



MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DIVISION OF COMMUNITY HEALTH

DRUG/DEVICE/PROTOCOL (DDP) COMMITTEE

November 2, 2016 – 10:00 A.M.

MEMBERS PRESENT

Mike Barnum, MD, Vice Chairman, AMR
Tressa Naik, MD, Henderson Fire Dept
Anthony Greenway, AMR
Troy Tuke, Clark County F.D.
Kim Moore, Henderson Fire Department
Frank Simone, North Las Vegas F.D.
Jarrod Johnson, DO, Mesquite Fire & Rescue

Eric Anderson, MD, MedicWest Ambulance
August Corrales, JTM
Jim Kindel, Boulder City F.D.
David Slattery, MD, Las Vegas Fire & Rescue
Melanie Ondik, RN, Community Ambulance
Rick Resnick, Mesquite Fire & Rescue
Derek Cox, Las Vegas Fire & Rescue

MEMBERS ABSENT

Bryan Bledsoe, DO, Chairman, MedicWest Ambulance
K. Alexander Malone, MD, North Las Vegas F.D.

Devon Eisma, RN, Mercy Air
Brandon Hunter, MedicWest Ambulance

SNHD STAFF PRESENT

John Hammond, EMSTS Manager
Michelle Stanton, Recording Secretary

Laura Palmer, EMSTS Supervisor

PUBLIC ATTENDANCE

Daniel Llamas, HCA
Tami Vogel, HCA
Sean Friedland, HFD
Jim McAllister, LVMS

Kathy Millhiser, HCA
Steve Krebs, MD, UMC
James Bunting, LVFR, CSN
TJ Smith, Henderson Fire Department

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The Drug/Device/Protocol Committee convened in the Red Rock Conference Room at the Southern Nevada Health District on Wednesday, November 2, 2016. Vice Chairman Mike Barnum, MD, called the meeting to order at 10:12 a.m. The Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law. Vice Chairman 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. Vice Chairman Barnum asked if anyone wished to address the Committee pertaining to items listed on the Agenda.

Dr. Eric Anderson noted he would like to make a comment as a member of the public. He stated he attended the October 10th, 2016 Medical Advisory Board (MAB) meeting as a member of the audience to address issues as both the Director of Southern Hills emergency department (ED) and The Lakes, a provider-based ED. He expressed concern that inappropriate comments were made at that MAB meeting. In his opinion it is not part of the MAB's purview to delve into the business model of multi-billion dollar corporations, which includes concerns with regard to market share. He noted that such comments were made by members of the MAB. The MAB's role is to determine whether a provider-based ED will serve the needs of our community. The questions that should be addressed are, "Is this provider-based ED qualified and appropriate to treat ambulance patients?" It is his opinion, The Lakes is totally capable. He noted that The Lakes has 12 fully functional beds. They also have an easy off-load and a pharmacy right next door; not affiliated, but convenient for the community. He noted that the ED patient volume rises in the winter by 10-20% every year in Las Vegas. Las Vegas is in dire need of more ED beds, which are available at both Southern Hills Hospital and The Lakes. They offer 24-hour CT (computed tomography), ultrasound, lab, and imaging. Both are staffed 24 hours a day by Board certified ED physicians, with additional APC (Medicare's Ambulatory Payment Classification) coverage which includes either a PA (Physician Assistant) or NP (Nurse Practitioner) nine hours a day. The nursing staff at The Lakes is exceptional and includes many of the same nursing staff from the Southern Hills ED. Dr. Anderson stated he feels they should strongly consider passing the Transportation Destinations protocol to allow EMS traffic to The Lakes. He added that not to do so would be a disservice to the community, and would greatly offend him.

As there were no additional comments, Dr. Barnum closed the Public Comment portion of the meeting.

II. CONSENT AGENDA

Vice Chairman Barnum stated the Consent Agenda consisted of matters to be considered by the Drug/Device/Protocol Committee 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.

Approve Minutes for the Drug/Device/Protocol Committee Meeting: May 4, 2016

Vice Chairman Barnum asked for a motion to approve the May 4, 2016 minutes of the Drug/Device/Protocol Committee meeting. A motion was made by Dr. David Slattery, seconded by Dr. Mike Barnum and carried unanimously to approve the minutes as written.

III. REPORT/DISCUSSION/POSSIBLE ACTION

A. Discussion of Alternate Receiving Facility Criteria for EMS

John Hammond provided the Committee with the "Transport Destinations" protocol and directed their attention to the draft language to include free-standing EDs as an alternate destination. He explained that the criteria were developed utilizing best practices from other systems, which were modified to fit the needs of our community. He stated that he and Dr. Young made additional revisions currently in place at South Texas Regional Medical Center that they believe to be a safe and effective use of the facility. The same criteria are being utilized in other areas of the country as well.

Dr. Tressa Naik inquired as to the criteria used with regard to stable vital signs. Mr. Hammond replied it mirrors the Waiting Room Criteria protocol, which the providers are directed to follow as stated in #2. Troy Tuke suggested they include the criteria in the Transport Destinations protocol to streamline the process.

Dr. David Slattery thanked Dr. Anderson for his earlier comments on the capabilities of the free-standing EDs, and agreed that further discussion needed to be brought to this subcommittee, not only with regard to The Lakes, but for future free-standing EDs. He stated he is fully supportive of patients going to the free-standing EDs, but they need to select the appropriate patients. In reading through the draft protocol, he feels that although it makes sense to the Medical Directors, the EMS providers may need further clarification. Although it is clear which patients may be transported to a free-standing ED, they need to be more explicit as to which patients may not be transported. Issues such as time sensitivity and critical intervention should be included. From a quality assurance standpoint, he stressed the importance of additional clarification for EMS providers who are placed in the position of making the correct decision.

Dr. Anderson commented that Southern Hills Hospital frequently receives gastrointestinal patients with flank pain, belly pain, and vomiting; patients that would require secondary transport. He asked if Dr. Slattery is referring to an appropriate patient as one that needs to be transferred to a higher level of care. The care they receive is the same care they will receive at Southern Hills Hospital; it's the doctor who provides the care, not the building. Dr. Slattery asked that they be more specific and further define which patients can be received by free-standing EDs. Dr. Anderson replied that patients with STEMIs, stroke, head bleeds, and trauma should definitely not be taken to a free-standing ED. A patient who walks through the door of a free-standing ED will be taken care of in the same manner as when they walk through the door at Southern Hills Hospital; they will be transported to a facility with cath lab capability. Dr. Naik noted that the Waiting Room Criteria protocol should cover those patients. If, in the judgment of the paramedic, the patient does not require continuous cardiac monitoring, can maintain a sitting position without adverse impact on their medical condition, and a verbal report is given to the hospital personnel, the waiting room criteria helps quite a bit in defining the patient. Dr. Slattery stated there are approximately six separate protocols that EMS providers have to process in their minds in terms of where to take a patient. He would like to provide EMS providers with further clarification so they are not admonished for taking a taking a patient to an inappropriate facility.

Dr. Young commented that the cognitive process only needs to happen when the patient has requested to go to a specific facility, as written in #1 which states, "Patients who require a medical or psychiatric evaluation, and do not have evidence of any potentially life-threatening illness or injury at the time of transport may be transported to a free-standing Emergency Department if requested by the patient..." If a STEMI patient requests to go to The Lakes, the EMS provider would need to tell the patient that they are unable to take them there; that's the reason the language was included.

Dr. Iser noted that this model is employed throughout the U.S. He asked whether they were aware of any issues that have been brought forth. Dr. Young responded that the issue of market share seems to have created the most heartburn. Other issues deal with EMS systems that are burdened with having to learn who is contracted with whom, and dealing with multiple private agencies. Dr. Iser commented that he would like to observe how The Lakes currently operates prior to approving this initial model in Southern Nevada. There was some discussion with regard to changing the name from "free-standing" to "provider-based" ED. Dr. Naik noted she believes the term others are using is "remote" ED. Mr. Hammond noted he will use the same language as what is listed on the facility's license. Dr. Iser agreed to use whichever term is appropriate.

Derek Cox asked if any current EMS providers would like to comment on the draft protocol as written, and whether they feel it will result in confusion. Dr. Young stated the current protocols are already fairly complex, and that's the reason they did not include specific off-site EDs; they didn't want to add another destination criteria to the current labyrinth of protocols. He noted they should put themselves in their situation and imagine the decision process that would take place. For example, if someone calls 9-1-1 with an orthopedic injury, a report is given to the EMS provider. The patient states they can't walk or drive, but they don't want to go to a hospital ED; they just want to go to a place where they can get an X-ray. With appropriate vital signs safety checks in place, including exclusion criteria, the Transport Destinations protocol makes this a viable option for the EMS provider. A simple algorithm can be implemented and followed up with education and training.

Mr. Cox inquired as to how a patient would know which facility to request, such as The Lakes. Dr. Young stated that most people are aware of the facilities near their residence and will likely request a familiar one they have visited before as a walk-in patient. Mr. Cox asked how the patients will suddenly know the ambulances are allowed to transport to an off-site facility. Mr. Hammond replied that the ambulance crews, acting as the patient's advocate, may suggest an appropriate facility. Mr. Cox expressed concern that the draft protocol doesn't list the appropriate alternate facilities. Timothy Smith agreed that there are pages and pages of destination criteria in the current protocol manual, and it may need to be more clearly defined. He added that the exclusion criteria should be included such as stroke, STEMI and trauma patients. He agreed with Dr. Naik the vital signs criteria should be included in the protocol as opposed to referencing another protocol. He asked whether EMS providers, if in doubt, could call for medical direction prior to transport. Dr. Anderson replied that would be all right. Dr. Young remarked that all transports outside the pre-existing destination criteria should begin with patient preference. He asked whether the level of decision of support at The Lakes will be available 24/7. Dr. Slattery agreed it would be a nice safety net to address any concerns with regard to decision making. Tony Greenway remarked that when flu

season hits, the agencies frequently grapple with the problem of internal disaster and hospital wait times, where half of the EDs are shut down to ambulance traffic. Opening up the free-standing remote EDs is a great idea, especially with the specific exclusion criteria and appropriate telemetry to ensure the right patients are transported to the right facility. From an operation director's point of view, it would lighten the load, especially when there is a shortage of beds.

Frank Simone asked whether The Lakes has telemetry capability. Dr. Anderson stated they have everything Southern Hills Hospital has, with the exception of a cath lab and an operating room. Mr. Simone asked if The Lakes is currently programmed into the 800 MHz radio. Daniel Llamas responded that they are awaiting Dr. Iser's approval prior to obtaining a designated channel. Mr. Cox questioned why telemetry is mandatory. Dr. Naik responded that telemetry is more mandatory in the Henderson area; they require telemetry on all calls. Mr. Smith related that the Henderson area got into the habit of full telemetry contact for every ED transport years ago to both of the St. Rose campuses, so the practice has become routine. He suggested they remove the verbiage, "...if requested by the patient..." since it is superseded by the verbiage in the current protocols which state that a stable patient may be transported to the hospital of their choice. He added that #7 above already covers patient preference. In addition, he suggested they add the exclusion criteria, including the verbiage, "If any questions, contact the receiving facility for further direction."

Mr. Hammond noted that Dr. Young mentioned in a sidebar conversation, that in addition to inclusionary/exclusionary criteria, they should include how busy they are. Mr. Hammond related that he toured The Lakes last week during an open house meeting; it's a great facility, but he noted that the waiting room is pretty small. If the waiting room is full, it would better serve the patient to go elsewhere, a message which can be established via telemetry. Dr. Young agreed that through telemetry contact, information such as prolonged wait times, anticipated wait times, and facility overload can be shared to facilitate the decision making process. He asked whether The Lakes is planning to alert EMResource about internal disaster and other issues so EMS providers can monitor the status of the system. Dr. Anderson responded they would alert EMResource about the number of holds or lack of inpatient beds, but will not unnecessarily go on internal disaster due to the number of people in the waiting room. Dr. Young asked if the decision process would be their ability/inability to accept patients, or will it be determined by the impending patient's condition? Dr. Anderson stated hadn't thought that far ahead at this point in time. Dr. Young stated that they are blazing new territory and it may become a concern as the facility gains popularity.

Mr. Llamas stated the HCA facilities utilize a management assessment tool for internal disaster. In terms of capacity, each facility has gone on internal disaster for less than 10 hours based on capacity issues and legal holds, which is quite impressive. Closures due to environmental issues are less than two hours for the year. As a result, they will mimic the same processes utilized at the Southern Hills Hospital ED. There will be no difference in terms of how to effectively communicate this information to the providers. They will utilize EMResources for both emergency and non-emergency calls, and also communicate with their operational supervisors with regard to the appropriate Southern Hills location. From a management and capacity point of view they see no reason to deviate from their current processes for the off-site campus. He explained that the reason they have a smaller ED is because their goal is to get their patients a bed immediately so they can be seen and treated quickly. They hope to reduce the number of hospitals going on internal disaster by offering an alternative for the community as a whole.

Dr. Young noted it is not necessarily the waiting room, in and of, itself. The internal disaster declaration is a resource of availability, and a resource of depletion; the fact of the matter is that it's a smaller facility with fewer resources in terms of space and volume. It is a new facility and they have no historical trend of their walk-in status. He asked how many beds they have and their current level of ability. He also noted that a smaller facility has less surge capacity. If it gets busy, what is their plan to monitor EMS traffic and walk-in patients? Dr. Anderson assured the committee that off-load times will only improve by adding The Lakes as there are 12 extra ED beds that will be available. Dr. Young asked, "Even if they're all full?" Dr. Anderson replied that the system does not currently have access to any of those beds by not allowing EMS traffic. Dr. Young stated they may still be full, whether they are allowing EMS traffic or not. Although the goal is to fill the beds they may face issues with walk-in traffic. Dr. Naik noted they will need to figure out what works best for their facility. Dr. Young responded that it is an operational issue and not for anyone to just figure out what will work best for

them. Dr. Anderson stated the bottom line is this adds an additional 24 hours of physician coverage in the valley; 12 extra beds, and an additional nine hours of board certified ED physician coverage.

Dr. Johnson related that from the perspective of working in a small critical access facility in Mesquite there really is not a whole lot of difference; they get a patient, they stabilize them, and if it's a critical patient, they may need to transfer them to a hospital, even though they have an operating room. There have been instances where a critical patient could not be managed and oftentimes had to be transferred to a higher level of care. He asked if The Lakes has a system in place to transfer patients from their ED to Southern Hills Hospital. Dr. Anderson stated that they will utilize the existing services with no burden to the patient or the system. Dr. Johnson asked if they have a dedicated transport service in place. Dr. Anderson noted that double transports are always a concern at every hospital and the current criteria will help limit the issue of the need for secondary transport. Dr. Slattery agreed that the goal is to explicitly define which patients will, or will not, be transported to The Lakes. He added there are specific cases they need to explicitly list in the protocol, i.e. an abdominal aortic aneurysm (AAA) or a ruptured ectopic pregnancy. He expressed concern with regard to restricting the waiting room criteria. As it stands, a patient with an injured or broken ankle who has received pain medication would be excluded per the waiting room criteria. Dr. Naik noted the patient can have one dose of medicine, as currently written. Dr. Slattery recommended they explicitly state "abnormal vital signs" in the protocol. In addition, strokes, excessive head bleeds and cardiac arrests need to be listed as not appropriate for transport to The Lakes.

Mr. Greenway asked where Legal 2000s fit into the protocol. He is curious to know why #3A includes "violent or uncooperative patients." In his opinion The Lakes has appropriate staff to handle this subset of patients. He asked why cooperative Legal 2000 patients do not meet the criteria. Dr. Anderson replied that they currently do not have the ability to hold a violent patient there for three days. Dr. Slattery stated they could transfer the patient in the same manner they would any other patient. Mr. Hammond noted the initial resources available at The Lakes are not equivalent to UMC's where there are 15 security guards on hand. They have adequate staff for their purposes, but not for that subset of patients. There is also no nutritionist on staff to address dietary needs. Dr. Anderson stated that if a walk-in patient claimed to be suicidal and they had to put them on a legal hold, they would go through the same process as Southern Hills Hospital where they have an appropriate, licensed and supervised psychiatric holding area. Dr. Slattery wanted confirmation that a non-violent Legal 2000 patient can be brought to The Lakes. Both Mr. Hammond and Dr. Anderson stated that is correct. Dr. Johnson stated that would help the system as a whole. Dr. Anderson agreed that a patient could be on hold for up to five days at their facility. Dr. Johnson noted that the telemetry should help both the crew and the ED at The Lakes with regard to whether to take the patient to The Lakes or Southern Hills Hospital. Dr. Naik pointed out the importance that the charge nurse and physicians need to have a relationship and understanding of what the expectations are.

Mr. Greenway suggested the EMS providers not be required to provide telemetry unless the patient clearly meets the criteria listed in the protocol. He agreed with Mr. Cox that it may create a roadblock for paramedics to provide telemetry outside of the Henderson area. Mr. Cox agreed that it's important to be explicit on what patients The Lakes can, or cannot, accept, such as an aortic dissection. Dr. Young remarked there is no protocol anywhere that is going to include an aortic dissection. Dr. Slattery agreed that that would need to be included in education and training. Dr. Anderson noted he knows of several board certified physicians who have been sued for missing the diagnosis of a ruptured aortic dissection. Dr. Slattery stated that if an EMS provider has a patient who meets the criteria but claims to have ripping chest pain into his back, the provider should know it would not be prudent to take that patient to The Lakes. He gave an example of a 70-year old patient with flank and abdominal pain. If the EMS provider suspects the patient may have an AAA, he/she should transport that patient to an appropriate facility. He gave another example of the pregnant patient, 20 weeks or over, with abdominal pain. Although she may meet the criteria, the EMS provider should suspect a ruptured ectopic pregnancy until proven otherwise. He stated that this needs to be explained explicitly in the protocol as they are time sensitive diseases; it would be a disservice to the EMS provider not to do so. Dr. Slattery agreed that requiring telemetry on patients who are questionable provides a safety net for them; the information they obtain will be valuable on the types of patients to include or exclude in the future. It is also important for the physician who receives the telemetry of the provider's diagnosis with regard to raising concern for certain types of disease states. Dr. Anderson addressed the Vice Chairman and stated he agrees with Dr. Slattery's end comment. However, by using that logic, the 70-year old with the tearing abdominal pain should not be going to Southern Hills, St. Rose

San Martin or DeLima either, along with several other hospitals in the valley. There are no current restrictions on established hospitals.

Dr. Barnum stated they are in a situation where they have the unpalatable option of filling the protocol with a list of about 20 different disease states that would exempt destination to The Lakes, which none of them want to do. They also have the suggestion of mandatory telemetry which can be discussed within their remaining time limit.

Sean Friedland, an AEMT for Henderson Fire Department, approached the podium and stated that when EMS providers have an atypical presentation they will more than likely err on the side of caution and transport to the most appropriate facility. If there is a suspicion the patient is having an AAA they will follow the stroke criteria and transport to an approved stroke center. He stated they could have a compendium for each facility that lists which types of patients they can accept, but the question is where to draw the line with regard to transport criteria. At what point are they just looking at extra beds for providers to offload their patients, and if so, why not include the urgent care facilities in cases such as an ankle fracture? Dr. Anderson responded that the level of care at The Lakes is much higher than an urgent care; an urgent care facility is not an ED. Mr. Friedland stated it was not his intent to imply The Lakes is an urgent care, but for something as simple as a broken ankle, why not take that patient to an urgent care instead of an ED? It was mentioned earlier that if a higher level of care is necessary the patient could be transported to another hospital. UMC Quick Care has done the same multiple times after assessing that a patient needs a higher level of care; so why not enable EMS providers to transport to urgent cares as well?

Dr. Naik stated that the problem is they don't know the capabilities of all the urgent care facilities. Southwest Medical Associates Urgent Care has the ability to do CT and X-ray; Urgent Care Now does not. They have the ability to do an ECG and give Albuterol, but that's it. There's a difference with The Lakes, as they are a remote ED functioning as the ED associated with a hospital, so they have more capacity to take those patients. Dr. Barnum noted that another important distinction is that you can be assured if they transport a patient to The Lakes they will be seen; whereas an urgent care may just turn the patient away based on their financial ability to pay for the visit. Mr. Friedland stated that is understandable, but EMS providers are currently unaware of the capabilities of the different stand-alone facilities, including urgent cares. Dr. Anderson stated he is fine with receiving a telemetry call on all transports. However, he would like to do so on a trial basis and revisit the issue in the future to review the need to continue that practice.

Dr. Iser asked whether they had covered all the issues enough to move forward. Mr. Hammond summarized his notes beginning with changing the name of the protocol to match the license issued by the Nevada State Health Division's Bureau of Health Care Quality and Compliance (HCQC). He continued that the Committee agreed to add the vital signs from the waiting room criteria protocol, and also to include the requirement for telemetry on all calls. He confirmed that they decided not to include suspicion of AAA in the list of exclusion criteria. Dr. Slattery stated that that can be addressed in the education portion of the rollout of the new protocol. Mr. Simone asked if they could remove "...if requested by the patient" from #1 to allow the EMS provider to give the patient the option. Dr. Anderson was in agreement with that recommendation.

Mr. Cox noted that telemetries are hit and miss with regard to whether they are answered, and the length of time the providers have to wait for a response, depending on volume. Dr. Anderson stated he works at Desert View Hospital where telemetry is also required. They answer the calls 100% of the time, and have done so for years. As the Director at The Lakes he assured the Committee they will do the same operationally. He ensured the Committee that he will address any problems associated with unanswered telemetry calls.

A motion made by Dr. Barnum to accept the draft protocol for approval with the following revisions:

1. Change the protocol name to the level of licensure issued by HCQC;
2. Remove "...if requested by the patient" from #1;
3. Include the list of normal vital signs from the Waiting Room Criteria protocol; and
4. Require 100% telemetry contact.

In addition, the Committee agreed to reconvene within 90 days of final approval by the Medical Advisory Board to discuss whether additional revisions need to be made.

The motion was seconded by Dr. Slattery and carried unanimously.

B. Discussion of Defining Successful Ventilatory Management in the Emergency Medical Care Protocols

Mr. Hammond referred to previous discussions regarding the ability to ventilate vs. intubate. Different verbiage is used throughout the protocol such as, “adequately ventilate,” “able to ventilate,” and “unable to oxygenate and ventilate.” The question arose as to whether there is a need to standardize the language throughout the protocol manual for the purpose of clarification.

Dr. Young related that historically the transport protocols would simply state that if you have an unstable airway, transport to the closest facility. Part of this is an education issue where an unstable airway means you can’t put in an endotracheal tube. From an EMS provider’s standpoint they would think, “I couldn’t intubate this patient, therefore I brought him to a facility that maybe wasn’t 100% appropriate.” It brings up the question for discussion, “What is an unstable airway?” If you have the ability to appropriately ventilate, you can use BLS adjuncts and you can safely bag the patient to a level of adequate oxygenation. Is that considered an unstable airway, just because you couldn’t get an endotracheal tube in? So, when we take a step back from the clinical arena, anesthesia, critical care, resuscitations. . . we use more terminology such as, “I can’t intubate, but I can ventilate” versus “I can’t intubate or ventilate.” For the provider, the decision tree cognitively conforms to the vernacular used in the ED. The medical personnel refer to airways in a variety of ways, i.e. stable, definitive, adequate, sufficient, etc. They counted at least 5-7 different ways the protocol refers to an airway. The question is, “Would it help to standardize the verbiage to provide clarity for EMS providers to facilitate the decision process?” Mr. Smith reported Henderson Fire Department conducted a survey within their organization to address this issue. It appears that a clean definition would be the inability to adequately “ventilate” and to remove the term “oxygenate” to be consistent. The definition of “adequate ventilation” should be covered in training. If you are unable to adequately ventilate, transport the patient to the closest facility.

Troy Tuke made a motion to standardize all related protocols to read “inability to adequately ventilate” in an effort to decrease confusion by EMS providers. The motion was seconded by Frank Simone.

Dr. Young asked about the pediatric aspect of standardizing the verbiage. If you’re across the street from a hospital, do you bring a pediatric patient to that hospital, knowing they aren’t necessarily pediatric specialty trained, but have the advanced equipment? Steve Krebs stated that a lot of pediatric patients with unstable airways show up at Nellis, only to be transferred out. He would rather that occur than spending an extra 15-20 minutes en route to a pediatric center. Dr. Young agreed that it puts both the doctors and the EMS providers in an uncomfortable position. Mr. Krebs agreed it would be best for the nearest facility to stabilize the airway prior to and transferring the patient to a more appropriate destination. After some discussion it was agreed that they would keep the draft language as written.

The motion was carried unanimously.

IV. INFORMATIONAL ITEMS/ DISCUSSION ONLY

Clark County Emergency Medical Care Protocols

Laura Palmer reported that a revision was made to the title page of the pediatric treatment protocols to clarify that pediatric patients are under the age of 12. She noted that it is also currently stated in the Foreword. In addition, she listed all related protocols where each specific medication is utilized in the Formulary.

Dr. Young stated he and Dr. Barnum have two additional informational items. He referenced the general patient care protocols with regard to the need for telemetry. There is “full” telemetry, “activation” telemetry and “informational” telemetry, which is used most commonly. They would like to see activation telemetry used more often to give the hospitals enough time to mobilize the necessary resources prior to the arrival of the patient. If EMS has a patient with a STEMI, they should call in and say “code STEMI,” “code white,” or “code sepsis,” and include the estimated time of arrival. If the EMS providers hear any feedback from the hospitals that they are not giving enough information, that needs to be addressed on a case-by-case basis. They have actually seen improvement with the stroke and STEMI patients in terms of prehospital activation, but there is still room for improvement.

In response to a question from Mr. Cox, Mr. Hammond clarified that all protocol changes need to be approved by the MAB, after which time the provider agencies will be given 90 days to roll out the training of a minimum of 90% of their EMS providers. Dr. Slattery noted that the MAB is scheduled to meet on December 7th.

V. 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 Barnum asked if anyone wished to address the Committee. Seeing no one, he closed the Public Comment portion of the meeting.

VI. ADJOURNMENT

There being no further business to come before the Committee, Vice Chairman Barnum called for a motion to adjourn. *A motion was made by Frank Simone, seconded by Mike Barnum and carried unanimously to adjourn at 11:24 am.*