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MEETING MINUTES

Emergency Medical Services Advisory Board

Date and Time of Meeting: Thursday, October 6, 2016, 10:30 a.m.
Place of Meeting: Reno City Council Chamber
One East First Street
Reno, Nevada 89501

***1. Call to Order**

Chair Slaughter called the meeting to order at 10:30 a.m.

***2. Roll Call and Determination of Quorum**

The following members and staff were present:

Members present: John Slaughter, Chair
Kevin Dick, Vice Chair
Bill Thomas
Steve Driscoll
Dr. Andrew Michelson

Members absent: Terri Ward

Ms. Spinola verified a quorum was present.

Staff present: Leslie Admirand, Deputy District Attorney
Dr. Randall Todd, Division Director, Epidemiology & Public Health Preparedness
Christina Conti, EMS Program Manager
Brittany Dayton, EMS Program Coordinator
Heather Kerwin, EMS Statistician
Dawn Spinola, Administrative Secretary, Recording Secretary

***3. Public Comment**

Chair Slaughter opened the public comment period.

Truckee Meadows Fire Protection District (TMFPD) Chief Moore distributed copies of an

article from the Wall Street Journal entitled The Revolution in EMS Care to the Board members, Deputy District Attorney (DDA) Admirand, and to Ms. Spinola for the record (Attachment A). He noted the article discussed changing EMS trends and opined the current model of sending a fire truck out with an ambulance to every single 9-1-1 call is not going to be sustainable.

Chair Slaughter closed the public comment period.

4. Approval of Agenda
October 6, 2016 Meeting

Mr. Driscoll moved to approve the agenda for the October 6, 2016, Emergency Medical Services Advisory Board regular meeting. Dr. Michelson seconded the motion which was approved five in favor and none against.

5. Approval of Draft Minutes
July 7, 2016 Meeting

Mr. Driscoll moved to approve the minutes as written.

Mr. Dick proposed corrections to include Changing "Chief 1" to Chief Moore" on Page 17 and changing "resource zap" to "resource sap." **He stated he would second the motion if Mr. Driscoll would accept the changes**.

Mr. Driscoll stated he would like to amend his motion to include the adjustments brought to the Board's attention by Mr. Dick. The motion was approved five in favor and none against.

6. *Prehospital Medical Advisory Committee (PMAC) Update
Dr. Andrew Michelson

Dr. Michelson reported the terms for PMAC leadership would lengthen member terms, providing an opportunity for them to gain more experience in their positions.

PMAC determined it will be more active in offering suggestions for change and education to Emergency Medical Service (EMS) providers. The intent is to assist in strengthening that environment. He noted they had not interacted with the Emergency Medical Services Advisory Board (EMSAB) in that capacity yet and asked if PMAC could bring updates to the EMSAB for oversight and approval of suggestions and recommendations PMAC would like to bring to the community. Dr. Michelson opined that although the PMAC has been in existence for some time, it should work with the EMSAB's approval regarding what they are recommending or suggesting to the community.

Mr. Thomas asked if EMSAB had asked PMAC to provide advice. Dr. Michelson stated they had not as of yet. The PMAC is comprised of primarily physicians, medical directors, and clinical medical providers that until now have not been as active in the past few years. Dr. Michelson opined it would be a good use of the PMAC, given that they are more active now, , that it would be appropriate for EMSAB to give responsibilities to PMAC.

Mr. Thomas noted a number of the members of the Board had no particular strength in experience with emergency medicine, and stated he would look to Dr. Michelson for expert advice regarding how best to utilize a partnership with PMAC.

Mr. Dick supported the statement about PMAC becoming more active. He suggested that as the region moves forward to look at patient outcomes in the EMS system, it would be appropriate for the PMAC to be engaged in providing input about how to improve the system.

Mr. Thomas noted all of the affected agencies were working to provide the best service at

the least cost to the citizens. He suggested the PMAC would provide good support for EMSAB and its role in the community.

Mr. Driscoll stated he agreed with Mr. Thomas. We are evolving EMS for this region, not only what is being done at this level, but the choices of the individual agencies to increase their medical capacity in the field, in conjunction and partnership with REMSA, who is currently the expert in the field. So coordinating with our medical professionals and understanding what is being contemplated and how it directly affects outcomes at the patient level is going to be important for us to understand, to the point that we have obligations getting the most knowledge we can.

Dr. Michelson noted the PMAC will be bringing a mission statement forward which speaks to that goal and he expects to be able to present it at the next EMSAB meeting. He opined that since the PMAC will likely be bringing in more up-to-date evidence-based ideas for EMS, those ideas might be used in combination with data in the future, which may help to filter out what is right for the region and the Interlocal Agreement (ILA).

Chair Slaughter noted the item was not agendized for action, but at the appropriate point on the agenda, he would ask that a PMAC update be added as an ongoing agenda item. If it is appropriate for those to be listed as action items, they should be.

[Mr. Thomas left the meeting at 10:40 a.m.]

7. *Program and Performance Data Updates
Christina Conti

Ms. Conti noted the full-scale evacuation exercise would be held on October 19. It will be a full evaluation and will be exercising the tagging system, so it will be a substantial feat for our region.

Ms. Conti stated a dispatch subcommittee is under development. Currently a committee meets in a public meeting format that discusses the dispatch centers within the region. The new committee is meant to be more of a working group to address identified issues, to come up with a solution and circles back to see if there are any continued recommendations. The first quarterly meeting would be held the following week.

Ms. Conti noted page 4 of the Program Update contained a staff report from Ms. Khimji with the City of Reno providing a Computer-Aided Dispatch (CAD)-to-CAD update. The request to utilize funds from the Enhanced 911 Fund will be heard by the City of Reno next week. Ms. Khimji has offered to reconvene the subcommittee if necessary to share information about the process.

Ms. Conti announced Washoe County had been approved for the Nevada Project Heartbeat HeartSafe designation. We will be proceeding on how to roll out that information and she thanked all the partners for their contributions. Mr. Driscoll asked what the designation meant and why it had been important to receive it. Ms. Conti explained it demonstrated to citizens that the County is prepared to respond quickly and have the best outcome for any person experiencing a cardiac event. It addressed resource capabilities as well as interaction, education and training in the community, to include private citizens. Additionally, it may support opportunities for grant funding for continuing education and potentially resources, such as AEDs for our community.

Mr. Driscoll asked how the community will be informed and Ms. Conti stated that would be planned and Mr. Driscoll would be invited. Mr. Driscoll opined all partners have a great interest as it is a focus. Most of the EMS systems have been built around the cardiac event.

Ms. Conti explained some of the preliminary ideas included a press conference with all partners present to demonstrate the collaboration. Also considered was a public service announcement or television advertisement. The Public Information Officers will be involved in the planning of the information distribution.

Mr. Dick noted he had met with the Fire Chiefs in August and there had been discussion regarding data submittals to the Washoe County EMS Oversight Program (WCEMS). There had been some disagreement regarding providing CAD in addition to the RMS data. He asked if the issues had been resolved and if the program had received any of the fire data for the first quarter.

Ms. Conti stated that to date, the EMS Oversight Program has received no fire data. They received REMSA's data because they have access to their Online Compliance Utility (OCU). She reiterated they did not have any fire department data at this time. She noted that would impact the Quarter 1 data report, as they would be unable to provide much analysis.

Ms. Conti went on to explain that as far as the difference went between CAD and RMS, program staff had not been provided with the new information gleaned from the individual meetings that had occurred. From staff's perspective, having the time values from the CAD is still the best practice, coupled with all of the information from RMS. She stated staff had not seen or been told anything to support coming back to the Board to request a change in their direction.

Mr. Dick noted he had met with Chief Brown, who had briefed him on the CAD-to-CAD interface that is being established and Chief Brown had been very optimistic that this would be the solution for the region moving forward. Additionally, the CAD would be linked with ePCR so all patient care information can be obtained through one system.

Mr. Dick noted Ms. Conti's earlier discussion regarding potentially reconvening the subcommittee and opined that would be an important thing to do. He felt it would provide a great opportunity for all parties to move forward together to resolve a regional situation.

Ms. Conti clarified that program staff had been told that the CAD-to-CAD interface was an 18-month process, and requested progress not be paused. She suggested staff continue submitting data the way they currently were, and incorporate the new data as it becomes available.

Robert Chisel, Director of Finance and Administration for the City of Reno, explained the City had gone to the 911 committee to seek funding for the CAD-to-CAD. The 911 committee had requested more information, and the City intended to bring that back to them in November. They are going ahead as the City of Reno to begin the project, Mr. Chisel stated that Tiburon was estimating the project would take between six and nine months once the contract is signed and Tiburon can assign project managers. Mr. Chisel went on to explain that since the City of Reno is taking the lead and paying for it, the first step is for them to secure the contract, and if the 911 committee is able to provide funds, then the other entities will be brought in, but at this time is it primarily the City of Reno.

8. Presentation, discussion, possible approval and recommendation to present the five-year Strategic Plan, a requirement of the Interlocal Agreement for Emergency Medical Services Oversight, to the District Board of Health.
Christina Conti

Ms. Conti took a moment to refresh the recollection of the Board on the process the region went through to complete the strategic plan. The region has been working on this since August 2015, with monthly meetings being held beginning in November. She thanked the regional

partners that had worked on the plan with her: Shawn Taylor, Clay Griffin, Alex Kukulus, Dena Avensino, Dave Cochran, Teresa Wiley, Tom Garrison, Chris Maples joined with his new appointment, Kevin Romero, Adam Heines, and Dennis Nolan also worked with the group. Those members of our community were really wonderful to work with, it wasn't always easy meetings, but for the most part we always came to a regional consensus thinking ahead for the five years and the possibility of five years ahead and what things could look like.

Ms. Conti publicly thanked Manager Driscoll for taking the time to mentor her through the process. She opined the plan would not be what it is without his mentorship and guidance. He also took time out of his schedule every month to meet with her and it was greatly appreciated.

Ms. Conti presented the strategic plan. The group met monthly, every meeting had a specific goal. Some items were put on a "parking lot" for discussion at a later date when it was more applicable or something that was really good idea that was not appropriate for a strategic plan but the group did not want to lose that train of thought.

Ms. Conti brought some items to the Boards attention. Ms. Conti pointed out page 4 of the strategic plan provided a graphic that was the strategic plan at a glance. It includes the vision and overarching goals of the region that had come out of the Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis. It also contained all the steps that would be taken to achieve the mission, vision and goals.

Ms. Conti noted that plan contained a reminder of what the ILA stated regarding the duties of WCEMS and the duties of the signatories of the ILA. The ILA and those duties imply cooperation to achieve the strategic planning goals and objectives.

Ms. Conti noted there had been an item that the partners had been unable to reach consensus on that she was requesting input, direction and hopefully a decision from the Board so the plan could be finalized. Page 14 of the plan has Strategy 2.4.1 which is the strategy that did not reach consensus. It is still in red, as is Objective 2.4, because it is so closely tied to the strategy.

She explained that the premise behind Strategy 2.4.1 was that the notion of a regional standard is not something that is achievable and desired at this point in time. Based on a meeting held August 18, WCEMS had recommended that measurements should be kept at a jurisdictional level. Perhaps in a few years a regional response standard could be discussed, or never. In its current form, each jurisdiction has its own identified response standards and WCEMS can provide the performance analysis and the opportunities for improvement based on what the jurisdictions themselves have identified.

Ms. Conti went on to explain that the current status of Strategy 2.4.1, which reads "Determine jurisdictional fire response measurement by _____," is the jurisdictions themselves identifying what their individual goals are for a response to emergency medical call. It proceeds by saying the jurisdictions will then meet with WCEMS, make sure that WCEMS clearly understand it, and then WCEMS will proceed with data reports utilizing that identified jurisdictional response measurement.

Ms. Conti state the final piece of the plan is that staff recommends the plan be reviewed every two years to evaluate current status, review future goals that are still written in the strategic plan to be sure they are still desirable and achievable and to work on the extension. In summary, every two years an updated five-year plan would be prepared.

Chair Slaughter clarified if 2.4.1 was asking the Board to determine the jurisdictional response, as it could be read that way. Ms. Conti clarified she was asking the Board to fill in a date with direction that the jurisdictions determine their response times. The intention is the

jurisdictions determine their response times. Chair Slaughter restated jurisdictional fire response measurements identified by a certain date and time. Ms. Conti confirmed.

Mr. Driscoll stated 2.4.1 is one we've talked about quite a bit, coming together regionally is important and having a way to think about ourselves as a continuum of service is important. And he thinks one of the things that came out of the meeting that Mr. Dick hosted in August, as well as conversations and many speeches from this dais. It's very important that, while we are looking at a regional system that is related to patient care, that right now response times are really up to the obligation of the individual partners as to what their obligations are that are based on the individual jurisdictions. As to what their elected boards have defined from a high level of what performance is going to be there, and then holding our individual jurisdictions internally accountable to those and then having the oversight committee have an understanding of how individually they are doing. And then, eventually, and hopefully not too long, there would be a way to look at a regional standard that everyone may agree to down the road. We don't agree to them today, and I can speak specifically for my jurisdiction. I'm not going to be held accountable as the manager for the City of Sparks to a standard that someone else decides I should be held to, because I don't have the policy in place and I don't have the funding in place to do that. But what I am going to do is work inside my organization to where my fire chief has decided and brought forward, and I've then brought that forward on behalf of the operation of the City to the Councils to say this is where we hold ourselves accountable and that is where we will go.

Mr. Driscoll opined that while it will have the oversight committee staff has to deal with four standards, for the four major partners today, seven major partners today, I understand the difficulty with that, but I think it's more important for individual jurisdictions to perform to the level that they hold themselves accountable to. And then eventually come to an overall standard. I think to continue is what is important. And one of the biggest pieces of the continuance will be the backside, hospital component that we have had long conversations and debates about, and those are the folks that we don't control. But we do control a lot of what is going on. I think that is a long way of me saying I'm going to hold myself accountable, and if someone can help me overlook that once in a while and maybe provide me some suggestions on what I can do better I would welcome that.

Ms. Conti pointed out that while we do have seven different partners, because we do have dispatch and would be looking at that separately as well, it is not a problem for us at all. That is where sitting down with Heather Kerwin and myself ensures we completely understand those internal goals and the code is written appropriately so we can move forward. So, it is incumbent upon the jurisdictions to be sure staff clearly understands the internal goals. She clarified that while seven data sources was not desirable, the program staff are there to serve the region and what is best for the region.

Ms. Conti clarified she had understood new proposed language for Strategy 2.4.1 to be "Jurisdictional fire response measurement identified by _____." Mr. Driscoll stated he had a question and might need to get a technical answer from partners, how long will each agency need. The technical question is that all jurisdictions needed to hold themselves accountable, and he asked how soon those individual seven definitions could be developed. He stated he would like all of the seven individual entities to have defined what they are holding themselves responsible to and how they are determining it within less than six months. Then they would then provide WCEMS the information on the oversight, as the education point.

Ms. Conti stated she would defer to the EMS partners, but noted from the meetings that the majority do have the established response times so there would not be a significant burden. She

explained some of the partners were reviewing updates to those, and she was not sure how long that would take. However, there were existing ones while the review and update was taking place. Before turning it over to her colleagues, Ms. Conti noted that as a group they had agreed that they could meet with WCEMS prior to December 31 to provide the required education to the EMS oversight staff needed for the purposes of beginning the analysis. That would allow WCEMS to achieve a Quarter 2 report for the EMSAB. Since that was an agreed upon date, it was her request that the first date be pushed before that.

Mr. Driscoll clarified the definitions were out there and Ms. Conti indicated they were. Mr. Driscoll then asked if December 31st was the date to sit down and provide WCEMS the education you need for the purposes of beginning the analysis on behalf of the information that each jurisdictions are holding themselves accountable to. Ms. Conti confirmed that was correct. She wanted to make it clear that not all partners have them; but the majority do. But some will need to develop them, whether developing from scratch or from an old system they don't use anymore. But the majority of the partners have something out there identified.

Mr. Driscoll asked if a December 31 date for 2.4.1 with the updated language it would be reasonable that the majority of the partners would have a defined response standard and would have had an adequate time to educate the oversight committee staff members on how it works for future analysis. He asked if that is what Ms. Conti was representing. Ms. Conti replied that is what she felt to be true, but deferred to her colleagues to clarify if they felt that was a timeline they could meet. She stated the group they had met with did feel the December 31st date was a sufficient amount of time to come educate WCEMS, the small workgroup did feel that was something that was achievable.

Chair Slaughter asked for the record who the seven partners were. Ms. Conti explained it was the three fire jurisdictions, REMSA, and the three dispatch centers, being Reno, Sparks and Washoe County, so all seven would have different response standards available to them. She noted there would be a discussion about the REMSA dispatch center, as well as any associated with them.

Mr. Driscoll proposed the December 31st holds us accountable and if an individual jurisdiction had a particular issue as to why they might not be able to have it defined and WCEMS educated, that he would rather have one or two not in compliance with five or six in compliance because if we don' have a date that is fairly aggressive, we will languish. He stated he would prefer that be the date, and then have the ability to discuss exceptions.

Mr. Driscoll stated that if he were motioning it before we had more discussion that would be the motion he would be contemplating.

Chair Slaughter opened the public comment period.

Chief Moore stated the Board of Fire Commissioners had tasked him with revising the standards of coverage for the District and are currently involved in that study. They have been involved in the process for about three months and probably have another three months to go. He noted the process was exhaustive analysis and the consultant will have something to present to the Fire Board after the calendar year, and probably will not adopt until February. He noted they did have standards of cover in place, but he preferred the Fire Board adopt that standards of cover and then submitted that to the EMSAB because that is what they will have going forward.

Reno Fire Chief Dave Cochran stated they would be one of the exceptions. Chief Cochran stated the issue with Reno is that they certainly have guidelines, they have goals that they strive to achieve, but they do not have a set, measurable policy. They certainly have response plan,

through dispatch protocols their run strengths and everything that goes with that, they do have a response plan that he can submit, but in terms of measurables, it does not include that. Chief Cochran's concern is that is really a policy decision that his council needs to make and he doesn't want to presume to dictate policy to them. At the August 18th meeting they talked about some of the fiscal implications that tie into that. Reno is not doing a standard of cover there would be fiscal implications to that if they chose to go down that road. His concern is that really any direction that we suggest that he dictate policy to his council, so Reno would be one of those exceptions and those are the reasons why.

Mr. Driscoll asked Chief Cochran if they were contemplating, any time in the near future, to seek direction from their elected body as it is related to standards of coverage. Chief Cochran stated they are not, he is not.

Chair Slaughter closed the public comment period.

Chair Slaughter clarified, summarizing that the Board was focusing on the one specific item but overall, staff would like a motion to approve and to forward the draft plan to the District Board of Health (DBOH). Ms. Conti stated that was correct; she was open to any feedback or any changes within the entire document. She noted this was the one item she had wanted to bring to their attention so that they understood she was not asking them to approve an incomplete document. She stated the intention would be to then go to the DBOH for approval since the EMSAB is under their prevue. It would then be the strategic plan for EMS for the region. Then, with the annual update to the signatories of the ILA, this would be something they would have made available to them and she would be available for questions on the strategic plan.

Mr. Dick clarified that updates to the jurisdictional response measurements would be acceptable under the plan and Ms. Conti replied that would be fine. She explained the quarterly report would contain a note pointing out any changes within the measurements within the quarterly time period. It would be clearly identified and split appropriately.

Chair Slaughter noted the plan was not dictating jurisdictional measurements. So, if a jurisdiction changes a measurement that's fine, in the same manner, if a jurisdiction does not have them currently, may in the future but not currently, will we move forward in that manner as well? Ms. Conti stated it could be done but would pose challenges when we start to look at patient outcomes if we do not have all jurisdictions participating. She stated that specifically, if the City of Reno is the agency not participating with that part, because they are such a large percentage of the call volume. But WCEMS would figure it out as we go along if that is the road we continue down.

Mr. Driscoll proposed that the Board complete the document by adding, on 2.4.1 the date of March 31, 2017. Mr. Driscoll asked if there was a proposal to change the language on 2.4.1. Ms. Conti replied that if the Board was comfortable with Chairman Slaughter's suggestion the language would be changed to read "Jurisdictional fire response measurement identified by March 31, 2017." Mr. Driscoll stated he was willing to do that with the March 31st date and the understanding is that if you don't its not there, if you change it, we go figure it out and understand that as we are building data changes to data may cause issues but no jurisdiction should be held accountable to something they are not willing to hold themselves accountable to.

Mr. Driscoll clarified that would close out the outstanding and the rest of his motion would also be to approve the plan as submitted with the changes so that it can be updated and taken forward to the DBOH.

Dr. Michelson seconded the motion.

Ms. Conti clarified that if 2.4.1 was going to be pushed to March 31st, then 2.4.2 should be as well, as they were the only ones with dates associated with them and that would ensure continuity. Mr. Driscoll stated that was his intent.

Chief Cochran stated he wanted to make a point of clarification. The target kind of moved there, he was talking about measurable response times, and that's been the crux of the discussion we've been having. We have talked about patient outcomes. We are all in on developing the best, most efficient patient outcomes in whatever form that takes so I don't want to suggest that we are not going to participate in a broad spectrum. When the real focus is that Reno does not have adopted response time standards, so that is just additional backup clarification.

The motion passed four in favor and none against. Chairman Slaughter wanted it noted that Mr. Thomas was absent.

9. Presentation, discussion and possible approval for distribution the Washoe County EMS Oversight Program FY 15-16 Annual Data Report.
Heather Kerwin

Ms. Kerwin noted the report was designed to be helpful for the general public to comprehend. It contains less data and more information relating to how the system is designed and how a 911 call might move through the system. Additionally it highlighted some of the EMS Oversight Program's accomplishments for the last fiscal year as well as partner accomplishments and highlights. She noted the short section on aggregate regional data and noted she did not utilize any of the fire variables in question.

Mr. Dick asked how it was possible for REMSA to get a 911 call before the Public Safety Answering Point (PSAP). Ms. Kerwin explained how she used the data, focusing on the time initially noted but acknowledged she was unable to directly answer his question. Mr. Dick noted there had been discussion regarding developing a regular schedule to correlate the time on PSAP and dispatch clocks with the Atomic clock and wondered if this was an issue that might be happening. Ms. Kerwin acknowledged differences and stated she could adapt the system to address anomalies in Atomic Clock times to coincide with language that allows clocks to be off by up to 5 seconds between centers. Ms. Kerwin stated that the calls included those outside the 5 second.

Mr. Dick then noted the number of total matched was larger than the number of total calls used. Ms. Kerwin explained that if the time stamp was missing, it was not utilized. She pointed out that was replicated through the other tables. The calls shown as <u>used</u> was the number of calls utilized for that particular analysis. The reason there are more matched than used is because not all of them have all the time stamps needed to conduct the analysis, so it was a comparison between a time stamp from fire and a time stamp from REMSA and if those are missing, they are not included.

Chair Slaughter requested they go back to the initial question. Ms. Conti noted what Ms. Kerwin was describing was a change in methodology employed last year after realizing that just using calls that are matched between REMSA and fire was not showing the entire system performance. She pointed out that throughout the document, there were different numbers of calls utilized so that the entire possible picture could be analyzed for every data set. It was a way to broaden what was looked at for the region.

Deena Avansino, Assistant Manager of Reno Dispatch, clarified that REMSA is not a PSAP, so they do not receive 911 calls. Any calls they receive are direct dial. If they receive a 911 call it is because it was transferred from a PSAP. She went on to state that their time clocks match.

Mr. Dick requested clarification that calls that were listed as going to REMSA first were not going through 911 and were going directly to REMSA. He requested confirmation from the WCEMS staff. Ms. Kerwin explained the data she pulled from REMSA was captured by the CAD and it has always been represented that they are 911 calls.

Chair Slaughter requested clarification of how a 911 call would go directly to REMSA, or if there was a seven-digit number that was going directly to REMSA. Ms. Conti opined the conversation was focusing on 911 calls and that calls were transferred to REMSA from many different entities and may not go through a PSAP. The calls that go to the PSAPs are classified as 911 calls. Ms. Conti opined the terminology should indicate that the calls were emergency calls for medical services, not 911. She supported Ms. Avansino's statement that a 911 call would never go directly to REMSA. Ms. Conti noted the change would be made to the terminology.

Chief Moore noted the first paragraph on page 9 referred to volunteer fire departments in the rural areas north of Reno. Although that is true, Truckee Meadows Fire Protection District (TMFPD) responds to every single emergency call in the Red Rock area because volunteers are not always available. He noted the Verdi Volunteer Fire Department no longer exists, although there are independent volunteers in that area.

Chair Slaughter noted the action requested was to approve the document with changes discussed.

Mr. Driscoll made the motion and Mr. Dick seconded. It was approved four in favor and none against.

10. Presentation, discussion and possible approval of updated EMS Advisory Board Bylaws or possible direction to staff to make changes as discussed and bring back to Board for final approval.
Brittany Dayton

Ms. Dayton presented the staff report. She noted Mr. Dick had requested revisions specific to the chair and vice chair terms. Staff had researched other EMS advisory boards to arrive at recommended updates and additions, which she reviewed.

Mr. Driscoll noted proxy votes were not permitted in the updated bylaws. He stated that was problematic, as there are times when he is away and has legally designated someone to have all of the duties and responsibilities of his position. Deputy District Attorney (DDA) Admirand stated that was a matter addressed in the Open Meeting Law, and the enabling legislation creating the Board, being the ILA, would have to have the authority for members to appoint proxies for that to be allowed for EMSAB. She reviewed the language of the ILA and stated it did not contain an allowance for proxies to be used. Mr. Driscoll stated he would defer to Open Meeting Law.

Mr. Driscoll asked DDA Admirand if the ILA would need to be changed to allow proxies and she indicated that was correct. Mr. Driscoll withdrew his objection.

Mr. Dick asked a clarifying question if a Manager is away from the community and has designed an Acting City Manager while they were away, would that satisfy for the purposes of the EMSAB that they are the City Manager. DDA Admirand stated she was not sure of the authorities designated under the City charters. She further provided an example that the District Health Officer is able to appoint an interim Health Officer when away on travel and stated she would look into the issue through research before providing the Board with an answer.

Mr. Dick noted page 1, under Section 2, provided an overview of the purpose of the Advisory Board is to review reports, evaluations and recommendations of the Regional

Emergency Medical Services Oversight Program, discuss issues related to regional emergency medical services and make recommendations to the respective jurisdictional Boards. He opined EMSAB's purpose was to make recommendations to the DBOH, and then the DBOH who is upholding the recommendations would be the body that would make the recommendations to the jurisdictions governing bodies; rather than the EMSAB providing recommendations directly without going to the DBOH. Ms. Conti asked for clarification if Mr. Dick was asking that the language be changed to have it only go the District Board of Health versus jurisdictions. Mr. Dick stated that was his understanding. Ms. Conti requested a moment to review the ILA.

Mr. Dick asked if the current appointees had been asked if they were amenable to the proposed term extensions. Ms. Dayton stated they had not, but clarified one had just indicated acceptance. She noted the following section clarified that DBOH appointees can submit a written letter of resignation at any time.

Ms. Conti stated she and DDA Admirand had reviewed the ILA and she remembers why that was included; there might be some things that the jurisdiction themselves would feel important to do their separate recommendation and approval specifically. But there is a desire to get to the point where jurisdictions have their employees come before the EMSAB to vet new processes. The recommendation would then be from this Board to go back to that jurisdictional Board with an agreement with the process forward, the path forward, and they think that it is a good idea and endorse it. Therefore, that is why it was put in, but Mr. Dick, you are correct; the ILA specifically says DHO and/or DBOH so it would be a deferral to the Board if it would like to include other jurisdictional boards.

Mr. Dick clarified, stating Ms. Conti's recommendation was to leave the language as it has been suggested with the track changes indicating jurisdictional boards, because there may be cases in which a jurisdiction may be seeking a recommendation from the EMSAB that they would then want their Council to act on directly without having to go through the process of going through the DBOH.

[Mr. Thomas returned to the meeting.]

Ms. Conti stated that was correct. Through the ILA, it provides that concurrent review. Ms. Conti provided an example with Truckee Meadows Fire Protection District that does not have a DBOH representative and that this provides a pathway for them as well as they are a signatory on the ILA. She noted the recommendation could be to go to their Board and not to DBOH, which would be an unnecessary step from their chain of command.

Mr. Dick stated he was comfortable with leaving the language as proposed with the explanation.

Mr. Thomas noted that the DBOH exists as the health department to the City of Reno, Sparks and also the Washoe County Health District (WCHD). He suggested this inferred that the WCHD was acting on behalf of all three jurisdictions. Obviously when there is a disagreement or alternate direction people want to go within the jurisdictions, you have the three managers that clearly are here representing the three jurisdictions. Whatever happens out of this group is going to get back through the other group. Particularly which has a direct bearing on the organization.

So I guess I'm less concerned about the process by which recommendations come out of this board, because the information will get back. I would just hope whatever we structure would be designed in a way that facilitates solving the discourse as opposed to accelerating it. And I don't know what I mean by that other than saying that that's probably one of the purposes of the DBOH is to look for common ground and not the parochial position. But you're still going to have situations for example where a jurisdiction simply does not want to do whatever the

recommended from the collegial, they just need a process by which that individual entity has the ability to address their grievance regarding Board decisions. I suppose that means going back to DBOH, right?

Mr. Dick opined that ultimately the way the ILA is set up, that the DBOH could make a decision, but it really was just a recommendation that was being made. Ultimately each jurisdiction is responsible for making a decision about how their EMS system will operate.

Mr. Dick explained the way the ILA clarified EMS oversight activities. EMSAB makes recommendations, the DBOH can then act and agree with that and make that recommendation. Ultimately it is a recommendation and the Board has not taken any authority away from each of the jurisdictions as to how they operate their fire and dispatch and the decisions that ultimately are made by them.

Ms. Dayton suggested keeping the term "…respective jurisdictional Boards." and add "…and/or DBOH." Mr. Dick stated he would support that change.

Chair Slaughter confirmed with Ms. Dayton that was the only item proposed to be changed. He noted he represented Washoe County and that he did not have authority over TMFPD. They have a separate Fire Board. I think with respective jurisdictional boards we could make recommendations to the Fire Board as well.

Mr. Driscoll stated he would be willing to forward a motion that approves the changes as discussed with the addition on Page 1, Section 2, second paragraph, with the end of the sentence that says "…jurisdictional Boards," to continue the sentence to say and/or DBOH.

He stated he was willing to accept the fact that some legal research needed to be done, specifically the legal question of whether the legally designated acting manager would be in lieu of or considered proxy.

Mr. Driscoll restated the motion, saying he was accepting it as it was presented with the addition of "and/or DBOH" in Section 2, Page 1, and the side comment that on Page 3, Article 3 Section 2 we'll be provided with some legal clarification in the future and that may or may not need change. Mr. Dick seconded the motion which passed five in favor and none against.

11. *Board Comment

Chair Slaughter repeated his request that future agendas include an update from PMAC, as an action item when appropriate. Ms. Conti asked there was an action item associated, would it require then a staff report and Chair Slaughter answered in the affirmative.

Mr. Dick requested a standing agenda item regarding the progress of the CAD-to-CAD implementation over the course of the anticipated 18-month period.

Mr. Thomas asked if emergency medical dispatch would be a topic of conversation anytime in the near future. He noted there had been substantial history surrounding that and there were issues that had not been fully resolved. Mr. Driscoll asked Mr. Thomas if he was suggesting an agenda item of an update on the status of emergency medical dispatch amongst the partners. Mr. Thomas indicated that would bring him up to speed with where we are on that issue. Mr. Driscoll further clarified it would be all the moving parts and all the partners.

Mr. Driscoll acknowledged was some of the action taken with the individual jurisdictions and the data collection and data analysis is putting a lot of time commitment by the statistical team from the EMS Oversight Board. He opined they should not lose the vision of what we are doing, we are asking them to get up to speed on a lot of different things, but we're asking them to do it

for the right reasons. He pointed out they were willing to take that on and he felt they should be acknowledged that the workload is being done and that team is taking on behalf of EMSAB. He publicly thanked the staff and the work that will be done with the seven partners.

12. *Public Comment

As there was no one wishing to speak, Chair Slaughter closed the public comment period.

13. Adjournment

At 11:14 a.m. Mr. Driscoll moved to adjourn. The motion passed five in favor and none against.

Respectfully submitted,

Dawn Spinola

Dawn Spinola, Administrative Secretary
Recording Secretary

Approved by Board in session on January 5, 2017.

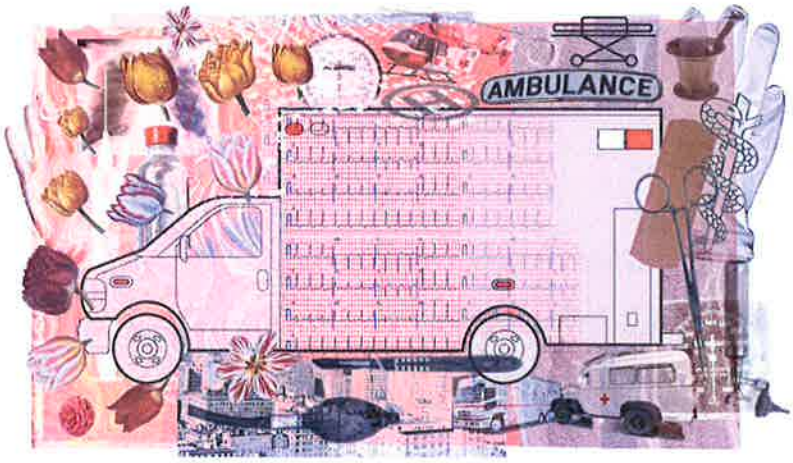
THE WALL STREET JOURNAL.

http://www.wsj.com/articles/the-revolution-in-ems-care-1474855802

LIFE | HEALTH | JOURNAL REPORTS: HEALTH CARE

The Revolution in EMS Care

Thanks to new technology, new life-saving techniques and new missions, ambulance crews are far from the 'horizontal taxicabs' they once were



New EMS models are being tested, including having so-called community paramedicine teams provide preventive care—and even make house calls. *ILLUSTRATION: MARGARET RIEGEL FOR THE WALL STREET JOURNAL*

By **LAURA LANDRO**

Sept. 25, 2016 10:10 p.m. ET

There's a revolution taking place in emergency medical services, and for many, it could be life changing.

From the increasingly sophisticated equipment they carry and the new lifesaving techniques they use, to the changing roles they play in some communities—providing preventive care and monitoring patients at home—ambulance crews today are hardly recognizable from their origins as "horizontal taxicabs."

Here's a look at some of the most important changes happening in EMS care around the country—including a few plans in the testing phase still, and the challenges EMS professionals face to bring those to reality.

In case of emergency ...

EMS crews today are better equipped than ever for the worst kinds of emergencies, from cardiac arrests and gunshot victims to car crashes and other life-threatening injuries. These days, more ground and air ambulances include X-ray and ultrasound devices, machines that perform automatic chest compressions for CPR, communications systems that forward electrocardiograms to the emergency room, and equipment for lab tests that can identify dangerous conditions such as a developing septic infection.

INNOVATIONS IN HEALTH CARE

Much of the best equipment—including a helicopter equipped as a mobile emergency room or intensive-care unit—can be found at the Mayo Clinic, in Rochester, Minn. Regarded as a leader in sophisticated onboard equipment and communications, Mayo often consults with other medical transport systems to share best patient care strategies, and works with U.S. military physicians to share expertise on how treatment of battlefield wounds might apply to civilian medicine.

Mayo provides increasingly advanced pre-hospital treatment, says Scott Zietlow, a trauma surgeon and medical director of the Mayo One trauma helicopter program.

External defibrillators and pacemakers are standard, as are portable analyzers for lab tests and noninvasive devices to determine if a blood transfusion or antibiotics are needed. Because Mayo has its own blood banks, its air ambulances are able to provide a growing array of blood products that most others don't carry.

In addition to featuring state-of-the-art equipment, Mayo's emergency medical service has helped test a number of EMS innovations, including capnography, a monitoring device that helps in the placement of breathing tubes and measures the concentration of carbon dioxide in exhaled air. This can guide the effectiveness of CPR chest compressions and gauge the likelihood that a patient can be revived. Mayo Clinic can also transport patients on a machine that does the work of a heart and lungs.

Alternative Routes

Giving emergency responders the flexibility to manage less-urgent 911 calls without taking patients to hospital emergency departments could generate substantial savings for Medicare, according to estimates from a Rand Corp. study

15.6%	$1 billion	$560 million
Portion of all Medicare-covered ambulance rides for patients whose conditions are not urgent or could be treated by primary-care providers	What Medicare spends annually on EMS and emergency-department costs for 911 patients who potentially could be treated outside of the hospital	Annual savings if some lower-level 911 cases were managed in less-expensive settings

Source: Health Affairs, 2013

THE WALL STREET JOURNAL.

Mayo's work with the military has led its EMS crews to adopt quick-clotting bandages and tourniquets for blunt trauma and penetrating wounds. A study of 125 patients that Dr. Zietlow co-wrote, published last year in the Journal of Special Operations Medicine, concluded that civilian use of tourniquets and hemostatic gauze is highly effective at stopping bleeding.

Mayo EMS crews also plan to adopt a practice the military uses as an alternative to intravenous lines, particularly when a limb has been lost: sternal intraosseous infusion, in which fluids and medications are administered into the bone marrow directly through the sternum.

Coming soon: preventive-care teams

In what could amount to a sea change for many EMS workers, health-care policy makers are looking at having so-called community paramedicine teams provide preventive care

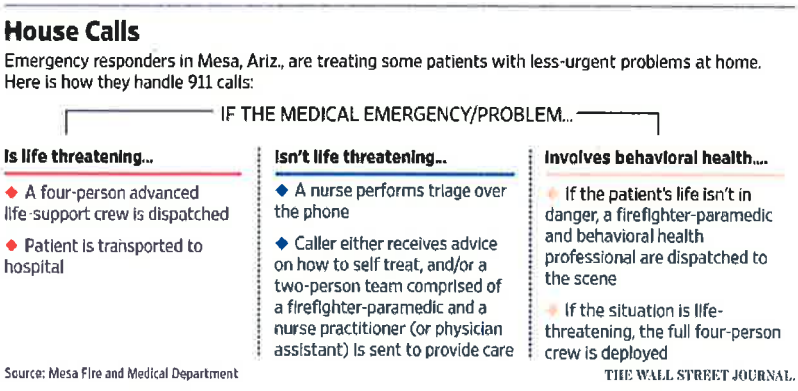
—and even make regularly scheduled house calls.

In a concept some are calling "EMS 3.0," ambulance crews with advanced medical training in more communities already are treating patients in their homes, including frail or elderly patients, helping to manage chronic conditions like diabetes, and are checking on recently discharged hospital patients to ensure they are following their care instructions.

"We are a natural provider of care outside of hospitals and other institutions," says Kevin McGinnis, program manager, community paramedicine, mobile integrated health care and rural emergency care for the National Association of State EMS Officials. "The majority of calls that go through 911 are nonemergencies, and we can use EMS resources to address otherwise unaddressed health needs in communities," Mr. McGinnis says.

Among the nonemergency calls that paramedics often respond to: shortness of breath, weakness and fatigue from dehydration, cuts and abrasions, abdominal pain, low-grade fevers, cold-like symptoms, urinary problems and minor falls in the home.

Dovetailing with efforts to align EMS workers more closely with core health-care delivery, EMS organizations in a draft report released last month called for "an EMS system that maximizes value to the community by providing new and essential services." Extending EMS responsibilities to helping people navigate the health-care system, coordinating care and better educating patients, the report said, can "ultimately lower cost and improve the quality of patient care."



The report cited big hurdles, including a highly fragmented national EMS system and payment policies which generally reimburse EMS providers only when they transport patients to a hospital. That could change as private insurance companies and the federal Medicare and Medicaid programs continue in their transition from a fee-for service model to one linked to the quality of care provided and measurable patient outcomes.

According to a 2013 study in the journal Health Affairs, if Medicare would reimburse EMS for services other than transporting patients to an ER, it would improve the

continuity of care and save the federal government as much as $560 million a year. If private insurance companies followed suit, the study added, overall savings could be twice as large. The Centers for Medicare and Medicaid Services is now funding several programs testing new models that would reimburse for such alternative models.

Many EMS services are financially strapped due to the hospital-transport-only reimbursement policy, says Kevin Munjal, director of prehospital care at the Mount Sinai Health System in New York. In smaller communities and rural areas, the model is too low-volume to support paid staff, so EMS is provided by volunteers. That, in turn, puts their ability to respond in a true emergency at risk.

By creating a system that reimburses EMS professionals to do things like treat patients at home, move them to other health-care providers and check on them after they leave the hospital, "we could unleash innovative new models of care that meet unmet needs, while making emergency response more reliable," says Dr. Munjal, who is leading a nationwide EMS innovation project. Otherwise, he warns, "many would argue that EMS's ability to be there in emergencies is under threat."

Treating more patients at home

Meanwhile, several pilot programs are working on ambulance services whose job is to *not* take people to the hospital.

Mount Sinai and a local ambulance company have established a community paramedicine program in which specially trained paramedics respond to calls from patients enrolled in the program or in Mount Sinai's visiting doctors program. The paramedics visit and examine the patients in their homes, and consult with doctors at the hospital via telemedicine, or two-way video, on what to do next. Out of 36 patients who called the service over a six-month period, only five were transported to the hospital, for an estimated savings of about $1,400 per encounter, Dr. Munjal says. The pilot program was started with a grant from the Centers for Medicare and Medicaid Services and is supported by private foundations.

In a similar pilot program in Mesa, Ariz., dispatchers in the Mesa Fire and Medical Department talk to patients who call the 911 center. For many whose problems are not deemed an emergency, nurses offer medical advice, or send a community-medicine unit to the caller's home. The units include firefighter paramedics, nurse practitioners or physician assistants, or behavioral-health counselors from local fire departments and health-care providers and a hospital. A test of 983 patient encounters from August 2012 to February 2013 showed a cost savings of over $1 million, according to Mesa Deputy Chief Steven Ward. In 2014, the Mesa program also received a grant from the Centers for Medicare and Medicaid Services.

PREVIOUSLY IN HEALTH CARE

- Are Antibacterial Soaps Safe?
- The Tough New Family Talk: Our Genes
- How to Take Charge of Your Medical Records
- E-Cigarettes and Quitting Smoking
- Is Being Overweight Good for You?

Caring for patients at home has advantages for everyone—when it's possible. Tony Lo Giudice, the Mesa department's community-care grant administrator, says that out of 55,000 calls a year, about 40% are low-acuity, "and it can be can be very expensive to place everyone in an ambulance and take them to the ER." The community-care units also visit some hospital patients after discharge that are at higher risk of being readmitted, to offer preventive-care measures and make sure the patients are following discharge instructions. Paramedics are then able to identify those that might need follow-up services such as a social worker or physician referral, says Mr. Lo Giudice.

Susie Jackson, who lived in Gilbert, Ariz., says the community unit was a big help when her mother, Nancy Long, 80, cut her arm badly. Ms. Jackson called 911 and jumped in her car to get to her mother, expecting to spend the day in the ER with her. Instead, a physician assistant with the community-care unit stitched up the wound in her mother's home. "It put my mother at so much ease that she didn't have to leave home to be taken care of," says Ms. Jackson.

A national emergency network

New information systems under development could make it far easier to share information in an emergency. First responders currently rely on thousands of separate and incompatible networks during emergencies, and often can't easily communicate and work together. A 2012 federal law created the First Responder Network Authority, known asFirstNet, an independent authority that is developing a high-speed, nationwide, wireless broadband network dedicated to public safety. EMS teams would be able to transmit live video and images from car crash scenes, for example, even in rural areas with limited coverage.

In another national effort, known as Next Generation 911, states are upgrading antiquated 911 systems, which can only receive phone calls, allowing callers to send video and pictures to dispatchers. A growing number of states have recently added 911 text messaging.

With such advances and mobile apps designed for EMS services, first responders could use smartphones to share information that is now often lost or incomplete when they hand over patients at the ER, says Benjamin Schooley, an assistant professor of integrated information systems at the University of South Carolina. His design of a

mobile system that allows paramedics to transmit video, pictures and other information to hospitals from car crashes has been tested in Idaho and Montana.

So far, Dr. Schooley says, EMS has only started to scratch the surface of what it can do with patient data in real time.

When less care is more

Counterintuitively, perhaps, researchers are finding that some patients may benefit from less intervention by paramedics. Studies have shown that in cases of penetrating trauma, such as gunshot or stab wounds in the torso, chest, abdomen or upper arms of legs, so-called advanced life support methods including providing IV fluids and inserting breathing tubes don't improve survival rates.

Ambulance crews around the country are using new techniques and testing new missions. *PHOTO: ISTOCKPHOTO/GETTY IMAGES*

Temple University Hospital in Philadelphia is embarking on a five-year study that will randomly group patients who are shot or stabbed. One group will receive advanced life support. The other group will be brought immediately to the hospital with only basic life-support therapy such as an oxygen mask if needed. The hospital has been meeting with city residents to explain the study and provide wristbands for those who want to opt out.

Zoe Maher, a trauma surgeon and researcher for the study, says that while the procedures can help in rural areas where trips to the hospital are long, in a city they might not help—and could hurt patients who are shot or stabbed and bleeding to death. For example, administering IV fluids can dilute the blood's clotting ability, and putting a tube down the victim's throat can increase pressure in the chest cavity and decrease the amount of blood coming back to the heart.

"Sometimes we think of innovation as adding more treatment, but innovation here means doing less," says Amy Goldberg, chair of Temple's department of surgery. "We need to embrace this just as we would a new device or a new technology."

Ms. Landro, a Wall Street Journal assistant managing editor, writes the Informed Patient column. Email: laura.landro@wsj.com.