MEETING MINUTES

Emergency Medical Services Advisory Board

Date and Time of Meeting:	Thursday, August 3, 2017, 9:00 a.m.
Place of Meeting:	Washoe County Health District 1001 E. Ninth Street, Building B, South Auditorium Reno, Nevada 89512

---

1. *Roll Call and Determination of Quorum

Chair Slaughter called the meeting to order at 9:00 a.m.

The following members and staff were present:

Members present:	John Slaughter, Manager, Washoe County, Chair Kevin Dick, District Health Officer, Vice Chair Steve Driscoll, Manager, City of Sparks Bill Thomas, Assistant Manager, City of Reno (non-voting member) Terri Ward, Hospital Continuous Quality Improvement Representative, Northern Nevada Medical Center (via telephone) Dr. Andrew Michelson, Emergency Room Physician, St. Mary's
Members absent:	Sabra Newby, Manager, City of Reno

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, Preparedness and Emergency Medical Program Manager Heather Kerwin, EMS Statistician Dawn Spinola, Administrative Secretary, Recording Secretary

---

2. ***Public Comment**
Limited to three (3) minutes per person. No action may be taken.

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

Chair Slaughter closed the public comment period.

---

3. Consent Items (For possible action**)**
Matters which the Emergency Medical Services Advisory Board may consider in one motion. Any exceptions to the Consent Agenda must be stated prior to approval.

A. **Approval of Agenda**
August 3, 2017

Chair Slaughter noted the agenda to be approved was for August 3, 2017.

B. **Approval of Draft Minutes**
April 6, 2017

Vice Chair Dick moved to approve the Consent agenda. Mr. Driscoll seconded the motion which was approved unanimously.

---

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

Dr. Michelson stated the PMAC met in mid-June. Much of the meeting was discussing the fast ED assessment that REMSA wants to start using, which is a stroke assessment. It helps to understand when someone's severity of stroke presentation is something that should be potentially brought to a facility that has interventional services, which currently is only Renown.

Dr. Lee, the medical director of REMSA, had asked that PMAC to either support that or not. Dr. Michelson would bring back a question to the PMAC and Dr. Lee, on how they plan to adapt the use of the fast ED assessment. This is a reminder that the PMAC is there for recommendations; in no way are they making hard directions that everyone must follow. The goal of that committee is such that all those medical directors have their voices shared and that there are discussions held.

There was little progress during the PMAC meeting in reviewing the protocols. However, it is the task force formed to work on regional protocols including, looking at the protocols in detail, weigh in, as PMAC is primarily composed of the EMS agency medical directors. There's a timing issue for getting all those docs to show up at the same time and be prepared with the same data.

---

5. *Program and Performance Data Updates
Christina Conti

Ms. Conti stated she was available to answer any questions on the program report. Following up with the NTSB training, since that training and our last meeting, the regional family assistance center plan, which is an annex to the mass fatality plan, has been updated, and it is currently with Dr. Knight for review and signature.

The state EMS committee formed three subcommittees: Trauma protocols subcommittee, air ambulance regulations and the state EMS policies and procedures. The WC EMS Oversight program will be on the policies and procedures workgroup so that WC can continue to be aware of what changes the state EMS program wants to implement.

The final thing within the meetings with partner agencies section to highlight is something we are proud of and we don't have an end product just yet but an evacuation video was created

for the mutual evacuation aid annex, MAEA. Currently those trainings are only held in person but with the creation of this training video, the health supervisors and EMS providers train at their continuing education programs throughout the year. It was a great partnership with the VA. One of the things to note, the VA hospital volunteered the time and personnel to film the video so there's no cost to the region for the development of this training video. The region is incredibly appreciative.

The regional response heat map is now live. Ms. Conti stated they hope this becomes a great resource for the region. When the data for all the partners for June is received, then the last quarter for FY16/17 will be uploaded and it'll have a full year available.

The final thing Ms. Conti pointed out is the data request to EMS Oversight program. When the political jurisdictions created the EMS Oversight Program, one of the goals was to have a place where partners could go for assistance to obtain data.

Mr. Driscoll had a question on the evacuation piece. Mr. Driscoll opinioned there was quite a bit of work done early where the region identified all the different facilities, the beds, the capabilities. Knowing that's been a little while, has that inventory been maintained, and is it current so if we run into a situation we know where those folks can go in the sister facilities?

Ms. Conti replied that yes, the MAEA just got updated, and it's on an every-other year cycle. One of the first things done is those hospital bed counts. The region has also begun adding the sub-acute care facilities so that their numbers can be in there as well.

Good morning, Rishma Kimji, City of Reno. We have some great news on the CAD to CAD project. Tiburon and TriTech have reached out to both City of Reno and REMSA and notified us that they are doing the back-end work now on their side with the programming. And then they will reach out to us in the next 30 days to create a kickoff meeting with both sides, so City of Reno and REMSA, and their project teams on their side, and we'll have a kickoff meeting. They're hoping to have a testing version available by end of October. They want at least a four-week testing period, we're going to push for at least a six- to eight-week testing period, that way we can get through if there are issues with not just the programming, but with the codes and any other CAD issues that may arise from it. We are hoping to have a go-live date of January next year, but again we won't have concrete dates until we have a kickoff meeting in the next 30 days. But we're very excited that they are finally moving ahead, and we should have something available to us next year.

Chair Slaughter asked clarification on the data request matrix where it says a complaint to the Manager's office, which of the three Manager's offices was that complaint made to. Ms. Conti replied it was Washoe County.

---

6. *Presentation to the EMS Advisory Board

- ALS Implementation, Sparks Fire Department

Good morning, Sparks Fire Chief, Chris Maples and Captain Ed McDonald, our department EMS coordinator, to give an update on our paramedic program and answer any questions.

EMS is a core service nearly all fire departments provide. Nationwide, EMS calls make up the majority of fire department responses, and Sparks is no exception. Over 82 percent of the calls SFD responded to in FY17 were medical. Until earlier this year, Sparks Fire was the only large department in the area that did not provide paramedic-level care. In June 2015

former Fire Chief Tom Garrison began exploring a variety of data including call types, response times, on-scene times, the performance of the two-tiered EMS system, and the difference between EMS provider certification levels. Through research and statistical analysis, he concluded that a higher level of EMS care was warranted and would benefit the members of our community. His research provided the justification to implement a paramedic program, and in August, 2016, the Sparks City Council authorized the department to begin providing that level.

After Chief Garrison's retirement it was up to Captain McDonald to get the program up and running and SFD began staffing paramedics at Stations 4 and 5 in April. The intent of moving to a higher level of EMS care was to provide our community with the same level of care that residents of Reno and Washoe County were receiving. Additionally, we wanted to ensure that no matter what type of medical emergency someone was having, the best field care would be available with the first arriving crews, whether those crews were REMSA or Sparks Fire.

Although Stations 4 and 5 are not the busiest stations, the response times are typically longer and this is where paramedics could have the greatest impact on patient care. Since April, we've been analyzing the data to determine how effective it's been; Captain McDonald will share some of this information with you.

Good morning, Ed McDonald, Sparks Fire Training Captain and EMS Coordinator. Going to this program we had 15 certified paramedics in the department that had been maintaining their certification level though training and continuing education. We brought in new equipment and new protocols we needed to ensure by April 3 they were going to be ready to go. Through in-house training, and a 40-hour, state-approved continuing education courses approved by the medical director and through third-party EMS educators, who made sure we were up to date with best practices, and validated our program -we were able to exercise our equipment, our protocols, during that week as well, and make some gains there.

Since April 3rd, SFD has hired five additional firefighter paramedics that started with paramedic certifications and will be functioning very soon on their own as firefighter paramedics with the department. Station 4 and Station 5, were our best opportunities, and have proven to be successful. Over the last four-month period SFD has been able to administer new paramedic medications, including pain management options and cardiac medication approximately 40 times and have used cardiac monitors,12 EKGs, manual defibrillation on approximately 50 cases. SFD has also assisted in transport approximately 20 times and have cases where they have been able to join protocols and equipment to maximize patient care.

Chief Maples wanted to touch on any significant cases that we have had. In this instance, we had a subject who drove to one of the stations, and said you guys are paramedics, right? The crew said yes, and she said I need you to put me on a cardiac monitor, fast, this individual had been dealing with a cardiac dysrhythmia over the course of about five years and it had never been captured. The crew was able to capture it, she was transported, but by the time she got to the ER, the cardiac dysrhythmia resolved again. It's just one case where the citizen was very appreciative and so was the medical community.

Chief Maples stated SFD will continue to evaluate their program to make sure it's effective and will make adjustments as needed. As they are able to hired more paramedics, they will staff the other stations beginning with Station 2 early next year. However, additional staffing of paramedics is dependent on our ability to hire more paramedics, either

through attrition, or if funding becomes available to increase our current staffing levels. With that, Ed and I are available to answer any questions you may have regarding the paramedic program.

Mr. Thomas questioned if they have three firefighters in the station for fire and then two for medical. Chief Maples clarified, no, they run three-man engine companies and one of those crew members will be a paramedic. Mr. Thomas followed up that SFD will then continue to respond to medical with three. Chief Maples answered in the affirmative.

Mr. Thomas then asked if they respond with a different device, or a different vehicle, or the same. Chief Maples stated, no, they run all their first-line apparatus.

- REMSA Health Line & Community Paramedicine, REMSA

Good morning, my name is Elaine Messerly, the Director of the Community Health Programs at REMSA, and one of our programs is our Nurse Health Line (NHL -Attachment A). From July 2016 through June 2017, the NHL has received over 25,000 calls, averaging per month is over 2,300 per month. These are patients who are not having an emergency or don't feel that they are having an emergency, and not quite sure where to go for their health care, and so they are calling into our NHL. As you can see, over 50 percent of patients are adults from 19-65 years and 30 percent of the people who get care from us are children less than two years of age. Young parents are calling and using the NHL maybe during afterhours or weekends when their pediatricians are not available to see what they need to do with their child.

There are over 200 protocols that the nurses can use when someone calls in to the NHL. These are the top 10 most frequently used protocols over the past year. Abdominal pain is the highest protocol and chest pain is the second. When someone calls into the NHL, the first thing that the nurse does is check for airway, breathing and circulation. Before they ever choose a protocol, they're talking to the patient to see if there is an emergency going on. If it's deemed that the patient needs an emergency response, they'll get the patient right over to the 911 system without ever going to a protocol to identified emergencies early on in the call. The goal is to get the caller to the appropriate level of care within the community where the patient is. The levels of care range from a 911 response, take themselves to the ER, see a provider within one to four hours, see a provider within 12 hours, one to three days, or stay at home with self-care instructions. Over the past year, 135 patients that called into our NHL and said if our service was not available they were going to call 911--those patients were not sent an ambulance. 359 patients said they were going to take themselves to the emergency room if our service wasn't available and they did not need to go to the ER. Those are avoided visits.

The biggest barrier is the hours of operation for urgent care clinics and MD offices. If it's on a holiday, a weekend or afterhours and someone needs to see their physician within 12 hours, we're probably going to have to send them to the ER because there's no urgent care clinics open at that time, and there are no providers available. Even though we may identify they don't need an ER visit, right now in our community we have to send them to the ER.

Additional barriers are when you go to the ER, you don't have to pay a co-pay up front, but when you go to urgent care or doctor's office you have to pay a co-pay. Even if we identify for them to go somewhere else besides the ED, they may take themselves to ED anyway to avoid a co-pay. Many callers of the NHL are Medicaid and uninsured patients, as Medicaid and uninsured persons are not accepted at some of our urgent care clinics.

In the past year we've gotten two contracts with two hospital systems and with one health

plan to help us keep our NHL sustainable. We're working really hard to get some more contracts to make sure that this service can be sustainable in our community. We still have a number that our entire community can utilize our service without having an insurance or a hospital that's paying for us, so anyone who calls into the NHL, we're going to talk to them and get them to the right level of care.

We send out patient satisfaction surveys and we ask six questions, and our satisfaction scores were extremely high for our callers that call in.

I want to touch just a minute on Omega calls. What I've been talking about up until this point has been the callers that pick up the phone and dial a phone number that gets them into the NHL. Those are the 28,000 calls called in on a seven-digit number and went to the NHL. Fewer than one percent of those calls actually had an emergency when they called in, and when we identify they have an emergency we get them to the 911 dispatcher.

The other route to the NHL is our 911 dispatch center, has a set of evidence-based protocols, and if the caller has an Omega determinant, a non-acuity, those calls are transferred over to the NHL. The nurse then selects the protocol and gets the patient to a recommended care level. Among calls that have come in to the NHL from the 911 dispatchers as an Omega, only 7 of those callers were returned back to the 911 system as an emergency.

When a call comes into the 911 system, and is determined an Omega call, and then goes to the NHL and then is referred back to the 911 system, 100 percent of those patients are reviewed by Dr. Lee, our CQI coordinator, and myself, to ensure that our system and our safety net is working to ensure that the patients are being cared for safely. So of those seven patients who got returned back to the 911 system from the Omega process, none of them were emergencies. These were patients who said send me an ambulance, I know I just stubbed my toe, but send me an ambulance. We had some patients that the first responders got on scene before the nurse got through the call, and they had called 911 so they want to go to the hospital. When we have patients who we could send to a lower level of care than the ED or actually send them to the ED without an ambulance, we have a process where we can send them a cab, and REMSA is paying for the cab services, for them to get to their health care provider and home, and some of these patients actually refused a cab as well. So of these seven people, none of them were true emergencies.

Mr. Driscoll asked about the nursing program, as he recalled it started with a grant, so how it is being funded, now that the grant is over.

Ms. Messerly responded they have two contracts with two of the hospital systems and one through an insurance company who are actually paying for patients who call into our NHL who have that insurance or who are with that hospital system and they are working on more.

Dr. Michelson asked if there was a follow-up system for those people other than the six-question questionnaire in the event a patient had a high-risk chief complaint and were deemed non-emergent, and the recommendation was not to seek emergent care.

Ms. Messerly answered although they do not currently have a follow-up process. They have looked into it however within the contracts that hold, the follow-up system is with the health care providers or the hospital systems on their end.

Mr. Thomas opined the NHL and Omega protocols are very productive tools for reducing costs, reduce hospital visits, and ambulance charges. Mr. Thomas then asked how do you

publicize this and how do you get it out to the public. Has anybody given thought to a way to maybe growing the senior part of the users? Mr. Thomas guessed a lot of the people who don't use the system properly, maybe seniors, because they're more inclined call an ambulance and go to an ER.

Ms. Messerly responded to the first question, that for the grant, a report was provided to CMMI, followed by an independent study by RTI International to assess the grant data. REMSA is currently in the process of writing a white paper that will be public knowledge as to how they determined our cost savings throughout the four-years during the grant. This will get the word out to the community.

I spend a lot of time with the senior population trying to get the word out. Right now, our number is on the back of their card for any senior with our contracted insurance provider. When we first started, we had a public number accepting all calls from anyone, which is still open, and did a lot of marketing in the senior communities.

Mr. Thomas stated there is a perceived financial benefit and interest from the local government standpoint in terms of calls that might be avoided and also a financial benefit to the hospitals. Maybe as a region we should explore how we continue this, if this is grant funded, and the grant evaporates. As far as everybody maybe kicking in some money to make sure we have a very robust nurse call in line for the citizens of our community.

Ms. Messerly agreed and clarified that REMSA currently does not have any grant funding as the grant funding ended July 1, 2016. The NHL provides cost savings on every level of patient care.

Mr. Dick commented that the Community Health Needs Assessment and the Community Improvement Plan have identified access to health care as a major issue in our community, and that REMSA pursuing this with the Innovation grant, and now maintaining it and working to develop sustainable funding for it is an important effort to try to improve access to health care. He understands this not only helps to control costs of people inappropriately accessing care at the wrong level, but also provides an entry way for people to get the care that they need. He optioned that both presentations from Sparks and REMSA this morning are capturing how we better use our EMS system and resources to improve access to health care for people in our community.

Ms. Ward asked if there was any data proving or substantiating that protocols had not been incorrectly initiated.

Ms. Messerly replied the NHL went through a quality process and became ACE accredited with the International Academy of Emergency Dispatch. REMSA is the first to be accredited and maintain their score including random audits of calls. For example, audits are done when a nurse does not pick a protocol. An attempt is made to select a protocol if they are symptomatic at all, but sometimes callers just want a refill or they call to ask for a phone number.

Mr. Driscoll commented as we continue to do some PSAs for appropriate use of 911. The other side is the positive getting the word out on this program to alleviate the burden on 911. Mr. Driscoll then asked if there was a future marketing plan for enhancing the utilization.

Ms. Messerly answered REMSA launched this program with the campaign on the radio and the television and it was very clear when to call 911 and when to call the NHL. Part of the issue is the sustainability. REMSA needs figure out payment for our system and funding the NHL and then to market it to everyone.

- REMSA System Status Management Overview, REMSA

Adam Heinz, Director of Communications for REMSA. Good morning, Chairman and members of the Board, does Ms. Ward have access to the presentation that says Growth Planning? (Attachment B) Ms. Ward: Yes sir.

I oversee our emergency medical dispatch, our air medical communications specialist, as well as our senior data analyst that was so gracious to provide this presentation. The previous meeting, Assistant Manager Thomas asked REMSA to provide insight into how we project and plan for growth. Specifically geographic growth, as well as, population growth.

It's a multi-faceted type of growth plan, some changes occur daily at REMSA, others are ongoing, and some through franchise requirements. High-performance EMS is deployed similar to the police department, and so it's not as evident that we're growing. I'm going to show you some graphs that are going to show specifically relating to scheduled units that are available in the County.

At 10:00 am our executive leadership meet to talk about system performance from the day before and internal performance such as schedule. These are in addition to the very stringent requirements of the District Board of Health for our oversight. Upcoming weather, with it being hot, do we need to deploy different ambulances or different types of resources certain places to ensure coverage. Special events – we know that Reno, Sparks and Washoe County is a destination place that sees an influx in people and to ensure that we're covered for that. Disaster mitigation –the Lemmon Valley incident, where the flood and the Hesco barriers were placed, there was an identified access challenge. Our daily meetings, identifying those issues and evaluate our ambulances deployment to ensure coverage.

A lot of this is the catalyst for permanent system changes. If we look at this graphically, just individual daily changes show the growth and purposeful planning of the EMS system. For example, this is one of 35 graphs that we look at, hourly by day, day of week, and this is just for one day, specifically looking at volume including hospital delays and staffing. We don't have to get too into detail unless you'd like to, but this is just one representation of what we're looking at daily at REMSA Communications.

The bi-annual review is the framework to build our staffing model. We use scheduled unit hours, people that are providing coverage. The previous 20 weeks of call volume r to project what we are going to need for the upcoming six months. That essentially is 20 Mondays at 1:00, 20 Mondays at 2:00, etc., etc., to be able to build a model. Sophisticated software program that reviews data and provides information on average calls, peak calls, and what should be staffed to ensure coverage. There are built-in buffers for unforeseen events. This can't project a multi-casualty incident so we have to ensure that the system is ready for that. Not only in internally within REMSA, but with our mutual aid and co-response partners.

That dark, shaded area is providing us the average calls for that hour of that day. The grey is the maximum calls, and blue represents a sophisticated algorithmic process that indicates if you have ambulances that are above that level, it may be wasteful. If you can see, what is labeled as D, the blue line, that's what we are staffing during those hours. This has to be modified to apply humanistic constrains, for example it may say somebody should start at 1:45am, which is difficult for staff to do. We have our data analysts and scheduling folks apply those criteria and produce something similar to this. This is Saturday, and the purple bars are the 90^{th} percentile demand, or the call volume. The grey is that task time based on 50 to 60 minutes of an ambulance being committed to a 911 call is what it looks like for

coverage. The solid grey line at the top is what our schedule is and includes the buffer.

That bi-annual review, starting in 2015, spring and then fall, so that we can plan our schedule based on seasons. In winter, we see different types of calls for complaint, as well as spring into summer there are differences due to special events, the heat, and people visiting our town. During each shift bid additional scheduled units are added into the system. This graphic takes us from 2011 up until April, showing the monthly commitment to the community, as well as the daily there for the annual at the bottom. We're continually adding units into the system to ensure that we are prepared for that. As represented by our ability to meet compliance, tells us that we are meeting that demand at least to suffice the stringent requirements for REMSA.

Additionally, we do a franchise map review every three and five years. Different things are reviewed including geographic population and coverage. One of the challenges that we saw was an increase in the number of calls. If we look at Zone A, there was a higher percent of calls, as Reno, Sparks, Washoe County begins to grow, and there's an expectation that you receive a REMSA paramedic ambulance within 8 minutes 59 seconds in Zone A. There were decreases in Zones B, C and D, those suburban and rural areas, posing a challenge. If you decrease the number of calls, you have to increase the number of calls that you are compliant in. There's not many calls in those areas, so one day you may meet one call, and then the next day you don't and you are 50 percent compliant. That's what this represents here, to show you the challenges of the dynamics that we face as we continue to evolve. However, monthly for the last 30 years REMSA has been meeting that compliance standard.

An additional example is where we created one of only four static posts, "Wingspan" a growing area that includes Sparks and Washoe County out Pyramid Highway. During the initial 10 months of the new 2016 response zone map implementation we were not satisfied with the response in that area, and moved the post. We have about 60 days' worth of data, but we were able to forecast, through using a model, to see that we are to be more compliant in those calls. This is a testament to the agile nimbleness of the ability to move things to ensure that we are covering the populations we serve.

REMSA is working with RTC and NDOT to address future access and impediment issues related to the Spaghetti Bowl including not just during construction periods, but how to better design the area. We appreciate that opportunity. An additional example is a community near Cold Springs, Stone Gate, we've met with their senior developers to facilitate EMS response to the future residents. There are a lot of great discussions that come of that and we're appreciative of it.

EMS system innovations include things we do in order to ensure sustainability. This includes the Omega program and NHL which allow low-acuity patients to get where they need, decreasing the need for an ambulance response. The inter-facility, intermediate life support (ILS) allows REMSA to transport 35 to 40 people from hospitals and non-acute care facilities to skilled nursing facilities, doctor's offices, or to their home. The ILS program has significantly decreased the demand in the ALS system side, not decreasing any of the ALS units, just an adjunct to them, which allows for ALS units to be available for 911 calls.

Public service campaigns provide the opportunity to educate the public on the use of 911 and reduce burden on resources to be available s for the people that are experiencing emergencies. Special event medical coverage, decreases the need for ambulances to respond into the venue, and saves time. The average response time for our bike team downtown, many times uncompensated, is about three minutes. Approximately 30 percent of our calls

are non-transport, either the patient refuses care, it's a non-medical problem, or cancelled, so they're able to decrease the need for an ALS unit to respond and be tied up for that. Specialty teams, TEMS and SAR, provide care to the patient and decrease the need for ambulances as do ALS single response, paramedics strategically placed to provide immediate rapid response and cancelling ambulances if not needed. With that if you have any questions I'd be glad to entertain them.

Chair Slaughter asked I'm not sure where else I'll need to ask this question so I'm going to do it now, and if we have to we can talk about it somewhere else. When we talk about Burning Man, I believe I understood that for the second year in a row, REMSA will have a unit in Gerlach, within an agreement with the County, Truckee Meadows Fire Protection District (TMFPD) and REMSA, thank you for that.

Mr. Heinz replied that is correct.

Chair Slaughter requested data about the impact of the event in Gerlach, directing the request to staff as well as to REMSA, to track the week of, before and after to make some comparisons. Clarified that REMSA is not on the playa, but will assist the County in Gerlach itself. With the two systems, REMSA and the Gerlach volunteer ambulance, determine a way to start tracking some data for that event.

Mr. Thomas thanked Mr. Heinz for the helpful information clarified that the REMSA report was based on emergency medical response, not transport –so reflect demand.

Mr. Heinz confirmed all calls, including facility transfers, all demand was included.

Mr. Thomas followed up with an additional question if the fire response was modeled into the system. Mr. Thomas recalls his own personal experience in Reno there were six people who showed up to an incident. As a resource-constrained environment that may not be the optimum way to respond when there are more calls than people to respond to them. Then lastly, how does the Health District standard for REMSA, 8 minutes, 59 seconds, relate to the local government response times? For example, at the City of Reno we shoot for 6 minutes. Is there overlap? Are we double-counting? How do we rectify that between the two agencies providing a response to a person who needs someone to show up?

Mr. Heinz answered relative to the responses with the fire department. REMSA, as an ACE-accredited center, conducts emergency medical dispatch (EMD), which triages calls based on chief complaint. Each fire jurisdiction, based on their response criteria, their geography, their oversight, decides what calls they respond to. When somebody calls 911 they may tell the dispatcher they have a medical emergency and don't know what's going on. That requires the fire service to respond immediately, and then the caller is transferred to REMSA whose dispatchers may find out the patient has an Omega or a non-acute complaint. REMSA has worked in collaboration with the fire services to communicate call priority, and routinely have fire officers call REMSA through the med channel for response information and then decide whether or not they are going to respond or cancel. This saves a resource for a higher-priority medical call.

Once the CAD to CAD project occurs, that information will be sent over and then each jurisdiction can decide whether or not they are going to respond. There have been recent talks with jurisdictions that want to save apparatus for true emergencies and are utilizing the academy's recommendations. Ms. Conti is also involved and facilitating those discussions.

Relative to response criteria, the annual report previously looked at response times regardless of which agency, REMSA or Fire, responded first and the Heat Map also shows

this for the whole county.

Mr. Driscoll requested that the PowerPoints from today be added to the packet and provided to the members of oversight committee for the records. Mr. Driscoll also emphasized that since this is a public meeting, information provided during the meeting is posted to websites and that requested that the presentations are provided in the packet, to allow for time to review the data and be able to better analyze and provide questions. He recognized and appreciated the amount of work that goes into them, but wished he had the presentations in time to look over them and potentially answer questions for his jurisdiction.

Ms. Ward thanked Mr. Heinz for presentation around the projections and the growth needs and asked about the strategic plan for human capital and recruitment, to meet the needs. Ms. Ward noted there are challenges with anything affiliated with health care with recruitment and retention of employees, and they are vital in the service that we provide.

Mr. Heinz thanked Ms. Ward for the question, and responded that yes, it is a challenge for all involved in pre-hospital emergency care. REMSA has identified as an area of opportunity to improve in their Strategic Plan. Mr. Heinz stated REMSA meets weekly regarding recruitment and retention. REMSA also hosts a paramedic program and are looking at different ways to incentivize program completion and recruiting directly into REMSA, perhaps through a form of commitment to REMSA for a period of time.

---

7. Presentation, discussion and possible acceptance of the EMS Program's FY 16-17 Annual Report template (For possible action**)**
Heather Kerwin

Ms. Kerwin stated she had nothing further to add to the staff report, but pointed out that it very closely mirrors the previous annual report for the sake of consistency. Ms. Kerwin was available to answer any questions.

Mr. Driscoll moved to accept the template. Vice Chair Dick seconded the motion which was approved unanimously.

---

8. Presentation and possible acceptance of an update on the Nevada Trauma Registry data for Washoe County (For possible action**)**
Heather Kerwin

Ms. Kerwin stated she wanted to highlight that this is the first time Washoe County has received the trauma data, for two full calendar years, 2015 and 2016. The tables in the county trauma data report were adopted from the National Trauma Data annual report for 2016. Ms. Kerwin was available to answer any questions.

[Chair Slaughter left the meeting at 10:05 a.m.]

Mr. Thomas apologized for not having read the report and asked if there were any conclusions or recommendations as a result of this report.

Ms. Kerwin replied over 60 percent of the trauma incidents involved a fall or motor vehicle accidents, so preventive messages would be to reduce likelihood of falls, and ways to stay safer on the roads.

Mr. Thomas sought clarification on falls and asked if the falls were due to construction

activity, work activity, or just people around their houses.

Ms. Kerwin responded after reviewing this data in conjunction with unintentional injury fatality data, there is a higher proportion of falls among adults over 50 or 60 years of age. Which will likely increase as the Baby Boomer generation ages and is one trend to keep an eye on.

Mr. Driscoll stated we know in hospital environments and care environments, fall protocols have been greatly improved and increased over the last decade. Mr. Driscoll asked if there is some attempt by us as a public agency to partner with them or on our own to do some kind of marketing, PSA-type campaigns to work specifically on falls as one of the two.

Ms. Kerwin replied she was not aware of any, but can work on it in the future.

Ms. Ward stated if there is a subcommittee or some type of collaboration she would love to be a part of that, as they have done a lot of work at Northern Nevada and had a huge decrease in falls.

Mr. Dick opined we could engage Senior Services, as well, in a partnership around fall prevention. There's public messaging that's occurring on accident prevention from law enforcement and NDOT, and those types of things, but is not aware if there's really a coordinated sort of regional effort. It may be worthwhile to look at how partnerships can be enhanced around both those areas of utilizing existing organizations working together on a common message.

Chris Maples, Sparks Fire Department Chief, commented that Sparks Fire Department has a program that's called Remembering When, and it's specifically designed to address slip-and-fall hazards for seniors and would be willing to collaborate with anybody, including the nurse health line, to get that message out.

[Chair Slaughter returned to the meeting at 10:09 a.m.]

Mr. Driscoll moved to accept the report and approve distribution. Chair Slaughter seconded the motion which was approved unanimously.

---

9. Presentation, discussion and possible acceptance of a presentation regarding the conferences attended by the EMS Statistician (For possible action**)**
Heather Kerwin

Ms. Kerwin, EMS Oversight Statistician, presented on slides for the 2017 annual conference for the Council of State and Territorial Epidemiologists (Attachment C). The Council of State and Territorial Epidemiologists (CSTE) helps foster relationships among epidemiologists not just across our nation, but internationally as well, their work is primarily focused on advancing public health policy and epidemiologic capacity. CSTE also develops case definitions for reportable and infectious diseases, and standards for practice and effective use of epidemiologic data. CSTE conference is the largest gathering of applied epidemiologists in the nation, with over 700 presentations and round table discussions during the three-day conference.

Most of the EMS-related information was within the surveillance and informatics, substance abuse, and injury epidemiology tracks. These presentations largely focused on falls, heat stroke, related injuries, and motor vehicle accidents. The substance use tracks focused on opioids and Fentanyl overdose-related injuries and deaths.

Ms. Kerwin attended over 45 presentations and breakout sessions. Examples of sessions attended included identifying risk factors for opioid overdose deaths, and bystander versus EMS-administered naloxone, and uses of syndromic surveillance data to monitor opioid-related overdoses, which is currently occurring at the Health District. There was a presentation on

importing electric case report forms, if and when, the region migrates to standardized data collection for patient care in the field, those data can then be reported through an automated system. There were also presentations on emergency preparedness and infection control practices in urgent cares.

Emerging themes include the opioid epidemic, and the shift to Fentanyl analogs, derivatives of opioids, which have a much higher potency level at much smaller dosage. Also that the emergency room and hospital EMS data are widely used for early warning systems, and those include everything from overdoses to environmental hazards and foodborne illnesses. Additionally retrospective studies are being used to describe populations impacted by events such as motor vehicle accidents, falls, heat-related illnesses this can help provide context for marketing campaigns aimed at prevention.

Ms. Kerwin demonstrated how syndromic surveillance works, as a live feed of data from health care services including EMS, ED, fire, paramedic providers, hospitals, pharmacies, and laboratory into ESSENCE software which creates alerts and warnings for specified conditions.

Future projects include working with state partners to explore any utilization or application of Nevada's prescription drug monitoring program data. Ms. Kerwin noted the Health District has also received requests to look at smoke inhalation, and any uptick in marijuana-related impacts with the legalization of recreational marijuana, and ESSENCE was used to review hospitalizations for those issues.

Ms. Kerwin stated they will continue to work with local hospitals to obtain the pertinent information so they can better evaluate our pre-hospital patient care. Ms. Kerwin finished by stating they will continue to work improving health outcomes with the overall understanding that data collection and analysis should be done with the intention to improve public health and was available for questions.

Vice Chair Dick moved to accept the report. Mr. Driscoll seconded the motion which was approved unanimously.

Chair Slaughter stated we're going to open Items 10 and 11 at the same time at request of staff.

10. Presentation and possible acceptance of an update on the five-year Strategic Plan, a requirement of the Interlocal Agreement for Emergency Medical Services Oversight (For possible action**)**
Christina Conti

11. Presentation and possible direction to staff on changes to completion dates outlined within the five-year Strategic Plan, a requirement of the Interlocal Agreement for Emergency Medical Services Oversight (For possible action**)**
Christina Conti

Ms. Conti appreciated the indulgence of the Chair and the Board. Agenda Item Number 10 is the quarterly update on what's happening with the strategic plan. Agenda Item Number 11 is noting that we have missed some deadlines that were originally laid out in the planning process and asking for direction from the Board on those new dates will be approved.

There was a nine-month process with members of the operations and dispatch for all of the political jurisdictions to develop the strategic plan. The group tried to create a plan that was realistic and attainable while pushing the envelope a little bit. The due dates, that had originally put together, were believed to be reasonable and attainable. But, while going through the process,

in order to do a complete and thorough job on reaching those objectives, the region needed more time than originally anticipated.

A quick note on the completed objectives with the Omega protocols, which is the second item listed, we are doing our first annual review of the protocol process. The EMS Oversight Program will take a look at the process that the partners put together and make sure that it is still working as designed and if there's any revisions that need to be put in place to ensure that both partners know that it's an Omega call. Those who responded indicate that the process as outlined is actually quite good and it is working. At this point we don't anticipate a change to that Omega process.

Looking at the in-process objectives, Low Acuity Priority 3 calls would be an item that needs a new date. The group has begun meeting, has a plan to move forward. Mr. Heinz referenced it in his presentations of looking at the Low-Acuity Priority 3 calls and the appropriate responses and if the region can come together and make some agreements on what that looks like. That subcommittee will identify a new completion date that we believe is attainable.

The jurisdictional response measurement needs a new date. We are just waiting for a couple partners to self-identify their measurements and. Otherwise we will be able to be done with that one.

The regional protocols are a perfect example of a project that had no unexpected delays. The task force has been incredible and the knowledge base has been inspiring. The task force met monthly and then increased to every other week to meet that original goal within the strategic plan.

Turning to page 3, there is an objective that requires some clarification one language within the franchise. What we are doing, is going to go back and we're going to listen to the meetings and read the minutes from that EMS Working Group from several years ago, to really understand what the background was for that language. We'll bring the information back to the District Health Officer; however we need more time to do that research.

The CAD-to-CAD interface as well as the AVL, we heard the update from Ms. Khimji, so those due dates are on track. However, the strategy 3.3.1, underneath the AVL, is something that we need to work on pretty quickly. We would like the AVL capability so that in the dispatch centers they can see where all of the different partner agencies are in response to different calls. At the time we were developing the strategic plan, not all partners knew their existing capabilities, if all their apparatus had the AVL technology that could then feed back to the dispatch centers. This is simply an assessment of where we are, so that we as a region can plan for where we are going with the advancement of the technology of CAD-to-CAD.

E-PCR is stalled at this moment because there are a lot of data-mapping elements that are being worked out through the individual jurisdictions, and so once those units are operating without error then this strategic planning item can proceed with being work done.

The annual hospital outcome data, Ms. Kerwin touched on that, we're working with Northern Nevada Medical Center (NNMC). We brought some examples of calls and we found that the REMSA ID, run number, is searchable in the hospital database. That is going to make the matching process of the calls that much better, when we get those calls from NNMC, we will sit down and start mocking up what the different analysis could look like, before we bring it to the region, to ensure that we're answering the different questions for hospital outcome.

PMAC, Dr. Michelson already touched on.

The annual franchise map review, this is another example of the subcommittee that put the

strategic plan together selecting a date we felt was realistic. However, we have a July 1 date on that. Ms. Kerwin does not get the data for the month of June until the middle of July. We can't do an annual review process based on the calls received before we even get the data, so we are going to be looking to change that date as well.

The last one is brand new with all the strategies included, and it's looking to see if we can do a regional quality improvement program. That is a several-year item.

Mr. Driscoll opined based on the circumstances and the reasonableness of delaying, do you have stretch dates that keeps you focused, that would allow you, to meet your new timelines on a stretch, not on a relaxed basis?

Ms. Conti stated if I understand your question, that's what we would like to begin doing. We have not in the past reset a date. It's been trying to achieve what's in there whether it was reasonable or not, which is why the task force started those every-other-week meetings. If we are not going to meet something, have the discussion with those that are involved in that project, and then together, assign a reasonable date that then becomes the hard line that we would move towards. Our goal would not be to continue pushing it out but to assign a new date.

Mr. Dick affirmed having a strategic plan that does have stretch goals to it, and would rather have to push back a date for achieving that goal versus having a relaxed plan where we're hitting all of the dates easily because we're not challenging ourselves very much. What I would suggest is that when you're coming to report to the Board on your progress with implementing the strategic plan, at the same time, you bring us any adjustments that you're seeing in the schedule and the deadlines, based on how you are progressing and what you anticipate hitting.

Ms. Conti stated this item is to approve the update of the 5-year strategic plan. On Agenda Item Number 11, the recommendation is actually what Mr. Dick said, that we would like the Board to direct us to bring back those new dates when we bring back the quarterly updates on the 5-year strategic plan.

Vice Chair Dick moved to approve Items 10 and 11. Mr. Driscoll seconded the motion for discussion.

Mr. Driscoll asked with all the adjustments that you're suggesting that be reviewed for possible new dates on a stretch goal type basis, are all of those ones that wait for approval three months from now? Are there some that the team would like some specific direction on so that they can be working towards satisfying certain outcomes inside between now and the next meeting?

Ms. Conti asserted that we had to push back our meeting from July due to quorum issues, we actually meet again in two months, and our packet is due in six weeks. I would prefer to be able to get with the partners and bring back those attainable goals. For regional protocols, the goal was June 30, and we will have those final protocols to medical directors in a week. I don't feel like there is a barrier to having it come back in the October meeting as long as the Board's comfortable with that. We haven't stalled these projects, we're continuing to move on them and we'll have those discussions for dates.

Mr. Driscoll opined that he understands this process, having been involved in it pretty heavily. Understanding where you're going and what you're trying to do, and you're accomplishing good things. I'm just wondering, in a 6-week period of time, if you were struggling with maybe direction, if the Board appointed a single point of contact where you can get some direction to get us to the end goal two months from now if that would be helpful. I'd be willing to do an amendment to the motion to provide you with that oversight.

Ms. Conti said that would be really helpful to us.

Mr. Dick stated he would be willing to amend the motion to include that. I think that Mr. Driscoll's been, as he noted, very involved with the strategic plan, and I would be quite comfortable with him serving as point for the EMSAB. Mr. Driscoll opined that he'd willing to take on that responsibility.

Mr. Dick, so moved. Mr. Driscoll seconded the amendment.

Chair Slaughter clarified ll in favor of the motion, I think we have one motion for two items. Ms. Conti affirmed yes, and for clarification of the motion, I believe that the amendment would be to Item 11. Chair Slaughter said yes, thank you. **The motion passed unanimously.**

---

12. Presentation, discussion and possible acceptance of an update on the regional protocol project, an objective of the Washoe County EMS 5-Year Strategic Plan (For possible action**)**
Christina Conti, on behalf of Brittany Dayton

Ms. Conti stated the regional protocol project, as I alluded to in the last agenda item, has been an incredible process to watch. The task force was created out of the PMAC committee, and is comprised of two representatives per jurisdictional partners. One of the things to note is that the regional protocols have no deviation from the partner agencies with the exception of the medications that they might carry. That has the possibility to change when the medical directors begin their review and recommendations. To this point, all of the partners within Washoe County, including North Lake Tahoe Fire Protection District, share the goal to utilize the same protocols. When we were doing the strategic plan, it was something that we really didn't believe was achievable to 100 percent to push the recommendations forward. We anticipated that there might be some variances. To get to the end of this project and have no identified variances in this moment that is pretty incredible.

Ms. Conti mentioned we had a June 30 target deadline, and we almost made it. The task force brought to the PMAC on June 14, an almost complete protocols for them to review. As Dr. Michelson said, that meeting was quite full and they weren't able to really discuss the items that were there. The task force met several times with their final meeting on August 1, and the document has now had a second final review. I say second, because each protocol was worked through and then received a final look before it got put into the document. .

By Monday, that document will be sent to the partners so that they can do their editing. The editing isn't necessarily the how to do, it's what is written to make sure that we as non-medical that we are providing that backbone support accurately captured the abbreviations of those methods.

The medical directors and PMAC members will receive the document on Monday August 14th. The task force decided on a four-week review period, because it correlated very well to the next PMAC meeting. Our desire and our hope is that those medical directors will meet with their operations personnel from the fire jurisdictions to discuss those protocols. Any revisions or recommendations that they would like to see made can then be discussed among all of those medical directors and the PMAC members at that PMAC meeting. The task force has already scheduled their next meeting, which would be the next week, to take a look at and discuss those recommended changes, and then the anticipated end goal is to bring the completed document at the next EMSAB meeting.

The task force needs to re-look at what that implementation date looks like because that date

was January 1, we haven't hit that yet, I'm going to make an assumption, it is not a reasonable one any more. Because we have to wait for all the medical directors to sign those protocols before training can occur.

We are incredibly proud of this project with the partners. It has been, like a said, it has been inspiring to watch. Each jurisdiction had the two, we have a couple of the members here and so if you have any questions, I would defer to my colleagues if they wanted to add about this process.

Mr. Driscoll moved to accept the update. Mr. Dick seconded the motion which was approved unanimously.

---

13. Presentation, discussion and possible acceptance on an update of the public service announcement (PSA) project relating to the appropriate use of 911 (For possible action**)**
Heather Kerwin, on behalf of Brittany Dayton

Ms. Kerwin opened by acknowledging that Brittany Dayton met regularly with leadership from across the spectrum of organizations that might be impacted by inappropriate use of 911. Ms. Dayton was able to coordinate with leadership from hospitals, all of the jurisdictional EMS partners, as well as law enforcement, to come together for a press conference on April 23rd. The press conference provided the opportunity to talk about some of the issues in their specific jurisdictions, related to their jurisdictions and their component within the health system, and how inappropriate use of 911 impacts the system.

Multiple segments were shown on two local television stations and PSAs were aired on Tahoe News Broadcast. A total of three PSAs were received, one from Sparks Fire Department and Sparks Police Department, as well as Carson City Sheriff's Office. All three are available on the Health District web page and we'd encourage people to look at all three PSAs.

Vice Chair Dick moved to accept the report. Mr. Driscoll seconded the motion which was approved unanimously.

---

14. *Board Comment
Limited to announcements or issues for future agendas. No action may be taken.

Chair Slaughter mentioned his interest in getting some data on Burning Man. I'm really interested in the entire corridor during those periods of time, that corridor being Pyramid Highway, County Road 34 all the way to Gerlach, all the way to the entrance off of Highway 34. I don't know what the time periods are, but I would trust the staff to work on that.

Mr. Driscoll confirmed that we were going to have a follow-up presentation on Item Number 12, final presentation of protocols would be on our next agenda. So, just to make sure that that's on there.

---

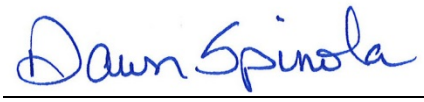
15. *Public Comment
Limited to three (3) minutes per person. No action may be taken.

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

---

16. Adjournment
At 10:45 a.m., **Mr. Driscoll moved to adjourn. Mr. Dick seconded the motion.**

Respectfully submitted,



Administrative Secretary

Approved by Board in session on October 5, 2017.