# MINUTES

## EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

## DIVISION OF COMMUNITY HEALTH

## MEDICAL ADVISORY BOARD (MAB) MEETING

**April 06, 2016 – 11:00 A.M.**

### MEMBERS PRESENT

Tressa Naik, MD, Vice Chair, Henderson Fire Department
Bryan Bledsoe, DO, MWA
Cole Sondrup, MD, Community Ambulance
Frank Simone, North Las Vegas Fire (Alt)
Chief Robert Horton, Las Vegas Fire & Rescue
Chief Kim Moore, Henderson Fire Department
Brandon Hunter, MedicWest Ambulance
Brian Rogers, Community Ambulance
David Slattery, MD, LVF&R
E.P. Homansky, MD, AMR
Jarrod Johnson, DO, Mesquite Fire & Rescue
Chief Rick Resnick, Mesquite Fire & Rescue
Tony Greenway, American Medical Response
Troy Tuke, Clark County Fire Dept.
Jim Kindel, Boulder City Fire Dept.
Chief Lisa Price, North Las Vegas Fire

### MEMBERS ABSENT

K. Alexander Malone, MD, North Las Vegas Fire
Dale Carrison, DO, Chairman, CCFD
Kim Dokken, RN, RTAB Representative
Ketan Patel, MD, Boulder City Fire Dept.

### SNHD STAFF PRESENT

John Hammond, EMSTS Manager
Laura Palmer, EMSTS Supervisor
Heather Anderson-Fintak, Associate Attorney
Judy Tabat, Recording Secretary
Christian Young, MD, EMSTS Medical Director
Gerald Julian, EMS Field Rep
Dr. Michael Johnson

### PUBLIC ATTENDANCE

Mike Barnum, MD, AMR
Steve Johnson, MWA
Dorita Sondereker, Southern Hills Hospital
Jim McAllister, LVMS
Brian Anderson, CA
Dineen McSwain, UMC
Kathy Millhiser, Southern Hills Hospital
Chris Stachyra, Mercy Air
Tim Gunderson, CSN
William Wilson, CSN
Tyler Chairsell, LVFR/CSN
Eric Anderson, MD, MWA
Ryan Bezemer, CA
Steven Carter, AMR
August Corrales, JTM
Jason Driggars, AMR/MW
Derek Cox, LVFR
Cathy Jones, VHS
Ashley Gonzalez, CSN
Rebecca Carmody, CSN
Stacy Johnson, MV
Steve Burton, LVFR

## CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The Medical Advisory Board convened in Red Rock Conference Room at The Southern Nevada Health District on Wednesday, April 06, 2016. Vice Chairman Tressa Naik, 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. Vice Chairman Naik noted that a quorum was present.

Mr. Hammond welcomed Dr. Michael Johnson as the Health District's new Community Health Director.

## 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. Vice Chairman Naik asked if anyone wished to address the Board pertaining to items listed on the Agenda. Seeing no one, she closed the Public Comment portion of the meeting.

## II. CONSENT AGENDA

Vice Chairman Naik 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. Approve Minutes/Medical Advisory Board Meeting: February 03, 2016

B. Review the Chronic Public Inebriate (CPI) Protocol to be Referred to the Drug/Device/Protocol Committee

*Vice Chairman Naik asked for a motion to approve the February 03, 2016 Minutes of the Medical Advisory Board. Motion made by Member Tuke, seconded by Member Bledsoe and carried unanimously.*

*Member Slattery made a motion to refer Item B of the Consent Agenda "Review the Chronic Public Inebriate (CPI) Protocol" to the Drug/Device/Protocol Committee. Seconded by Member Tuke and carried unanimously.*

## III. CHIEF HEALTH OFFICE REPORT

No report given

## IV. REPORT/DISCUSSION/POSSIBLE ACTION

A. Committee Report: Education Committee (04/06/2016)

- Education Workshop Report
  - Discussion of the Skills Proficiency Record

Mr. Simone reported that the Education Committee met this morning to review the draft Skills Proficiency Record that was put together by the Education Workshop. The Workshop was tasked to examine the skills proficiency record for convention, viability and modernize it so the skills sheet would be using similar language to the current protocols and procedures. He referred to the draft Skills Proficiency Record in the handouts and stated that it is the Education Committee's recommendation to the MAB to approve this as the new Skills Proficiency Record.

Dr. Naik asked for a motion to approve the Draft Skills Proficiency Record as written. *Motion made by Member Homansky, seconded by Member Tuke and carried unanimously.*

B. Committee Report: Drug/Device/Protocol Committee (04/06/2016)

- DDP Workshop Report
  - Review of the AHA Changes that Pertain to EMS
  - Discussion on a Cardiac Arrest Protocol for Pregnant Patients
  - Review the Use of Pain Medications in the System with an Emphasis on Expanding the Use of Ketamine

Dr. Bledsoe reported that they had a very productive DDP meeting and have (3) revised protocols to present to the MAB for consideration.

Target Temperature Management & Post-Resuscitation Care

Dr. Bledsoe stated that this protocol previously named Therapeutic Hypothermia & Post-Resuscitation Care is the adoption of the new term and appears in line with AHA standards by limiting the cold saline to 250 ml/hr up to 1 liter. The DDP Committee approved this protocol as written and asked that that MAB approve this protocol.

*Vice Chairman Naik asked for a motion to approve the Target Temperature Management & Post Resuscitation Care Protocol as written. Motion made by Member Slattery, seconded by Member Bledsoe and carried unanimously.*

Cardiac Arrest (Non-Traumatic) (Adult CCC CPR)

Dr. Bledsoe stated that the Cardiac Arrest Protocol was revised to include additional pearls for the cardiac arrest patients who are pregnant. This reflects recommendations from the American College of Obstetricians and Gynecologists and the AHA as to a strategy to help improve resuscitation in gravid females. This addendum is teaching our crews how to do uterine displacement to get the gravid uterus off the inferior vena cava to help with the efficacy of CPR. He asked the MAB to approve this addendum to be added to the Cardiac Arrest Protocol.

*Vice Chairman Naik asked for a motion to approve the Cardiac Arrest (Non-Traumatic) (Adult CCC CPR) Protocol with the educational addendum. Motion made by Member Tuke, seconded by Member Simone and carried unanimously.*

Pain Management

Dr. Bledsoe reported that they are giving the paramedics more options in terms of pain management in the prehospital setting primarily by adding the administration of sub-dissociative dosing of Ketamine. Ketamine is an agent that basically disconnects the conscious part of the brain from the sub conscious part of the brain using lower doses, Ketamine becomes a very effective analgesic. Literature support of this is very good and the DDP Committee has approved the protocol in front of you with the following changes:
Doses for Ketamine in a sub-dissociative range for the prehospital setting will be 0.2mg/kg with no repeat dose. They have taken out the requirement that radio contact be made on subsequent doses for Fentanyl and Hydromorphone so those radio icons will be removed. As a formatting change, they will lateralize the 4 choices of pain medications into equal boxes. An important caveat suggested by Dr. Slattery on which we all agreed is that they want to enhance and emphasize the use of end tidal wave form capnography when they are using these potent analgesics & dissociate agents. The other change is housekeeping on page 163 of the formulary in terms of the reference to Ketamine. They changed the sub-dissociative dose to 0.2mg/kg IN/IV/IO which will be specified for pain management. The 2mg/kg IV/IO and the 4.0mg/kg IM doses will be specified for sedation. We are adding a caveat to emphasize the importance of end tidal $CO_2$ wave form capnography. He added that there will be a statement made in the pearls section of the protocol concerning mixing medications. The issue came up with regard to switching categories of drugs between a sub-dissociate agent and an opiate. He stated that they as physicians and other members of the DDP are comfortable if they are using wave form capnography to identify respiratory depression early. With a chronic pain patient for example, they get 10mg of morphine and they realize it is a chronic pain patient it would allow them to switch to Ketamine in agreement with the new guidelines coming down from CDC.

*Member Bledsoe made a motion to approve the Pain Management Protocol with the discussed changes. Seconded by Member Slattery and carried unanimously.*

C. Discussion of Adding the Handtevy Tool as a Broselow Equivalent to be Referred to the Drug/Device/Protocol Committee

Mr. Hammond stated that Mr. Tuke brought this to his attention in regard to dosing medications for pediatric patients as a replacement or augmentation to the length/weight based tape that they currently use. Handtevy has an online web based process where you can input our own protocols and after you determine the weight of the patient, it will actually figure out all the other things that you use specifically rather than what is not used that is currently on the Broselow tape. Mr. Hammond played the video for the Board and then asked Mr. Tuke for additional input.

Mr. Tuke stated that the one thing that interested him at the last NAEMSP was the ability to put this on tablets. Most everybody is on EPCRs, so the ability to put this on a tablet and have it customized to our protocols not only for pediatric codes but for all the other pediatric emergencies and medical emergencies up to a 100kg patient. He felt this product is worth investigating and suggested that the MAB direct it to DDP for further investigation to see how it may be able to apply to our system to improve patient care.

Dr. Slattery commented that he knows Dr. Peter Antevy well from NAEMSP and stated that they have built a very impressive product. There have been a lot of research papers on the use of this not only for EMS but also in the emergency medicine setting. The psychology portion of it is just invaluable. It is a really simple system and Dr. Slattery felt that it would probably be one of the most important changes to our system if it was decided to go with this system.

Dr. Young felt that it was important to note that it is not the only electronic system out there. There is an eBroselow SafeDose System which is another system and felt that due diligence may be good to compare other products.

Dr. Homansky suggested that they make sure that they pediatric experts that have been participating come to this meeting are invited to the committee. Dr. Young agreed.

*Dr. Naik asked for a motion to send this to the Drug/Device/Protocol Committee for further review. Motion made by Member Tuke, seconded by Member Slattery and carried unanimously.*

D. Transfer of Care (TOC) 1st Quarter 2016 Report

Total TOC: Total number of EMS transports
Noncompliant TOC: Total TOC that did not meet the 35 minute standard
Compliant TOC: Total TOC that did met the 35 minute standard

Transfer of Care Compliance by Facility, Clark County NV

| | Total TOC | Noncompliant TOC | Compliant TOC | Compliance Rate (%) |
|---|---|---|---|---|
| Total | 22,115 | 9,106 | 13,009 | 58.8% |

Total TOC: Total number of EMS transports
TOC not completed by ED: Total TOC where the facility did not enter TOC time
TOC completed by ED: Total TOC where the facility did enter TOC time
Completion rate %: Percentage of facility completed TOC time

Transfer of Care Time Completion by Facility, Clark County NV

| | Total TOC | TOC not completed by ED | TOC completed by ED | Completion Rate (%) |
|---|---|---|---|---|
| Total | 26,311 | 19,485 | 6,826 | 25.9% |

Total TOC: Total number of EMS transports
TOC Outlier: TOC time< 5 minutes or TOC time >= 5 hours

Transfer of Care Time Outlier Report by Facility, Clark County NV

| | Total TOC | TOC Outlier | < 0 Min | 0-1 mins | 1-2 mins | 2-3 mins | 3-4 mins | 4-5 mins | >= 5 hrs |
|---|---|---|---|---|---|---|---|---|---|
| Total | 32427 | 2881 | 454 | 593 | 330 | 492 | 487 | 520 | 5 |

E. Internal Disaster 1st Quarter 2016 Report / Mental Health Holds 1st Quarter 2016 Report

Mr. Julian reported the average hours per day for internal disaster (ID) for first quarter 2016 which he compared with the first quarter 2015.

| | January | February | March |
|---|---|---|---|
| 2015 | 19.24 | 20.16 | 13.77 |
| 2016 | 57.21 | 69.86 | 65.52 |

Mr. Julian reported the daily average of mental health holds for first quarter 2016.

| | Total L2K's | Inpatient | Emergency Dept. | Awaiting SNAMHS |
|---|---|---|---|---|
| January | 224 | 108 | 123 | 97 |
| February | 257 | 117 | 141 | 121 |
| March | 261 | 113 | 137 | 116 |

## V. INFORMATIONAL ITEMS/ DISCUSSION ONLY

A. Committee Report: QI Directors (04/06/2016)

Dr. Young reported that there were not enough members present to reach quorum so they had an informal discussion with regard to internal disaster. He informed the Board that the EMResource tool has been reconfigured in map view to only show hospitals which also includes O'Callaghan and the VA hospital so you can see visually which hospitals are on internal disaster by the black icon. The List Region view in EMResource has also been changed from alphabetical to region designation, (ex. NW, SW, Central). He reported that the quarterly meeting for Mission Lifeline was held on March 24th discussing regional STEMI care. He advised the Board that they are still having issues with the hospitals getting data abstracted so it is not painting an accurate picture of care. He added the meetings are quarterly and will inform the Board the date and time of the next meeting.

B. Code Resource Report

Dr. Naik discussed the issue of internal disaster versus code resource. She wants to make it easier for facilities to go on some sort of a closure status but to have it be as accurate as possible so the EMS crews know what the facility is capable of handling at that time. She added that there also needs to be education with ER staff because many are under the impression that being on internal disaster means they do not receive ambulances, which is not the case. She advised the Board that EMSystem is willing to do this and she is meeting with Jason Guinn next month for the preparedness meeting to see if they have bought in to the concept.

Dr. Sondrup stated that this is an important topic and needs to be addressed. He stated that we are suggesting changing the nomenclature at the hospital from internal disaster to Code Resource as well as EMS and questioned compliance issues. He felt that it might be easier to create a "Code Black" for example which would mean you can't go to this hospital right now.

Dr. Bledsoe stated that the prevailing trend across the county for EMS is not to recognize hospital diversion and felt that it is starting to happen here.

Dr. Sondrup agreed and added that it is because they use it for resource management.

Dr. Naik stated that her only concern is they are currently using internal disaster and they are not actually giving the reason why. She wants to give the Health District and the crews more information on why they are on internal disaster which makes a difference. She stated that they will have to present it in group format and actually get the details out, bring in the hospitals, bring in the crews and see how they want to change it.

Mr. Hammond stated that currently there is a requirement that the hospitals have to put reasons in but they don't use it. He expressed concern over the term Code Resource as returning to the battle days of divert. He felt a better plan would be to have the internal disaster be mandated by a stop gap with the reason why they are on internal disaster. He stated that he could speak with Mr. Wright at the State and have him see if he could program that to make you put in a reason or you can't go on internal disaster.

Dr. Bledsoe felt that there are 2 issues. At UMC they will tell us they are on ID but as the only level I hospital they have to select patients. The other thing is they know that the Health District doesn't have the resources to enforce.

Mr. Hammond agreed and added that they have to work collaboratively to get the patient to the right place at the right time and not unduly burden the EMS providers.

Mr. Hunter agreed and added that when their crews go available for the day, their dispatchers come over the radio and will let the crews as soon as they start their shift what hospitals are on internal disaster which is a big help.

Dr. Slattery suggested engaging the Facilities Advisory Board (FAB) and let the hospitals be aware of the problem but help us solve the problem.

Dr. Naik stated that her goal today was not to do anything on this but to inform you where she is at with this process.

C. Presentation from WestCare with Regard to Mental Health Capabilities

No presentation given

## 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. Vice Chairman Naik asked if anyone wished to address the Board.

Mr. Cox recognized Dr. Slattery and Sarah McCrea for their work with training the first educational class on how to give Narcan to family members or friends of an individual who may be at risk for an opioid overdose.

Dr. Slattery thanked Mr. Cox and stated that he got engaged with this group called There is no Hero in Heroin (TINHIH), a nonprofit group here in Southern Nevada and was asked to speak to them. He stated that he found this group to be extremely motivated to protect their loved ones that are struggling with addiction. He stated that he didn't appreciate the scope of the problem until speaking with them and added that they are very fortunate to have a bill that allows and enables bystanders to use Narcan.

Vice Chairman Naik asked if anyone else wished to address the Board. Seeing no one, she closed the Public Comment portion of the meeting.

## VII. ADJOURNMENT

There being no further business to come before the Board, Vice Chairman Naik called for a motion to adjourn; *the motion made, seconded and passed unanimously to adjourn at 11:55a.m.*