Draft Minutes of Meeting – Subject to Change Upon Approval by the Medical Advisory Board at their next regularly scheduled meeting

MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DIVISION OF COMMUNITY HEALTH

MEDICAL ADVISORY BOARD (MAB) MEETING

March 6, 2019 – 11:00 A.M.

MEMBERS PRESENT

Mike Barnum, MD, AMR (Chair)
Jim Kindel, BCFD
Jessica Leduc, DO, HFD
Chief Jon Stevenson II, LVFR
Stephen Johnson, MWA (Alt)
L. Cole Sondrup, MD, CA
Frank Simone, NLVFD (Alt)
Matthew Horbal, MD, MCFD
Karen Dalmaso-Hughey, AMR (Alt)
John Fildes, MD, RTAB Representative
Chief Troy Tuke, CCFD
Chief Kim Moore, HFD
Chief Lisa Price, NLVFD
Chief Shawn Tobler, MFR
Jarrod Johnson, DO, MFR
Mike Holtz, MD, CCFD
Brian Anderson, CA (Alt)

MEMBERS ABSENT

Jeff Davidson, MD, MWA
Jorge Gonzalez, MCFD
Daniel Rollins, MD, BCFD
Scott Scherr, MD, GEMS
David Slattery, MD, LVFR

SNHD STAFF PRESENT

Christian Young, MD, EMSTS Medical Director
Laura Palmer, EMSTS Supervisor
Gerry Julian, EMSTS Field Representative
John Hammond, EMSTS Manager
Chad Kingsley, MD, EMSTS RTC
Rae Pettie, Recording Secretary

PUBLIC ATTENDANCE

Jim McAllister
Braiden Green
Devon Eisma
Leslie Kosak
Sabrina Taylor, MD
Samuel Scheller
Steve Krebs, MD
Chris Stachyra
Carl Bottorf
Laura Hennum
Derek Minyard

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, March 6, 2019. Dr. Mike Barnum called the meeting to order at 11:10 a.m. Dr. Barnum stated 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. Barnum 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 Barnum asked if anyone wished to address the Board pertaining to items listed on the Agenda.

Brett Olbur, EMS liaison for Dignity Health, reported that effective April 9, 2019 the St. Rose Dominican, Rose de Lima Campus will be a micro-hospital as opposed to a full-service receiving facility. Dr. Sabrina Taylor stated they will no longer have in-patient capabilities. There are 32 beds available and they are very happy and excited to receive any EMS traffic to bring patients in that have medical care needs. They receive the greatest volume of patients in the North Las Vegas location, but they also have three other sites: Blue Diamond, Flamingo Road and Sahara Ave. The primary volume of patients are walk-ins, but they are willing to accept all patients. However, they would like to limit the volume of L2K patients because they only have eight E.R. beds.

Dr. Kevin Slaughter stated that when the divert policy was eliminated, EMS did a great job of level loading the system. He recommended they re-examine the process. Dr. Barnum suggested it be placed on the ED/EMS Leadership Committee's next agenda. They meet the first Wednesday of every month at 8:00 a.m. at the Health District. The committee will provide a forum for the receiving facilities and EMS providers to discuss the difficulties encountered when hospitals are on divert.

Major Stephanie Streit introduced herself as a proud airman and community member excited to share news about Mike O'Callaghan Federal Medical Center's future in support of emergency medical services in North Las Vegas and the unincorporated areas around Nellis Air Force Base (NAFB). She related that as early as 2009 NAFB and UMC have had a training agreement through which surgeons, physicians, nurses, and technicians have been integrated into the trauma and intensive care teams at UMC. As an Air Force Trauma Surgeon at Mike O'Callaghan, she has worked seamlessly with the trauma team at UMC since 2017. She was one of the four Air Force trauma surgeons who responded to UMC during the October 1 shooting; she personally cared for 23 patients and performed three procedures. She was deployed to Afghanistan in 2018 where she served as the general surgery consultant and surgical intensivist for Afghan operations. Since returning she has been able to make meaningful contributions for the advancement of trauma care in Las Vegas. This is consistent with a long tradition of military medical center personnel advancing civilian medical care that goes back to the Civil War.

Major Streit related that in October 2018 the military health system started an aggressive and massive reorganization directed by Congress that will take place over the next three years. She noted she is proud to announce they are preparing to offer the same level of advanced care to our community by opening their doors to non-Department of Defense (DOD) EMS patients in the future. Mike O'Callaghan has largely been a closed system, focused on DOD beneficiaries with limited after-hours and weekend staffing. The Air Force and Defense Health Agency (DHA) are concentrating their medical resources in a limited number of communities with large military and veteran populations, as well as a community need; NAFB fits this mandate. The DHA is making significant human, equipment, and infrastructure investments throughout 2019. In fact, Nellis is the Air Force Surgeon General's number one strategic priority. By the end of 2019 NAFB will be ready for advanced resuscitation in their newly constructed E.D. They will have an increase in manning to a level sufficient to provide advanced medical care 24/7. By late 2020, utilizing new authorities granted by Congress, they will welcome EMS transports of civilian patients from the community. The increase in the complexities of patients they care for at their facility will keep their medical team sharp for combat and expand upon the scale and scope of their training programs. In addition, they will continue staffing surgical teams at UMC and continue to build upon their partnerships with UNSOM and other local hospitals as they further invest in the Las Vegas valley. Their goal to open the doors for civilian ambulances in late 2019 to early 2020.

Dr. Fildes stated he was a Down Range Consultant in Afghanistan in 2009. It became rapidly apparent that the medics being sent overseas hadn't had sufficient time to ramp-up so there was an inability to sustain their battlefield readiness between deployments. Projects like the SMART Scholarship-for-Service Program were created in several cities in the U.S., with Las Vegas being one of those sites. To take that to the next level of having an integrated health system where military assets are blended with civilian assets to care for the communities that they reside in is the next logical step. It exists in cities like San Antonio and other places where the system is quite mature. Dr. Sondrup inquired whether NAFB is subject to EMTALA. Colonel Pietszak, Chief

of the NAFB Medical Staff, replied they are not subject to EMTALA because they're on federal land, but they try to comply with their rules as much as possible.

II. CONSENT AGENDA

Dr. Barnum 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: December 5, 2018

Dr. Barnum asked for a motion to approve the December 5, 2018 minutes of the Medical Advisory Board. *A motion was made by Dr. Fildes and seconded by Chief Tuke to approve the minutes as written. The motion carried unanimously.*

B. Discussion of Destination Criteria for Outpatient Remote Emergency Departments for Referral to DDP

A motion was made by Chief Tuke to refer the discussion of destination criteria for outpatient remote emergency departments to the DDP for further discussion. The motion was seconded by Dr. Horbal and carried unanimously.

III. CHIEF HEALTH OFFICE REPORT

No report.

IV. REPORT/DISCUSSION/POSSIBLE ACTION

A. Review/Discuss Patient Tracking and Movement During a Mass Casualty Incident

Steve Kramer, supervisor for the Office of Public Health Preparedness (OPHP), gave a presentation on the Juvare patient tracking system EmTrack. He stated the information that is entered into EmTrack will transfer over to WebEOC in a read-only version. Most of the entities have access. The information that is transferred is non-PHI, which is what they need. After the presentation Mr. Kramer related there has been a lot of discussion about getting everyone comfortable with using EmTrack so they are prepared for the next MCI.

B. Committee Report: Education Committee

Review/Discuss Changes to the SNHD Mentorship/Internship Program 80% Critical Call Requirement

Frank Simone reported there was a recommendation for a change to the current program after it was identified that it's possible for a paramedic to complete the internship program without ever having to run a single critical call. What they found was there was no legal way to hold them back from passing their internship because the student can still pass with enough lower level calls. It was suggested they have an additional requirement that they need to successfully complete 80% of the critical calls, including scenarios. They agreed on a minimum of five critical calls in both the mentorship phase and the evaluation phase, whether live or simulated. He noted the committee used the CMS (Centers for Medicare & Medicaid Services) Manual System to identify a critical call, also referred to as an ALS2 call.

The Committee discussed the need to revise the language to clearly state the scenarios must be done in a simulated environment.

A motion was made by Chief Tuke to revise the SNHD Mentorship/Internship Program to add the requirement that scenarios must be demonstrated in a simulated environment. The motion was seconded by Dr. Fildes and carried unanimously.

C. Committee Report: Drug/Device/Protocol Committee (DDP)

1. Review/Discuss Behavioral Emergencies Protocol

Dr. Barnum referred the DDP to the draft Behavioral Emergencies Protocol and noted that the behavioral restraints verbiage was revised.

A motion was made by Troy Tuke to accept revisions to the Behavioral Emergencies Protocol as written. The motion was seconded by Steve Johnson and carried unanimously.

2. Review/Discuss Prehospital Death Determination (PDD) Protocol

   Ms. Palmer referred the MAB to revisions made to the PDD protocol.

3. Review Discuss Termination of Resuscitation (TOR) Protocol

   Ms. Palmer reported that the DDP discussed the need to include language in the TOR protocol to refer providers to the DNR/POLST protocol when presented with a valid DNR/POST order. She outlined the following revisions:

   1. Strike the first sentence in #1 that reads, "Resuscitation that is started in the field by licensed EMS personnel CANNOT be discontinued without a physician order."
   2. Add #2 "Resuscitation should be terminated or not initiated if a valid DNR, POLST or physician written order is provided without telemetry contact."
   3. Revise #3 to read, "Resuscitation started in the field may be discontinued only by telemetry physician order when the following conditions have been met:"

   A motion was made by Chief Tuke to approve revisions made to the Prehospital Death Determination and Termination of Resuscitation protocols. The motion was seconded by Steve Johnson and carried unanimously.

   Dr. Fildes noted that the American Burn Association no longer supports the term "sterile burn sheet." They now use the term "clean, dry sheet." Chief Moore shared that police officers have repeatedly asked them not to use a hospital sheet because it could introduce possible contaminants into the crime scenes.

   A motion was made by Chief Tuke to revise the note at the bottom of the Prehospital Death Determination and Termination of Resuscitation protocols to read, "…the body can be covered with a clean burn sheet obtained from the EMS vehicle." The motion was seconded by Dr. Fildes and carried unanimously.

4. Review Discuss Endotracheal Intubation Procedure Protocol

   Dr. Barnum stated the only revisions was to add Ketamine to the Endotracheal Intubation protocol an alternative for sedation.

   A motion was made by Steve Johnson to add Ketamine to the Endotracheal Intubation protocol as an alternative for sedation. The motion was seconded by Chief Tuke and carried unanimously.

5. Discuss DDP Bylaws

   Ms. Palmer referred the MAB to Article III, Section 1 of the draft bylaws which currently states the membership shall be comprised of no more than 12 members. She expressed that although she welcomes the increased participation, the concern is that the group has become too large and unruly. She noted there are currently 14 agencies in the EMS system and all should be given the opportunity to be represented. She proposed they revise the bylaws to allow for a maximum of 14 members. In addition, draft language was included in Article III, Section 6 which states, "A motion shall be passed by a simple majority. Voting shall be done by roll call vote." She explained that this will provide for a more equitable way to control the votes. Ms. Palmer stated that additional housekeeping changes were made to Sections 1 and 4 of Article III, and Article V, Section 3.

   A motion was made by Steve Johnson to accept the revisions made to the DDP bylaws. The motion was seconded by Chief Tuke and carried unanimously.

D. OEMSTS 4th Quarter 2018 Reports

Transfer of Care (TOC) Report

Gerry Julian reported the 4th quarter TOC compliance met the 35-minute standard. The TOC time being completed was at 39.2%, up from 30.6% in 4th quarter 2017. There were no outliers.

Transfer of Care Compliance by Facility, Clark County NV

	Total TOC	Noncompliant TOC	Compliant TOC	Compliance Rate (%)
Total	43,645	10,721	32,924	75.4

Transfer of Care Time Completion by Facility, Clark County NV

	Total TOC	TOC not Completed by ED	TOC Completed by ED	Completion Rate (%)
Total	43,645	26,548	17,097	39.2

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	48,256	4,611	0	436	771	1,071	1,162	1,171	0

Internal Disaster 4th Quarter 2018 Report

	October	November	December
2017	1.47	2.65	14.51
2018	0.10	1.50	1.01

Mental Health Holds 4th Quarter 2018 Report

	Total L2Ks 2018/2017	Inpatient 2018/2017	Emergency Dept. 2018/2017	Awaiting SNAMHS 2018/2017
October	259/208	111/104	147/104	147/100
November	234/225	97/102	135/123	113/88
December	240/221	100/95	140/126	133/107

Mr. Julian noted that the daily average of hours for Internal Disaster in December 2018 was 1.01, which was significantly down from 14.51 in December 2017. There is a rise in the total number of mental health holds for 4th quarter 2018 as compared with 4th quarter 2017.

V. INFORMATIONAL ITEMS/ DISCUSSION ONLY

A. ED/EMS Regional Leadership Committee Update

Chief Tuke reported there has been a solid turnout from the receiving facilities and prehospital providers. They now have a metric sheet for both STEMI and Stroke that all parties have agreed upon, along with a steady stream of data. They're waiting for one more month of data so they have a full quarter to refine their reports based on that data. They will then set goals quarterly and mark the improvement on those data points. The committee would like to place the development of a sepsis protocol on the next MAB consent agenda to be referred to the DDP.

B. QI Directors Committee Update

Dr. Young reported the committee reviewed examples and scenarios related to the Prehospital Death Determination and Termination of Resuscitation protocols. Dr. Barnum noted they look forward to obtaining QI feedback in the future as they continue to monitor its efficacy.

C. 2017 Clark County Trauma System Report

Dr. Chad Kingsley, EMSTS Regional Trauma Coordinator, reported that two educational meetings were scheduled to inform interested parties about the Clark County Trauma System. He noted that the report describes the status, activities, and achievements of the Clark County Trauma System, and includes the goals of the trauma care delivery system. Dr. Kingsley stated that from this point forward, the report will be done on an annual basis, and will include a basic representation of the compiled data from an EMS standpoint.

Dr. Fildes remarked that the CDC published the TFTC in the 2012 MMWR that was adopted by the ACS and subsequently through most EMS authorities before end of calendar year 2012. There was adoption in 2017 that Step 4 for special populations or special considerations had been recommended that they could be transported to trauma centers or to hospitals capable of evaluating and treating patients with such injuries. That was changed in our system that those patients would just be sent to the trauma centers within our system. He referenced the pie chart on page 16 that shows more than 88% of the patients in our system are Step 3 and Step 4 patients which are fully awake and alert, with stable vital signs, breathing normally, and being transported without lights or sirens. He noted that's a rather large number compared to the rest of the country. Across the system, the RTAB noted that as many as 2 out of 3, and in some trauma centers 3 out of 4, of those patients are discharged on the same day they arrive. When the 2018 data is released, there may be discussion about reconsidering whether Step 4 should be optional or required for trauma center delivery. These are patients who are not at risk of dying, so trying to improve their outcomes is extremely difficult. But the cost of care is exponentially higher when they are treated outside of their community hospitals and that will need to be looked at as well. He noted they revised the language for Step 4 patients in the TFTC protocol that states "The patient *MUST* be transported to a Level 1, 2, or 3 center for the treatment of trauma in accordance with the catchment area designated. For patients who are injured outside a 50-mile radius from a trauma center, the licensee providing emergency medical care shall call and consider transport to the nearest receiving facility." Dr. Fildes emphasized this was a very big change to the protocol. Dr. Kingsley remarked that while a discussion of that change started in 2017, it wasn't until October 2018 that the protocol change went into effect. A bias could be a driver towards the increase but corresponding national data also shows an increase, which should be considered.

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. Barnum asked if anyone wished to address the Board.

A demonstration was given on the Kepi Infant Safety Transporter, a medical device specifically designed to hold and carry a newborn baby. It is the only patented newborn support system designed to protect the newborn's head, neck, and spine and allows first responders to hold and pass the newborn with confidence while keeping the baby safe. It can also be securely attached to a gurney.

Mr. Hammond announced that the Community Health Division will institute an adjusted work schedule beginning the week of March 11th on a 3-month trial basis. Although staff will have different start/end times and different days off, the office itself will be remain open for business Monday through Friday from 8:00 a.m. to 4:30 p.m.

VII. ADJOURNMENT

There being no further business, the meeting was adjourned at 12:15 p.m.