



MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DIVISION OF COMMUNITY HEALTH

EDUCATION COMMITTEE

February 4, 2026 – 8:00 A.M.

MEMBERS PRESENT

Troy Tuke, MVHPI
Chief John Lansing, NLVFD
Chris Stachyra, CA
Ryan Young, PIMA
Mike Whitehead, AMR
Braiden Green, CSN

Matthew Dryden, LVFR, Chair
Debra Dailey, EMSTC
Rebecca Carmody, CCFD
Spencer Lewis, MFR
Todd Ford, HFD

MEMBERS ABSENT

Mario Perkins, Guardian Flight

Brandon Miles, Mercy Air

SNHD STAFF PRESENT

John Hammond, EMSTS Manager
Christian Young, MD, EMSTS Med. Director
Roni Mauro, EMSTS Field Representative
Kristen Anderson, EMSTS Program/Project Coordinator
Rae Pettie, Recording Secretary

Laura Palmer, EMSTS Supervisor
Dustin Johnson, EMSTS Field Representative
Stacy Johnson, EMSTS Regional Trauma Coordinator
Devin Atwood, Senior Admin. Assistant

PUBLIC ATTENDANCE

Kat Fivelstad, MD
Mike Barnum, MD
John Osborn
Jeff Friend
Sun Kang
Sarita Lundin
Joshua LoMonaco
Michael Schafer

Sandra Horning, MD
Capt. James Whitworth
Kady Dabash-Meiningner
Christopher Dobson
Christian Mockler
Chancelyn Sisson
Justin Peck

I. CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The Education Committee convened in the Red Rock Conference Room at the Southern Nevada Health District on Wednesday, February 4, 2026. Laura Palmer, EMSTS Supervisor, called the meeting to order at 8:01 a.m. and stated the Affidavit of Posting was posted in accordance with the Nevada Open Meeting Law. Some committee members joined the meeting via teleconference. Ms. Palmer noted that a quorum was present.

II. DIRECTIONS FOR PUBLIC ACCESS TO MEETINGS

III. FIRST PUBLIC COMMENT

Members of the public are allowed to speak on Action items after the Committee's discussion and prior to their vote. Each speaker will be given five (5) minutes to address the Committee on the pending topic. No person may yield his or her time to another person. In those situations where large groups of people desire to address the Committee on the same matter, the Chair may request that those groups select only one or two speakers from the group to address the Committee on behalf of the group. Once the action item is closed, no additional public comment will be accepted. Chair Tuke asked if anyone wished to address the Board concerning items listed on the agenda. Seeing no one, he closed the Public Comment portion of the meeting.

IV. ADOPTION OF THE FEBRUARY 4, 2026 AGENDA

A motion was made by Mr. Whitehead, seconded by Chief Lansing, and carried unanimously to adopt the February 4, 2026 agenda.

V. CONSENT AGENDA

Chair Tuke stated the Consent Agenda consisted of matters to be considered by the Education Committee that can be enacted by one motion. Any item may be discussed separately by Committee member request. Any exceptions to the Consent Agenda must be stated prior to approval.

Approve Minutes for the Education Committee Meeting: December 3, 2025

A motion was made by Chief Lansing, seconded by Mr. Dryden, and carried unanimously to approve the Consent Agenda.

VI. REPORT/DISCUSSION/POSSIBLE ACTION

A. Discussion of the Formalization of Education on Neonatal Resuscitation

Mr. Tuke stated that MVHPI held a meeting a few weeks prior to discuss education options related to neonatal resuscitation. He noted one option was to require a nationally recognized class such as NRP (Neonatal Resuscitation Program). Chief Lansing reported that his team at North Las Vegas Fire Department (NLVFD) researched every neonatal call they ran in the past year. There was a total of four calls, one of which was a congested baby who was not transported. There were three deliveries: two deliveries occurred prior to the crew's arrival; one delivery occurred in the ambulance bay. There were no adverse outcomes. The vitals were good, and none of them were considered high acuity where there was a need for care to be administered at higher than an EMT level. Chief Lansing expressed concern about mandating an NRP class that will significantly increase the cost of training, particularly in lieu of the infrequency of this subset of calls. He stated that no clear data on the number of neonatal calls was provided at their meeting, which makes it difficult to define the issues. Mr. Dryden stated he is also hesitant to mandate the NRP credential. Alternatively, each agency can modify their training to fit their specific needs. Ms. Dailey asserted that having discussions with her instructors to emphasize the need for additional education to address target issues in the valley may be enough to address their concerns. Ultimately, a course is only as good as the instructor who teaches the course; the instructors and FTOs are the key to getting the education out there. She noted that Dr. Horning has provided very good indications of where the issues lay.

Mr. Tuke stated the goal of the Education Committee is to try to identify shortfalls and arrive at sensible solutions through education. Although the neonatal call may be infrequent, the providers need to be adequately trained to manage a high acuity event. He proposed that they meet with subject matter experts such as neonatologists and pediatric ER specialists to ask about the top three issues they see on a consistent basis that they would want addressed at the prehospital level. They could use that information to develop a class directed at those problem areas, then subsequently assess their progress, and modify the education as appropriate.

Mr. Hammond remarked that each agency should be able to determine the existing gaps between education and implementation, and to reinforce the education in those areas, such as keeping the baby warm and starting a line. Chief Lansing remarked that neonatal calls comprise the fewest number of calls for all the agencies in the county. They're rare and unique calls, but in his experience, they have not been high acuity calls. On the other hand, NLVFD ran 220 high acuity cardiac arrest calls last year. He remarked that if we're going to start

focusing on where we can make the biggest impact, shouldn't we be looking at the most frequent calls that have the propensity to lead to bad outcomes? Perhaps they should be gathering data on the most frequent, highest critical calls that have the biggest impact. Further, they shouldn't be making changes without having the data first because that's just a belief-based argument that can't be quantified. Will it help to fix the problem by way of increasing education, or is that just a guess? Additionally, in the absence of data, how will we be able to put our finger on whether the changes we put into place are effective?

Dr. Young stated there is a concept nationally regarding pre-hospital pediatric readiness. They hospitals have PECCs in place where a pediatric emergency care coordinator is responsible for ensuring EMS agencies and EDs follow national recommendations for pediatric emergency care. Responsibilities include familiarizing colleagues with pediatric-specific policies and protocols, promoting pediatric quality improvement efforts, and managing pediatric equipment and supplies. PECC is one of the strongest drivers of improved pediatric outcomes. Dr. Young stated if there are multiple agencies who are experiencing multiple issues, the QI Directors Committee can look at it to identify any issues and decide whether the education component needs to be augmented.

Dr. Horning stated that EMSC (EMS for Children) for the state of Nevada has developed a pediatric resident readiness program that they're rolling out this month where hospitals will need to show that they have the right equipment, right drugs, and everything necessary related to appropriate pediatric care. It's a national program that we're trying to institute in Nevada. Dr. Horning agreed that the NRP card will be costly for the agencies, particularly because the card needs to be renewed every two years. She suggested they ask for feedback from the EMS agencies on specific issues they recognize so they can then formulate and assimilate their own program to address those issues utilizing our instructors and training officers. Mr. Hammond asked whether the initiative was being funded by EMSC monies, and if so, is there enough to support the entire state? Dr. Horning replied that the funding exists. She added that there are a lot of people in our community who are willing to help in any way to contribute to helping the providers to gain the confidence to handle these infrequent, possible high acuity events. Dr. Young noted that the Clinical Simulation Center of Las Vegas has a 31,000 square-foot facility who offers educational resources and medical education.

The committee discussed the current training that takes place within the various agencies. Ryan Young suggested they develop specific HALO (high acuity, low occurrence) training utilizing the data derived from the individual agencies. The training could change per agency, as issues are identified. If we create a system approach to identify the issues system-wide, then we can develop focused training where everyone is reading from the same playbook. The committee discussed the logistics of obtaining clean data. It was agreed that the data be aggregated for the system as a whole and omit any agency identifiers, prior to being sent to committee for review.

B. Discussion of the Paramedic Mentorship Program and Preceptor Education

Mr. Tuke asked the committee for feedback on the new system. He noted MVHPI identified issues with the 70% and 80% pass percentages required for critical calls in Phases 1 and 2. Ryan Young agreed, stating that if a student fails two out of four critical calls, they will have a long climb back to where they need to be regarding their internship completion timeline. He noted the Eureka grading scale was intended to fix that issue. He stated he would be happy to remove the percentages as currently listed. Mr. Ford noted that that style of grading doesn't take effect until Phase 2. He has two students that were struggling in shifts 1-5, but by the 6th shift they started improving, and are doing well in shifts 7-9. But they're never going to make up from shifts 1-5, so we may want to utilize the Eureka style of grading in Phase 1, as well. Ryan Young asked if the proposal is to remove the requirement for critical calls in Phase 1, and the 80% requirement for critical calls in Phase 2; the student must pass three critical calls at any point in both Phase 1 and Phase 2, for a total of six successes. That will help the current interns who are struggling to overcome their low percentages.

A motion was made by Ryan Young, seconded by Chief Lansing, and carried unanimously to make the following revisions to the Paramedic Mentorship/Internship Program:

- 1) Phase 1: Remove the 70% requirement from the last paragraph (in bold print);*
- 2) Phase 2: Remove the 80% requirement from the last paragraph (in bold print); and*
- 3) A simulation being substituted for a critical call must be conducted in a collaborative manner with both the training center and the agency.*

Mr. Tuke clarified that we're keeping the overall percentage, but just not applying it to the critical calls. The committee agreed to meet again to discuss the logistics of having HALO or critical event simulations pre-approved through the EMSTS.

VII. BOARD REPORTS

No report.

VIII. INFORMATIONAL ITEMS

Ms. Dailey announced that EMS Training Center will be holding an Instructor II course on February 20th and 27th if anyone is interested.

Mr. Tuke announced that MVHPI will be holding an Instructor I course on February 23rd and March 3rd, if anyone is interested.

IX. SECOND PUBLIC COMMENT

Members of the public are allowed to speak on Action items after the Committee's discussion and prior to their vote. Each speaker will be given five (5) minutes to address the Committee on the pending topic. No person may yield his or her time to another person. In those situations where large groups of people desire to address the Committee on the same matter, the Chair may request that those groups select only one or two speakers from the group to address the Committee on behalf of the group. Once the action item is closed, no additional public comment will be accepted. Chief Dryden 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.

X. ADJOURNMENT

There being no further business to come before the committee, the meeting was adjourned at 9:02 a.m.