MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DIVISION OF COMMUNITY HEALTH

MEDICAL ADVISORY BOARD (MAB) MEETING

December 5, 2018 – 11:00 A.M.

MEMBERS PRESENT

Tressa Naik, MD, HFD (Chair)
Jim Kindel, BCFD
Chelsea Monge, CA (Alt.)
Chief Jon Stevenson II, LVFR
Stephen Johnson, MWA (Alt.)
L. Cole Sondrup, MD, CA
Jeff Davidson, MD, MWA
John Fildes, MD, RTAB Representative
Jarrod Johnson, DO, MFR
Mike Barnum, MD, AMR
Chief Troy Tuke, CCFD
Chief Kim Moore, HFD
David Slattery, MD, LVFR
Chief Shawn Tobler, MFR
Scott Scherr, MD, GEMS
K. Alexander Malone, MD, NLVFR
Mike Holtz, MD, CCFD
Karen Dalmaso-Hughey, AMR (Alt.)

MEMBERS ABSENT

Sam Scheller, GEMS
Jorge Gonzalez, MCFD
Daniel Rollins, MD, BCFD
Chief Lisa Price, NLVFD
Matthew Horbal, MD, MCFD

SNHD STAFF PRESENT

Christian Young, MD, EMSTS Medical Director
John Hammond, EMSTS Manager
Scott Wagner, EMSTS Field Representative
Rae Pettie, Recording Secretary
Joseph Iser, MD, Chief Health Officer
Laura Palmer, EMSTS Supervisor
Gerry Julian, EMSTS Field Representative

PUBLIC ATTENDANCE

Jim McAllister
Jessica Bryce
Anthony Viggiano
Tiffany Pinkerton
Braiden Green
Michelle Zahn
Jason Driggars
Syed Saquib, MD
Brian Anderson
Erin Lynch
Steve Krebs, MD
Citlali Mejia
Alex Lynn
Melanie Robison
Chester Barnes
Chris Stachyra
August Corrales
Dan Shinn
Maya Holmes

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The Medical Advisory Board convened in the Red Rock Trails Conference Room at the Southern Nevada Health District on Wednesday, December 5, 2018. Dr. Tressa Naik called the meeting to order at 11:10 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. Naik 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. Chairperson 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

Dr. 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: October 3, 2018

Dr. Naik asked for a motion to approve the October 3, 2018 minutes of the Medical Advisory Board. *A motion was made by Mr. Johnson and seconded by Mr. Simone to approve the minutes as written. The motion carried unanimously by the Board.*

B. Develop a Protocol for the Use of Metaclopramide (Reglan) and Compazine as an Alternative to Ondansetron (Zofran) to be Referred to the Drug/Device/Protocol Committee

A motion was made by Chief Tuke to refer the development of a protocol for the use of Metaclopramide (Reglan) and Compazine as an alternative to Ondansetron (Zofran) to the Drug/Device/Protocol Committee for further discussion. The motion was seconded by Mr. Johnson and carried unanimously by the Board.

C. Develop a Protocol for the Use of Dexamethasone (Decadron) and Methylprednisolone (Solu-Medrol) as Alternatives to Diphenhydramine (Benadryl) to be Referred to the Drug/Device/Protocol Committee

A motion was made by Chief Tuke to refer the development of a protocol for the use of Dexamethasone (Decadron) and Methylprednisolone (Solu-Medrol) as alternatives to Diphenhydramine (Benadryl) to be referred to the Drug/Device/Protocol Committee for further discussion. The motion was seconded by Mr. Johnson and carried unanimously by the Board.

III. CHIEF HEALTH OFFICE REPORT

Dr. Joseph Iser reported that the Health District's audit went well compared to the last couple of years and they are starting to develop the budget for the upcoming fiscal year. The Health District is now providing primary care services and is in the process of hiring more people to manage the variety of diseases. In Clark County there are many people who are under-served, particularly in East Las Vegas and North Las Vegas who have Medicaid but no true access to care. There are also many who are uninsured. In the future there will be OB services provided for referral out during the last trimester. In April the Board of Health (BOH) gave the direction to move forward to provide primary care and dental services. The dental services offered will be primarily for preventive care. He will be working with the UNLV School of Dentistry to expand those services in the future.

Dr. Iser noted that the next hurdle to becoming a sponsoring institution for residency programs is the Accreditation Council for Graduate Medical Education. The goal is to provide general preventive medicine in a public health residency program. The Health District has three employees who are board certified in preventive medicine. More people need to be trained to manage mass disasters and bio-terrorism events throughout the state. Dr. Iser expressed that he hopes to have the support of the MAB with the direction the Health District is moving.

IV. REPORT/DISCUSSION/POSSIBLE ACTION

A. Review/Discuss Selection of a Chairman

A motion was made by Dr. Slattery to nominate Dr. Barnum as Chairman of the MAB for the next two fiscal years. The motion was seconded by Dr. Malone and carried unanimously by the Board.

B. Review/Discuss Selection of a Vice-Chairman

A motion was made by Chief Tuke to nominate Dr. Malone as Vice-Chairman of the MAB for the next two fiscal years. The motion was seconded by Dr. Slattery and carried unanimously by the Board.

C. Review/Discuss Draft Burns Adult/Pediatric Protocols

Mr. Wagner referred the Board to the draft adult/pediatric Burns protocols and stated that the Drug/ Device/Protocol Committee (DDP) approved the recommendations as written. He noted that Dr. Syed Saquib, the medical director at UMC's Burn Care Center, was present for the meeting. Mr. Wagner read through the revisions to the two protocols:

1) Fluid resuscitation for adults
   - Adult defined as 13 years and above
   - NS at 500 ml/hr; LR can substitute for NS
   - Addresses prolonged transports >30 minutes
2) Fluid resuscitation for pediatrics
   - Age group 5 years or less: LR at 125 ml/hr
   - Age group 6-12 years: LR at 125 ml/hr
   - Addresses prolonged transports >30 minutes
3) Vascular Access for both adults and pediatrics
   - Fluid bolus isn't administered unless >20% TBSA
4) Pearls for both adults and pediatrics
   - Revised the 4th pearl to read, "Consider early intubation with patients experiencing significant inhalation injuries"
   - Added "elevate extremity" to the 6th pearl
5) Criteria for transport to UMC Burn Center via the Adult or Pediatric Trauma Center
   - Second degree burns >10% BSA
   - Any third degree burns
   - Burns that involve the face, hands, feet, genitalia, perineum or major joints
   - Electrical burns, including lightning injury
   - Chemical burns
   - Circumferential burns
   - Inhalation injury
   - Burn injury with concomitant trauma
6) Parkland Formula for Fluid Replacement
   - Removed from both the adult and pediatric protocols

Dr. Davidson stated there were concerns about the boluses creating more confusion with calculations of weights, ages and drip rates. Although he understands Dr. Saquib's concerns about secondary co-morbidities they should make it simpler for the EMS providers. They also discussed adding in the need for establishing radio contact for long transports. Dr. Fildes stated he agrees with the concept of getting the doses 100% correct for 90% of the patients with the easiest possible approach. However, there has been a trend towards over-resuscitating these patients in the early phase which the American Burn Association is trying to walk back. Unlike hemorrhagic shock, these patients don't go into shock for the first few hours until they start spacing fluid. He feels judicious boluses or rates should be considered, if that's the simpler approach. But there's no need to write an exotic description because of short transport

times or the ability to go online and get telemetry guidance. He noted that if the patient is exhibiting hypotension it's probably not from the burn; they were probably injured and burned.

A motion was made by Dr. Slattery to approve both the adult and pediatric draft Burns protocols as written, with the addition of establishing radio contact for long transports. The motion was seconded by Dr. Fildes and carried unanimously by the Board.

D. Review/Discuss Draft Droperidol Protocol

Mr. Wagner referred the Board to the draft Droperidol formulary page. He stated the DDP approved the draft revisions to the formulary that includes a warning box that it is contraindicated in suspected STEMI and chest pain patients. In addition, they approved removing Droperidol from all cardiac pathway protocols.

Dr. Davidson noted that AMR and MW don't carry Droperidol. He added that the ED's aren't using it much for a lot of restrictive reasons. Dr. Barnum stated there was concern about the drug shortages so they were hesitant to remove it at this time.

A motion was made Mr. Simone to approve the draft formulary for Droperidol as written. The motion was seconded by Dr. Sondrup and carried unanimously by the Board.

E. Review/Discuss Draft Endotracheal Intubation Protocol

Mr. Wagner reported the DDP approved the draft Endotracheal Intubation protocol with Oxymetazoline added as an option to Phenylephrine.

A motion was made by Mr. Johnson to approve the draft Endotracheal Protocol as written. The motion was seconded by Mr. Simone and carried unanimously by the Board.

There was discussion about adding another indication to the protocol, so the Board agreed to put it on the next agenda to be referred to the DDP.

F. Review/Discuss STEMI (Suspected) Protocol

Tabled.

G. Review/Discuss Draft Vascular Access Protocol

Mr. Wagner reported the DDP approved the draft Vascular Access Protocol with the following changes:

1) Revised the contraindications to reflect language that is more specific to the manufacturer's recommendations:
   - Placement in, or distal to a fractured bone
   - Previous, significant orthopedic procedure at the site; prosthetic limb or joint; IO catheter use in the past 48 hours of the target bone
   - Infection at the area of insertion
   - Absence of adequate anatomical landmarks
2) Added 1% preservative-free lidocaine as an option to 2%

A motion was made by Mr. Johnson to approve revisions to the draft Vascular Access Protocol. The motion was seconded by Ms. Dalmaso-Hughey and carried unanimously by the Board.

H. Review/Discuss Addition of Lidocaine and Oxymetazoline to the Formulary

Mr. Wagner reported that revisions to the formulary includes the addition of 1% Lidocaine and lists Endotracheal Intubation as a related protocol for the use of Oxymetazoline.

A motion was made by Ms. Dalmaso-Hughey to approve the revisions made to the formulary for Lidocaine and Oxymetazoline. The motion was seconded by Mr. Johnson and carried unanimously by the Board.

I. Review/Discuss Adding Appendix E: MCI to the Protocol Manual

Mr. Hammond stated that the decision to add MCI language to the protocol manual was made after the unfortunate October 1st experience. It was determined that the presence of EMS professionals on-site at hospitals during a MCI would be beneficial. However, at the time there was no regulatory framework put in place to allow SNHD to do that. It was developed as an appendix to the protocol manual that allows licensees to practice within the listed restrictions. A hospital would first need to make the request through the Incident Commander (IC), and only during those instances that have met a high number of casualties; according to the current standard MCI Level 3, 2, 1, extreme, or hostile MCI's. The goal is to allow for a little more judicious use of resources at hospitals where people self-refer. Mr. Hammond noted that he had previously spoken to the hospital groups.

Chief Stevenson stated that having the hospital notify the on-scene IC may be difficult. He cautioned against the protocol being too restrictive because he can imagine the situation where a hospital is overwhelmed, and the IC is managing their own resources. He gave the scenario where paramedics on-scene are saying they're drowning. The FAO may deploy resources to the hospital, but the IC may be too encumbered to respond. The IC is technically responsible for all the actions, safety or otherwise, for the person who is assigned to that area. Mr. Hammond stated there are multiple methods of communication that can occur. The hospital can make the request directly through the FAO, or whomever is managing the incident. The providers at the hospital can then use their own dispatch centers to make the request. But the decision coming from the IC is required in that they have to be aware of everything that's going on. The way it's structured they will then have their deputies actually implement the plan. He believes CCFD is still working on how to operationalize that. Mr. Hammond asked the Board whether they wanted to expand the language to say either the "IC or designee" which would be within the confines of the fire department, whether it would be a chief or above. Dr. Barnum asked whether the inclusion of the phrase designee would address the problem adequately. It would then allow anybody within the incident command structure of the responding organization to make that call and approve the deployment of those resources.

Mr. Corrales stated he was with some of the EMS agencies as they discussed the plan. He stated it was exactly as Chief Stevenson described. The call would come into the FAO. There would be a FAO set up that would handle that, not the on-scene IC, whose duties would not be diluted by worrying about that hospital command.

There was some discussion that the way the protocol is written the request does not need to go through the IC; it may be made by an authorized agent of the receiving facility. Mr. Hammond clarified that the hospital does not own the crew. The hospital is requesting the crew.

Dr. Naik asked whether a paramedic could be asked to intubate and give succinylcholine. Mr. Hammond stated that they cannot operate outside their level of licensure or scope of practice. Mr. Simone responded that the paramedic can intubate, but he would need to give either Etomidate or Versed. Dr. Holtz asked why a paramedic rotating through the ED under the supervision of a doctor is allowed to operate outside their level of licensure. Mr. Hammond responded that the protocol only applies to licensees, not students.

Mr. Simone made a motion to approve adding Appendix E: MCI to the protocol manual with the addition of IC "or designee." The motion was seconded by Steve Johnson and carried unanimously by the Board.

Dr. Fildes stated that he feels they have made a very important first movement. What he would also like to take place is a discussion on how to level load a system when there's a lot of self-delivery. On October 1st several hospitals were overloaded with the walking wounded; people who only required first aid who could have been redistributed to hospitals that were idle. That was a major finding from the federal agents when they did their after-action reporting. Mr. Hammond stated it is incumbent upon the hospital to properly and rapidly provide the medical screening exam because EMTALA is not waived during a MCI. The patient will still need to be seen by a physician and have a medical screening exam before they can be transferred out. Dr. Fildes noted that that gets you through the first items in a procedure that has about 20 items. He would like to see the other items fleshed out. He gave the scenario where a medical screening exam finds the patient stable and they have a simple closed fracture or a laceration and they could be taken to a hospital that's idle. He asked how they move that patient. Who do you call? Who

comes by and picks them up? Mr. Hammond stated that inter-facility transfers are performed every day in the EMS System. The hospitals just need to be more expeditious in completing the proper paperwork. Chief Stevenson asked if a CAT bus can be utilized to transfer patients from one hospital to another. Mr. Hammond stated that if there are licensees in the back of the bus with their equipment after a MCI has been declared there are certain exigencies that will be expected. He certainly would not contact the Attorney General's office to cite them for doing that.

Dr. Slattery noted this issue deserve more discussion, especially since there appears to be a blur where the IC needs to take action, even on hospital grounds. There are situations that we may need to exert that IC at an overwhelmed facility and they need to have a way to work through that so it's agreeable on both sides. If a hospital can absorb that, that's fine. But when a hospital can't absorb it, i.e. internal disaster, the IC system can move into the hospital's environment and manage that incident—at least from the outside perspective. Dr. Fildes stated that all he asks is for more discussion, because a CAT bus dropped off a large number of patients at a hospital. UMC received 20 transfers. He doesn't even know how they got there; some of them actually got pushed across the street on a gurney. They could have been transported on CAT buses. He noted there seems to be a resistance to having that discussion. Mr. Hammond responded that he is not resistant to having that discussion, but he has purview over EMS, and a CAT bus is not EMS. Dr. Fildes stated he's not denying that, but he would like to have another level of discussion to find another way. He related that in 1980 when the MGM fire took place 85 people died and over 500 self-delivered. Fast forward 37 years, 58 people died and 550 self-delivered. It's happened twice here, and in both instances there were hospitals that were overrun and hospitals that were idle. He stressed that discussing level loading is an important issue and they need to find a way forward on that discussion. Dr. Young noted that the issue crosses into Southern Nevada public health preparedness and emergency planning; it's multi-faceted. Dr. Fildes replied that he didn't say it would be easy, but he believes this venue is likely the smartest group to advance the discussion. Dr. Young stated that the discussion has started, preliminarily, and they will certainly involve everyone when that comes into play. Dr. Iser agreed that the discussion needs to take place and most likely would involve bringing in public health emergency preparedness to look at the broader scope of the multi-casualty incident plan.

J. Committee Report: Education Committee

Review/Discuss the Clark County Paramedic Education Clinical Hours Requirements

Mr. Simone reported there was a request by Chief Tuke to do a pilot program on the clinical hours for paramedic education. He referred the Board to the proposed break-down of clinical hours. The current criteria requirement is 290 clinical hours. Chief Tuke is looking to re-arrange the hours and add ten more for a total of 300 hours. There are also increases in field rides with a preceptor and some simulation labs.

Chief Tuke stated that Community Ambulance, UMC and CCFD are joining forces to create another community-based paramedic program. It will be primarily for current AEMTs that have some experience in the field. Other paramedic programs accept people with no field experience at all, and that's fine. They are not trying to change their curriculum. What they want is to adjust the curriculum to meet the needs of those that will be attending their paramedic program. Chief Tuke noted that in speaking with his QA Director and other agencies there is a lack of practical experience that leads to many students not being able to complete their internships, or not ready when it's time to start their internship. They would like some of the OB/Gyn hours to be done in a simulation lab where they actually have to deliver a breech presentation, a cord presentation, a limb presentation; things they would see less than 1% of the time on an actual OB floor. They will do it under the direction of residents and certified instructors, which he believes will provide an invaluable experience. They are not changing the current requirements, they are moving them around to make the education more practical based and adding, rather than subtracting, to the experience.

Mr. Hammond related that Chief Tuke and he have had discussions on this issue for quite some time in an effort to make the system better as we move forward. However, he still has concerns with some of the training. He asked what the student will be doing during field rides with a preceptor. Chief Tuke replied they will be doing assessments on-scene with real patients; something they don't

currently get the opportunity to do in other clinical areas. They will be partnered with trusted FTO's to watch and teach them. He believes the paramedic students will have a better outcome as far as being more seasoned once they complete the process. They will only be doing nine field rides, which is not in inordinate number in his opinion after his 30 years or experience in the system. The students can learn a great deal in the actual setting where they will be eventually working. Mr. Hammond stated he appreciates all the work Troy has put into the program and they can continue to work together to put up the proper bumpers around the frame work. It must be regulatorily feasible so the licensees are protected; that is one of his main concerns. Chief Tuke replied that that is his goal as well.

Braiden Green stated that he has been the hospital director at CSN for about six years. Their program is structured a little differently. He asked Chief Tuke which simulation lab would be utilized. Chief Tuke replied that the labs are going to be supported by HCA and UMC that are utilized by ER doctors and residents. HCA has made an offer, but an agreement has not yet been made. Mr. Green stated UMC has an NSHE based simulation lab, which in his opinion would be a conflict of interest. His issue is with the labor and delivery (L&D) hours. The way the proposed program's lab is written is that they would approach the lab at the EMT level. At CSN, the EMT has very few hours in L&D and then that content is never seen again until the paramedic level. That could be an expansion of 2, 3, or 4 years potentially, and that's "if" they see a live birth at the EMT level. And now they're proposing the training would be completed in a simulation lab, which means that they won't see a live birth until they're potentially a paramedic. Changing over to simulation labs would be a huge change for CSN. Chief Tuke noted there are only four hours of simulation labs, and there are eight hours on an OB floor. Mr. Green wanted clarification that the proposed training will be run as a trial and that CSN can maintain the status quo. Chief Tuke answered in the affirmative and stated they are not asking for a system-wide change. This will provide the opportunity to re-evaluate the program and see if they have better outcomes. Mr. Green asked what they would use as a measurement of "better." Chief Tuke replied they would look at test scores and overall reports from the students' preceptors.

Mr. Hammond stated the motion needs to be more broad-based in that they either signify support of the concept and allow education to further flesh this out or not. As written, he would be uncomfortable approving it. For example, they don't have an authorization letter for a training center. Chief Tuke stated that when they submit the syllabus it will come from UMC, a post-secondary institution. He asked whether they will be able to start their program on January 14th. Mr. Hammond stated the authorization comes with other caveats as well, such as approval from SNHD's legal staff. They should be able to start their program as long as all of the required items are in place. Right now they don't even have an affiliation agreement, which can be time-consuming. He would also like a tool developed to determine whether the program is going to be effective.

Dr. Sondrup asked for clarification on what need the proposed paramedic program will fulfill. Is it better trained paramedics? What is the community's need? Chief Tuke stated they are having difficulty with the current program's scheduling as it relates to availability and opportunities for their students to attend. Dr. Sondrup asked whether there is need in the community because there are AEMTs who are trying to get through the paramedic program. He noted that if we have the ability to tailor a paramedic program to what we think will better meet our needs, he thinks it's a good opportunity. Chief Tuke reiterated they would like to try something that hasn't been tried before to see if they can come up with a better product. They're looking for accreditation. He noted that he can ask the same question, "What do other programs measure to ensure they are getting a good product?" He stated they see a need; they are not trying to cut corners.

Mr. Hammond emphasized that he didn't mean to imply that they are trying to deliver a shoddy product. He stated he has known Chief Tuke for many years and has regarded him as a person with high integrity. However, based on the hypothesis that they will make a better product in the end, there will need to be evaluation tools in place. He would like to see everything in place prior to making the determination to approve the program. Chief Tuke stated he is seeking support from the Board to move forward.

Dr. Slattery asked for clarification that all Chief Tuke is asking for is adding four hours of simulation lab for airway and four hours of simulation lab for OB/Gyn. Chief Troy added that they are also requesting more ride-along time. Dr. Slattery responded that innovation and looking at things differently never hurts.

Dr. Slattery made a motion to accept the concept to approve the Clark County Paramedic Education Program and breakdown of clinical hours as written. The motion was seconded by Dr. Johnson and carried unanimously by the Board.

Dr. Davidson noted that with HIPAA and the lack of intubations they do now, they are moving more and more towards simulation labs in the future. The medical student's entire year of cadaver training is done in a simulation lab. He stated the additional hours of field training is probably one of the most important parts of the new program.

Review/Discuss Addition of a Portfolio Requirement to the Health District Procedure for Master Instructor

Mr. Simone stated the current procedure to become a Master EMS Instructor requires either a bachelor's degree in education or proof of passing the NEMSEC (National Association of EMS Educators) examination. The NEMSEC is a standardized test that is not offered in Nevada. It's been difficult for agencies to employ individuals who satisfy that requirement. The group decided on a portfolio requirement as an alternative option for the applicant who does not have the degree or NEMSEC. That applicant would need to submit a portfolio that includes a resume or CV that includes 100 hours of original content to include 84 hours in medical, trauma or operations. In addition, the portfolio would need to include courses they developed, including course objectives, lesson plans, course evaluations, rosters, and any other documentation that shows the instructor both developed and taught the course. Upon approval by the OEMSTS, the applicant must develop and teach a 16-hour instructor course as the capstone project to be evaluated and signed off by a Master EMS Instructor. He noted that the difference between an EMS Instructor II and a Master EMS Instructor is the latter can teach train-the-trainer courses. The EMS Instructor II can teach, but they can't create other instructors. There are currently only ten Master EMS Instructors, and certain agencies don't have a way creating new preceptors and other classroom educators. This route will allow for a third option to become a Master EMS Instructor and also meet the needs of the valley.

Dr. Slattery made a motion to approve the revisions made to the draft District Procedure for Master EMS Instructor Endorsement. The motion was seconded by Chief Tuke and carried unanimously by the Board.

K. Committee Report: Drug/Device/Protocol Committee

Dr. Barnum stated he would report only on the action items that were not already covered and voted on by the MAB.

1) The DDP recommended adding a warning statement to Chest Pain (Non-Traumatic) and Suspected Acute Coronary Syndrome, STEMI (Suspected), and Pain Management protocols.
2) CCFD will research and draft an IV Acetaminophen protocol as a non-opioid alternative for pain management.
3) With the addition of push dose Epinephrine, they struck the 4th pearl in the adult and pediatric Allergic Reaction protocols.
4) The 5th pearl was struck from the Pediatric Abdominal Pain, Nausea & Vomiting protocol to make it consistent with language in the Pediatric Shock protocol.

L. OEMSTS 3rd Quarter 2018 Reports

Transfer of Care (TOC) Report

Mr. Julian reported that the 3rd quarter TOC statistics were not ready to report at the last meeting. The TOC compliance met the 35-minute standard. The TOC time being completed was at 41%. There were no outliers.

Transfer of Care Compliance by Facility, Clark County NV

	Total TOC	Noncompliant TOC	Compliant TOC	Compliance Rate (%)
Total	45,303	10,814	34,489	76.1

Transfer of Care Time Completion by Facility, Clark County NV

	Total TOC	TOC not Completed by ED	TOC Completed by ED	Completion Rate (%)
Total	45,303	26,693	18,610	41.1

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

	Total TOC	TOC	< 0 min	0-1 mins	1-2 mins	2-3 mins	3-4 mins	4-5 mins	≥ 5 hrs
Total	50,457	5,154	0	580	827	1121	1301	1325	0

V. INFORMATIONAL ITEMS/ DISCUSSION ONLY

A. ED/EMS Regional Leadership Committee Update

Chief Tuke reported the committee had two solid months of data on the agreed upon STEMI performance measures. They're waiting for one more month of data so they have a full quarter they could use to refine the reports based on that data. They will then set goals quarterly and mark the improvement on those data points. The members were tasked with coming up with the performance metrics for stroke and sepsis so they can employ that same modality.

B. QI Directors Committee Update

Dr. Young reported the committee is looking at some clinical vignettes related to the Prehospital Death Determination and Termination of Resuscitation. The discussion will be continued, and they will report back in the near future.

C. Community Paramedicine & Nevada Medicaid

Erin Lynch introduced herself as the Chief of Hospital & Physician Services for Nevada Medicaid. She shared her PowerPoint presentation with the Board (attached).

Following the PointPoint there were questions about CPT Codes for mental health. Ms. Lynch stated she will go back and research whether they can open up another CPT Code. Currently, REMSA is the only one who is billing Nevada Medicaid. There are five rural hospitals funded through a grant who are getting on board. They will start billing Medicaid after they get educated and trained. She stated that MedicWest has eight Community Paramedics (CP) in their new program, and that they have enrolled with Nevada Medicaid.

Ms. Lynch stated that Nevada Medicaid's overarching goal is to provide care in the recipient's home, reduce ER visits, and reduce hospital utilization to provide primary care service rather than the high cost at an ER. She stated the purpose of her visit was to ask them for advice on how she can help them create CP programs. She stated this is a great opportunity with a reimbursement side at the State, especially for one of the most vulnerable populations.

In response to a question about mileage not being covered, Ms. Lynch stated there is a transportation side of Medicaid where they can schedule their own ride, or they can sign up a family member to give them a ride and the family member would get paid mileage. There is no current mechanism in place to pay an EMS provider to give someone a ride to a doctor's appointment. Dr. Young asked if they do an on-site assessment

and determine the patient needs to go to a mental health facility for psychiatric assistance and the only place they can end up is in the ER, that's sub-optimal. Ms. Lynch stated that in that example, there is a non-emergency behavioral health transport.

Dr. Young stated that Nevada is brought up frequently at national conferences on EMS. North Carolina, Minnesota and Nevada are up there with some of the best CP innovators, and are the leaders to get the legislation. He congratulated Ms. Lynch on her efforts.

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 included on an agenda as an item upon which action may be taken pursuant to NRS 241.020. All comments are limited to five (5) minutes. Dr. Naik asked if anyone wished to address the Board.

Dr. Naik stated this is her last meeting as the MAB Chair and as the Medical Director for Henderson Fire Department. Dr. Slattery thanked Dr. Naik for her leadership and direction for the past two years. She stated it has been an honor to serve.

VII. ADJOURNMENT

A motion was made by Dr. Johnson to adjourn the meeting. The motion was seconded by Mr. Simone and carried unanimously to adjourn at 12:18 p.m.