



MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

PEDIATRIC DESTINATION WORKGROUP

December 3, 2008 -- 11:00 A.M.

SNHD STAFF PRESENT

Rory Chetelat, EMSTS Manager
Joseph J. Heck, DO, Operational Medical Director
Trish Beckwith, EMSTS Field Rep
Lan Lam, Recording Secretary

Mary Ellen Britt, Regional Trauma Coordinator
John Hammond, EMSTS Field Rep
Judy Tabat, Administrative Assistant

PUBLIC ATTENDANCE

Sajit Pullarkat, Summerlin Hospital
Frank Pape, DO, Summerlin Hospital
Kathy Banusevish, MountainView Hospital
Susan Crowder, MountainView Hospital
Jen Renner, Sunrise Hospital
John Henner, DO, MountainView Hospital
Troy Tuke, EMT-P, Clark County Fire Dept
Chad Henry, EMT-P, MedicWest Ambulance
Jay Fisher, MD, UMC Hospital
Jackie Levy, UMC Hospital
Jason Meilleur, EMT-P, American Medical Response
Lorelie O'Campo, St Rose Siena Hospital
Diana Lipscomb, MD, St Rose Siena Hospital
Joshua Gray, CSN

Kristine Bruning, Summerlin Hospital
Will Wagnon, CEO, MountainView Hospital
Sandy Young, RN, Las Vegas Fire & Rescue
Todd Sklamberg, Sunrise Children's Hospital
Willa Dixon, Summerlin Hospital
Brian Rogers, EMT-P, Henderson Fire Dept
Jo Ellen Hannom, RN, Clark County Fire Dept
Chief Randy Howell, Henderson Fire Dept
Nancy Harpin, RN, UMC Hospital
Bob Byrd, EMT-P, American Medical Response
Kathy Silver, UMC Hospital
Debbie Pavlica, RN, St Rose Siena Hospital
James Swift, MD, Sunrise Children's Hospital

CALL TO ORDER:

Rory Chetelat called the meeting to order at 11:05 a.m.

I. ITEMS FOR DISCUSSION:

Discussion of Hospital Requirements for Pediatric Destination Protocol

Mr. Chetelat stated the purpose of the workgroup was to discuss the need for potential changes to the Pediatric Destination Protocol. It was announced at the November Medical Advisory Board meeting that MountainView Hospital expressed a desire to be included in the Pediatric Destination Protocol as a primary hospital to receive pediatric patients. It was noted MountainView Hospital met the criteria, but the MAB felt that the protocol needed to be reviewed since it was developed over four years ago. Mr. Chetelat stated that the Southern Nevada Health District is looking to the experts in the field to help in this process to insure pediatric patients will be treated appropriately and with the best care. There are

currently four hospitals designated as Pediatric Destination Hospitals: St. Rose Siena; UMC; Sunrise; and Summerlin Hospital. Mr. Chetelat noted there were three topics for discussion:

1. What is the best system that could be put together for pediatric care that would insure pediatric patients are getting appropriate care in the field and are transported to the appropriate facility? Which facilities?
2. Keep the current protocol, but model it after the California model which sets broad criteria.
3. Eliminate the destination protocol and assume all emergency rooms should be able to stabilize a pediatric patient and will transfer the patient to a higher level of care if needed.

Dr. Jay Fisher felt that this would be a great opportunity to maximize resources throughout the county. He recommended we look at other systems that are more developed. One example given was Los Angeles County. They have a tiered system where the county certifies particular hospitals to receive pediatric patients. With this system, some hospitals do not receive any pediatric patients; those that receive pediatric patients are classified as Emergency Department Approved for Pediatrics (EDAPS) or Pediatric Medical Centers. EDAPS are staffed by adult emergency physicians who have committed themselves to provide services that meet the pediatric criteria. Pediatric Medical Centers are staffed with pediatric critical care providers and have pediatric surgeons available. Mr. Chetelat stated the issue with this approach is that the Southern Nevada Health District only has authority over the EMS providers and not the hospitals; therefore, SNHD does not have the authority to certify hospitals.

Dr. James Swift liked the idea of leaving it open and letting the hospitals meet the standards of various programs; however, he warned that the development of a tiered system should be done with care. He noted that Mattel Children's Hospital did not meet EDAP or Emergency Medical Services for Children (EMSC) criteria following their certification because they lost some of their physician coverage. He stated that he would like the guarantee of an around the clock pediatric physician response, or at least within a certain time frame for the facilities.

Will Wagon believed there to be a consensus among the group that children require a certain level of expertise but pointed out another factor to consider would be the comfort level in the field with EMS assessing children and routing them to the appropriate facility. They would also need clarification on gray areas such as the assessment of pediatric trauma injuries.

Dr. Heck asked EMS for their input with regard to a 3-tiered system. Chief Randy Howell felt the more complex this system becomes, the less accurate the outcomes will be. With the tiered system there are things to consider such as location, traffic patterns etc., but Chief Howell stated he would like EMS to be given a little leniency if patients get transported to the wrong facility. He feels that with the trauma system, the EMS providers are being scolded for transporting patients to the wrong facility and he doesn't want to be put in the same position with pediatric destination. Sandy Young stated that EMS has gotten so regulated through the years that they have to provide extra reports to explain why they transported their patient to the wrong facility. Ms. Young agreed that the provider agencies don't want to be over regulated.

Nancy Harpin noted that other states use Emergency Medical Services for Children (EMSC) as an advisory board. For instance, Minnesota has a comprehensive packet which incorporates destination criteria and recommendations presented in an advisory forum to the EMS system, rather than a mandate. The policy presented from California demonstrates the minimum standards for a facility if they should receive children; it is not intended for destination. Ms. Harpin stated that Nevada has an EMSC Advisory Committee that has been meeting for years. It looks at the system as a whole including the rural areas and northern part of the state such as Reno and Elko.

In looking at the policy from California, Dr. Heck stated that any acute care general hospital would be able to meet those requirements so it doesn't hold a lot of utility. Although EMS providers are called out

for transporting trauma patients to the wrong facility, he believes the trauma system is simple and easy to work with. He recommended looking at the current policy to better define what the criteria will be and designate whether facilities are or are not pediatric receiving facilities as opposed to starting a tiered system that would make it more difficult for EMS to follow. For facilities that may be designated as a pediatric receiving facility but may not have the level of expertise as another, transfer agreements will be in place to move pediatric patients to a higher level of care. Some of the questions Dr. Heck put on the table for discussion to be used as a starting point to build upon are as follows:

1. Should there be pediatric Emergency Medicine (EM) coverage? If so, does it need to be 24/7?
2. Does in-patient pediatrics mean a general pediatric floor or Pediatric Intensive Care Unit (PICU)?
3. Does in-patient coverage mean pediatric hospitalists that are 24/7? Or is it the general pediatrician who is making the rounds?

Dr. Swift suggested we inquire what each facility's coverage includes as standards differ across the country. Dr. Frank Pape stated that getting adequate pediatric coverage will be difficult because the number of fellowship trained physicians coming out is minimal. Dr. Heck asked what could be used in lieu of this criterion. Dr. Swift stated that he is involved with the largest pediatric hospital medical group in the country and one of the programs that he manages in Las Vegas has home calls for pediatric intensive care which meets the standards for both the American Academy of Pediatrics and for most states in the nation. It would be best to have Pediatric ER people in-house 24 hours a day but most facilities are unable to afford it. Dr. Swift stated that he is not trying to water down the healthcare system, but it should be known that there are workforce and manpower issues beyond our control. Dr. Heck stated the issue is not looking at the best standard but rather looking at an acceptable standard for the Las Vegas community to ensure enough access is provided. EMS cannot bring people from the far northwest bypassing multiple hospitals just to get to UMC or Sunrise Hospital; an acceptable community standard will need to be put in place.

The four designated hospitals currently have the following coverage in place:

- UMC: 24/7 Pediatric EM Coverage, 24 hour PICU
- Sunrise: 24/7 Pediatric EM Coverage, 24 hour PICU
- St Rose Siena: 24/7 Pediatric EM Coverage, PICU must be called in
- Summerlin: 12-18 hours of Pediatric EM Coverage, PICU coverage is 12-18 hours

Dr. Heck commented a de facto community standard has been set. Currently, each pediatric destination facility has a PICU with some level of pediatric intensivist coverage and some degree of pediatric emergency medicine coverage each day.

Dr. Fisher expressed concern with taking pediatric patients to one facility just to be transferred to a higher level of care. He feels they should be initially transported to the hospital(s) that are able to provide the necessary level of care. Dr. Swift stated that with the growth in the community, care should be rendered at multiple facilities spanning throughout the valley. Dr. Heck agreed that a child is better served by being taken to an emergency room that could stabilize the child and transfer them to the appropriate facility rather than have EMS try to manage the child for the additional ride to one of the four facilities.

Ms. Harpin noted one component that needs to be discussed is the quality of care that can be provided once a patient gets to the facility. First year residents out of school could be hospitalists so they need to determine whether this would be an acceptable standard. For instance, UMC staff has been trained and received certifications to take care of children; therefore, certain things that are considered a major crisis in one hospital isn't at UMC because they're used to dealing with children and have the appropriate equipment.

Mr. Wagon stated that as a potential tiered facility, he would prefer that acute arrest children be taken straight to Sunrise. Dr. Heck stated this would pose an issue for EMS. There is a caveat in the protocols that allow for EMS to go to the closest facility if they have a critically ill child that needs immediate care. For example, a status epileptic child coming from the northwest side of town will be dropped off at the nearest facility as opposed to keeping that child in the back of the ambulance and passing up three hospitals while driving to a pediatric medical center. That's the issue with the tiered approach. Dr. Heck stated there's a baseline of pediatric capability that outlines minimum requirements to qualify and it would be up to the facilities to have transfer agreements in place in the event they need to transport to a higher level of care. Dr. Fisher stated that in 17 years of practicing, he could count on one hand the number of times where 7 minutes would have impacted the patient's welfare. Dr. Heck believes this statement supports his argument that a tiered system is unnecessary. If 7 minutes doesn't make a difference, then every facility with basic pediatric capability should be able to care for the patient, acutely. Sandy Young stated that distance is not only a concern for the patient but to the provider as well. There are areas with limited coverage for dual response and it isn't practical to pull these units out of their designated areas to transport patients to the downtown region to go to UMC or Sunrise. After transporting, these units need to get restocked and get back to their area of response. At times, this unit is the only one that covers that area and it would be in everyone's best interest to keep these units geographically based. However, Ms. Young agrees with Ms. Harpin regarding handing over a sick child to a pediatric ER because these professionals have a calming influence on the child and the medic. She would like to see this same capability in all hospitals when accepting pediatric patients.

Mr. Chetelat suggested the sub-committee make a recommendation to the Medical Advisory Board to form a workgroup of experts to research the issues and decide on the best approach. In the interim, the standard that is currently in place should stay in place until this is worked out.

II. PUBLIC APPEARANCE/CITIZEN PARTICIPATION

None.

III. ADJOURNMENT

There being no further business, Mr. Chetelat adjourned the meeting at 12:16 p.m.