.

B. Committee Report: Drug/Device/Protocol (DDP) Committee (06/03/2015)

Examination of a Procedure for Austere/Hostile Mass Casualty Incidents (MCI)

Dr. Barnum reported that the DDP Committee met earlier and discussed the Draft Hostile Mass Casualty Incident protocol. There were a few recommended changes that included under the “No” branch of the protocol, in the 2nd bullet point, change that to read just “Provide treatment for immediate life threats” and strike everything else after including bullet point 3 to keep it general and clean. They also recommended changing the verbiage under the “Yes” branch of the protocol in the 4th box to reflect the official name of the protocol manual. The DDP Committee unanimous approved this protocol with the recommended changes.

Chairman Carrison questioned a standalone protocol for MCI when it would fall under the incident command system. He also questioned the statement “if properly trained” because the private agencies are not trained.

Mr. Tuke stated that the whole reason that this came forward was because a lot of the providers on the force protection teams were worried about deviating from the protocols. This document would allow them, based on a hostile MCI, to depart from the actual protocol for as long as necessary to get the patient to the cold zone to reinstitute the actual SNHD protocols. He added that this protocol will be sent to the Education Committee for definitions and educational pearls.

Chairman Carrison asked the Board if everyone was comfortable with this protocol. The Board agreed.
Member Tuke made a motion to approve the Hostile Mass Casualty Incident Protocol with the recommended changes and refer it to the Education Committee for the educational pearls. Member Naik seconded and carried unanimously.

Dr. Johnson commented that the overall goal of the DDP was to continue to revise and review protocols, come up with a set of recommendations to roll out on a yearly basis. He added that over that last several months they have revised a couple of protocols and questioned when these would be going into effect. Chief Vivier agreed and added that substantive changes should only happen yearly when the protocol revisions happen but felt that the the Hostile MCI is operationally already in effect with all the agencies. He added that the psychiatric clearance would be a new protocol and that wouldn’t take effect until the new protocols have rolled out. Chairman Carrison agreed and stated that things that are going to affect training should be done once a year but felt an agency should have the ability to do a pilot at any time.

C. Discussion of Dextrose 10%/250ml Dosing

Dr. Young referred to the Draft Altered Mental Status/Syncope and Draft Pediatric Altered Mental Status Protocols in the handouts. He stated that they had discussed in the past the downfalls of giving D50 so to minimize the complications and storage implications, D10 was approved with a D50 sunset date of September 1, 2015. The protocols were revised and approved but originally it was written to receive D10 1ml/kg with a max dose of 250ml. They revisited this and amended the actual formulation. The newer version for the draft AMS and Syncope, now reads, “D10 25gm IV” which is 250mL of 10% solution. From the pediatric standpoint, it was previously written as “0.1 gm/kg IV” which definitely had math involved. To be more consistent with PALS dosing it was changed to “D10, 5ml/kg IV”.

Mr. Tuke stated that their logistics person at CCFD said that the supply of D10 in the IV form may be suspect and questioned if D50 will be the backup in case they run into a shortage.

Chairman Carrison stated that if the supply runs short for D10 then they would address an alternative solution at that time.

D. Report on Stakeholder Meeting for EMS Criteria for Transport to Psychiatric Receiving Facilities

Previously discussed in the Education Committee report.

E. Discussion of Creating a Work Group to Explore Alternatives to Transporting Patients to Emergency Departments

Dr. Slattery stated that currently our providers have two options when it comes to a patient. One option is to take the patient to the emergency department and if the patient refuses to go, the other option is to have that patient sign a release of medical assistance or against medical advice (AMA). He stated that they need to have a third disposition alternative for EMS for those low risk patients who don’t want to go to the hospital and the providers that are on scene believe the patient doesn’t need to go to the hospital. Medicare and other payors determine what a medical emergency is, and what is allowed to be not only reimbursed, but if an ambulance transport is billed, that isn’t deemed retrospectively to be an emergency not only is that sometimes not paid, but the more concerning for us in our jurisdiction is that it can be viewed as fraud. He voiced some concerns with regard to the overall system volume, and giving them the option of taking the time and being strategic about developing some good, solid criteria that are safe and supported, and then monitored for being able to taking low risk patients and do something else with them. The providers really don’t think they need to go to the hospital, the patient doesn’t want to go to the hospital, and yet they are signing them out AMA. We need that other option for the system.

Chief Vivier questioned if the workgroup would be looking to find alternative destinations other than an emergency department like quick cares and doctor offices. Dr. Slattery stated he was looking more towards alternatives to transporting patients. There’s patients that don’t need to be transported anywhere, and there’s some patients that are safe to go by private auto to urgent care or private doctor. He stated he was looking at enabling their providers to make that decision in a safe fashion. Chief Vivier stated that he was referring to other than transport or AMA, have another option that’s not an AMA like a declination of transport.

Member Slattery made a motion to take the concept of an alternative destination option for EMS and move it to a workgroup to start developing consensus among the medical directors and operations chiefs about #1 do we want to do this, and #2 how can we do it safely? And start putting that protocol and those parameters together.

Member Homansky seconded and carried unanimously.
F. Discussion of Proposed EMS First Response Assessment and Release Procedure for Low Risk Alpha Level Calls to be Referred to the DDP Committee

Dr. Slattery referred to the Proposed Criteria for First Response Evaluate/Release for Low-Risk Alpha Calls handout. Anticipating the continued increase in volume that they are seeing in the 9-1-1 system, he proposed as a starting point some parameters to release their first responders from a scene while waiting for the ambulance to arrive for low risk patients that have normal vital signs, with no high risk criteria.

*Member Slattery made the motion to refer the Proposed Criteria for First Response Evaluate/Release for Low-Risk Alpha Calls to the Drug/Device/Protocol Committee to iron out the logistics of a protocol. Seconded by Member Simone and carried unanimously.*

Mr. Tuke commented that they are looking at data to determine if there really is a need for a 9-1-1 ALS provider to respond to an Alpha non-emergent call. With the call volumes increasing, he felt they need to better triage all the calls and determine which ones they need to go on.

Chief Vivier stated that this was in place many years ago and questioned if there was a reason why this protocol went away. Ms. Britt stated that when she researched this, it was first introduced in January of 1997 and was implemented and that they were not aware it was not in place. She added that there was no action from the Health Districts perspective.

G. Transfer of Care (TOC) Report

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<th>Transfer of Care Compliance by Facility, Clark County NV</th>
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<td>Total TOC</td>
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<th>Transfer of Care Time Completion by Facility, Clark County NV</th>
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<td>Total TOC</td>
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<tr>
<th>Transfer of Care Time Outlier Report by Facility, Clark County NV</th>
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<tr>
<td>Total TOC</td>
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H. Internal Disaster Report / Mental Health Holds Report

Mr. Julian reported the average hours per day for internal disaster (ID) for first quarter 2015 which he compared with first quarter of 2014.

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<tr>
<th></th>
<th>January</th>
<th>February</th>
<th>March</th>
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<tbody>
<tr>
<td>2014</td>
<td>19.24</td>
<td>20.16</td>
<td>13.77</td>
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<tr>
<td>2015</td>
<td>36.73</td>
<td>33.85</td>
<td>30.35</td>
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Mr. Julian reported the daily average of mental health holds for first quarter 2015:

<table>
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<tr>
<th>Total L2K’s</th>
<th>Inpatient</th>
<th>Emergency Dept.</th>
<th>Awaiting SNAMHS</th>
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<tbody>
<tr>
<td>January</td>
<td>244</td>
<td>137</td>
<td>142</td>
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<tr>
<td>February</td>
<td>232</td>
<td>133</td>
<td>123</td>
</tr>
<tr>
<td>March</td>
<td>220</td>
<td>119</td>
<td>115</td>
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Chairman Carrison stated that it would be interesting and more meaningful to correlate that with the increase in the number of patients that are being seen also. Mr. Julian stated that he couldn’t do a facility to facility, but as far as volume, he track that daily, and I am seeing increases. It’s up into the 530’s a day now.

Chief Vivier questioned if there was a facility that can advise on what they’re walk in census is increasing to. Because we know our call volume has increased, and that’s going to impact your census, but is your walk-in volume increasing also.
V. INFORMATIONAL ITEMS/ DISCUSSION ONLY

A. ED/EMS Regional Leadership Committee Update

- Meeting time: EMS and hospital representatives indicated they see value in the meeting. Most nurse managers felt moving the meeting to 0800 might help attendance because once they arrive at the hospital it is often difficult to leave again. It was recommended that a brief survey be sent out to give everyone a chance to express their preference.
- Increased patient volume: Everyone commented that the daily volume of patients being transported and being seen in the EDs has increased. EMS representatives feel the hospitals are doing a good job with transfer of care when they arrive.
- L2K patient volume: Overall the number of L2K patients being held in hospitals seems to be decreasing. Gerry Julian with the OEMSTS stated the numbers recorded on EMResource have dropped. Dr. Young stated he believes improved access to health care coverage, increased availability of mental health professionals to evaluate patients in the EDs and an increase in the number of psychiatric beds in the community have all contributed to the reduction.
- L2K Study Report: The final draft of the 2015 L2K Study Report has been completed and sent to Dr. Lockett and Dr. Iser for review and comment. Once that is accomplished the results will be shared.

Transfer of Care (TOC) Process: In spite of the general feeling that the transfer of care in the EDs is not significantly prolonged, the data collected through FirstWatch still shows increased TOC times. We discussed the challenges with the current process that requires the EMS provider and the ED nurse to log patient arrival and transfer of care into a computer terminal that may be different than the terminal they are using for their internal e-systems. The group felt it was time to re-visit the process to see if there is a way to automate it. Troy Tuke with Clark County Fire Department offered to discuss some possibilities with FirstWatch and report back on his findings.

B. Committee Report: QI Directors (06/03/2015)

- Clinical Case Review: Dr. Young reported that they had a clinical case review done from Sarah McCrea at LVFR. This case was presented from Trauma Medical Audit Committee (TMAC) to either address a QI concern or opportunity for improvement on the part of the trauma system.
- Data Sharing Agreement: Dr. Young reported they continue to work on data sharing. The SNHD administration is trying to decide which type of memorandum agreement would be most appropriate. The data will need to be protected in accordance with federal and state law.
- First Watch and Drowning Reporting: Dr. Young stated that historically, there’s been about a 61% response rate on the Submersion Incident Reports. He added that they are going to continue to try and work on efforts to improve that and get a better handle on this since it clearly has made a difference in terms of where the resources and education has been put in the past.

C. Trauma Report

Ms. Britt reported that the Regional Trauma Advisory Board (RTAB) met on April 15th. They are in the nomination process for new members for the non-standing seats. Those seats that are up for reappointment are the administrator from a non-trauma center hospital, payors of medical benefits for victims of trauma, the private franchise provider, public franchise provider or EMS, rehabilitation services, and system financing and funding. The nomination committee will be meeting on June 12th to look at the individuals, who have been nominated, and then make a recommendation. The RTAB will endorse those nominations, and Dr. Iser will appoint those individuals to begin their term on July 1st.

Mr. Tuke came and did a presentation about the hospital MCI, which was very well received. Dr. Fildes commented that he has seen this move nationally, and really applauded the work that’s being done in that area.

D. Legislative Update

Previously Discussed in Dr. Iser’s report

Chairman Carrison announced the retirement of Mary Ellen Britt and recognized her for her exceptional work she has done for the Health District and this Board.
Chief Vivier thanked Ms. Britt for her dedication and added that it been a pleasure working with the Health District under her leadership and guidance.

VI. 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 Carrison asked if anyone wished to address the Committee. Seeing no one, he closed the Public Comment portion of the meeting.

VII. ADJOURNMENT
There being no further business to come before the Board, Chairman Carrison called for a motion to adjourn; Motion made by Member Tuke, seconded by Member Homansky and passed unanimously to adjourn the meeting at 12:17 p.m.