John Slaughter, Chair
County Manager
Washoe County

Kevin Dick, Vice Chair
District Health Officer
Washoe County Health District

Steve Driscoll
City Manager
City of Sparks

Bill Thomas
Acting City Manager
City of Reno

Dr. Andrew Michelson
Emergency Room Physician
St. Mary's Regional Medical Center

Terri Ward
Administrative Director
Northern Nevada Medical Center

1001 East Ninth Street, Reno, Nevada 89512
P.O. Box 11130, Reno, Nevada 89520
Telephone 775.328-2400 • Fax 775.328.3752
www.washoecounty.us/health

MEETING NOTICE AND AGENDA

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

All items numbered or lettered below are hereby designated **for possible action** as if the words "for possible action" were written next to each item (NRS 241.020). An item listed with asterisk (*) next to it is an item for which no action will be taken.

***1. Call to Order**

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

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

4. Approval of Agenda
October 6, 2016 Meeting

5. Approval of Draft Minutes
July 7, 2016 Meeting

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

***7. Program and Performance Data Updates**
Christina Conti

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

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

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

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

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

13. **Adjournment**

Items on the agenda may be taken out of order, combined with other items, withdrawn from the agenda, moved to the agenda of a later meeting; or they may be voted on in a block. Items with a specific time designation will not be heard prior to the stated time, but may be heard later.

The Emergency Medical Services Advisory Board meetings are accessible to the disabled. Disabled members of the public who require special accommodations or assistance at the meeting are requested to notify Administrative Health Services at the Washoe County Health District, PO Box 11130, Reno, NV 89520-0027, or by calling 775.328.2415, at least 24 hours prior to the meeting.

Time Limits: Public comments are welcome during the Public Comment periods for all matters whether listed on the agenda or not. All comments are limited to three (3) minutes per person. Additionally, public comment of three (3) minutes per person may be heard during individual action items on the agenda. Persons are invited to submit comments in writing on the agenda items and/or attend and make comment on that item at the Board meeting. Persons may not allocate unused time to other speakers.

Response to Public Comments: The Emergency Medical Services Advisory Board can deliberate or take action only if a matter has been listed on an agenda properly posted prior to the meeting. During the public comment period, speakers may address matters listed or not listed on the published agenda. The Open Meeting Law does not expressly prohibit responses to public comments by the Emergency Medical Services Advisory Board. However, responses from the Board members to unlisted public comment topics could become deliberation on a matter without notice to the public. On the advice of legal counsel and to ensure the public has notice of all matters the Emergency Medical Services Advisory Board will consider, Board members may choose not to respond to public comments, except to correct factual inaccuracies, ask for Health District Staff action or to ask that a matter be listed on a future agenda. The Emergency Medical Services Advisory Board may do this either during the public comment item or during the following item: "Board Comments – Limited to Announcements or Issues for future Agendas."

Pursuant to NRS 241.020, Notice of this meeting was posted at the following locations:

Washoe County Health District, 1001 E. 9th St., Reno, NV
Reno City Hall, 1 E. 1st St., Reno, NV
Sparks City Hall, 431 Prater Way, Sparks, NV
Downtown Reno Library, 301 S. Center St., Reno, NV
Washoe County Administration Building, 1001 E. 9th St, Reno, NV
Washoe County Health District Website www.washoecounty.us/health
State of Nevada Website: https://notice.nv.gov

Supporting materials are available to the public at the Washoe County Health District located at 1001 E. 9th Street, in Reno, Nevada. Ms. Jeanne Harris, Administrative Secretary to the Emergency Medical Services Advisory Board, is the person designated by the Emergency Medical Services Advisory Board to respond to requests for supporting materials. Ms. Harris is located at the Washoe County Health District and may be reached by telephone at (775) 326-6049 or by email at jharris@washoecounty.us. Supporting materials are also available at the Washoe County Health District Website www.washoecounty.us/health pursuant to the requirements of NRS 241.020.

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County Manager
Washoe County

Kevin Dick, Vice Chair
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Washoe County WCHD

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MEETING MINUTES

Emergency Medical Services Advisory Board

Date and Time of Meeting:	Thursday, July 7, 2016, 9:00 a.m.
Place of Meeting:	Washoe County Health District 1001 E. Ninth Street, Building B, Conference Room B Reno, Nevada 89512

The Emergency Medical Services Advisory Board met on Thursday, July 7, 2016, in the Health District Conference Room B, 1001 East Ninth Street, Reno, Nevada.

1. Call to Order

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

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2. Roll Call and Determination of Quorum

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
Andrew Clinger, Manager, City of Reno
Terri Ward, Hospital Continuous Quality Improvement Representative, Northern Nevada Medical Center
Dr. Andrew Michelson, Emergency Room Physician, St. Mary's

Ms. Harris 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
Jeanne Harris, Administrative Secretary, Recording Secretary

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3. Public Comment

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

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4. Approval of Agenda
July 7, 2016 Meeting

Mr. Clinger moved to approve the July 7, 2016 agenda. Mr. Driscoll seconded the motion which was approved unanimously.

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5. Approval of Draft Minutes
April 7, 2016 Meeting

Mr. Dick moved to approve the April 7, 2016 minutes with one correction. On Page 4, the second line should read: "being used approximately 30-60 days before they started the ILS, and then data showing". Mr. Driscoll seconded the motion which was approved unanimously.

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6. Election of Regional EMS Advisory Committee Chair and Vice Chair

Based on the frequency of the committee and where it is in its infancy, **Mr. Driscoll moved to maintain Mr. Slaughter as Chair and Mr. Dick as Vice Chair for another year for continuity purposes.** Chair Slaughter asked for any discussion. As there was none, **Mr. Clinger seconded the motion which was approved unanimously.**

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7. Program and Performance Data Updates
Staff Representative: Christina Conti

Ms. Conti highlighted the following:

- The Statewide Medical Surge Plan regional plans went into effect on July 1. This plan includes seven counties with the ability to go to nine, if the two other counties want to participate.
- Regional data meetings have been held and will be discussed in Agenda Item 11. The Oversight Program will be asking for direction on two different matters in that item.
- The Disaster Behavioral Health Tabletop Exercise was held in May. This is the first time in the region that there has been an exercise solely focused on the mental health component of a disaster, which is often the second part of the emergency to the citizens.

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- A full-scale evacuation exercise is currently being planned with partner hospitals.
- Ms. Conti discussed the concept of “scoop and run” with an NTSB representative who was involved in the 2015 Philadelphia Amtrak train derailment incident. The premise of scoop and run is that law enforcement is often first on scene, and if there are no criminal elements, there is a potential to utilize that capacity for a large-scale event with many casualties. The EMS staff already met with the Reno Police Department and is going to the Chiefs’ meeting to talk about their possible assistance during a declared MCI.
- EMS Oversight staff presented to the Prehospital Medical Advisory Committee (PMAC) on possible implementation of operational and clinical items they learned about at the conferences EMS staff attended. The presentation was very well received by the PMAC.

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8. Presentation to the EMS Advisory Board

- Ms. Conti reported on the revisions to NAC 450b (aligns with NRS for emergency medical services) and NAC 629. State of Nevada EMS is responsible for spearheading revisions that come from the Legislature. There have been several workshops on the NAC revisions as well as on their program policies and procedures. They are updating internal processes and adding new fees that may have some fiscal impact on partner agencies. They are also adding regulations for community paramedicine in response to recent changes to the NRS and are going to be updating several sections. Ms. Conti noted she would send this information to the board.
    - Training requirements for paramedics. Training requirements for Paramedic licensure are currently being worked through. Now that the region has community paramedicine, there is discussion about the type of training, whether individuals will be required to have extra training on top of what is currently required or will some of the trainings include both. This becomes a potential burden on some of the region’s EMS partners.
    - Air ambulance. This section includes the provision that the transport cannot occur unless it is deemed necessary by a physician, physician assistant or nurse practitioner. This has garnered a lot of discussion, because a patient may want to transfer to another facility, but the doctor may not agree with that. Also, for air transport, a signature is required, so that they know the patient is stable and able to be transported. This concern may not be valid, because a signature by someone will be obtained anyway. This part is still being worked through.
    - Investigation fines. State EMS conducts an investigation if someone calls and complains about a service or a licensed person. The change from the revision of 2014 is that if the investigation turns out to be substantiated, whoever was being investigated must pay a fine. The section does not list the amount, but Ms. Conti thought it would be the staff time used for the investigation.
    - Trauma Data Registry. The new regulations allow the Health Division or the State Board of Health to request any type of information, and the hospitals must comply. Ms. Conti reported that the hospital representative in the meeting was saying it does not work for the hospitals for this to be open-ended. They are happy to comply with anything that the Health District or the State Board of Health may ask, as long as it is tied back to a nationally-recognized benchmark data set.

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- o Voluntary healthcare service. The legislative session of 2013 put the voluntary healthcare service into NRS with regulations developed by State EMS. With this, anyone with a license from any state can practice within Nevada as long as they are associated back to some kind of health event. The first identified concern is that there is no local oversight over the healthcare workers that are in the community providing care to citizens. Another concern is that special events might try to utilize this regulation to bypass what are currently in the special events requirements of NAC 450b.

  Ms. Conti and the workgroup thought it would be beneficial to inform the Board of these changes.

- Chair Slaughter presented a recognition and appreciation of service gift to Chief Mike Brown, who recently retired. Mr. Driscoll noted that Chief Garrison, who is planning to retire in September, was unable to attend the meeting to receive his recognition and appreciation of service gift. Mr. Driscoll requested that Chief Maples provide the gift to Chief Garrison.

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9. Presentation and possible acceptance of an update on the progress of the implementation and utilization of Intermediate Life Support (ILS) ambulances in the REMSA service area.

Mr. Don Vonarx, Chief Operations Officer for REMSA, presented a brief update on the ILS program. He provided some background information on the history of using ILS ambulances for inter-facility transfers in October 2014. Last fall of 2015, REMSA began discussions with the EMS Oversight team and the regional EMS partners about using ILS ambulances for low acuity and no-acuity 911 calls. In February, they decided to table that due to some concerns from their EMS partners, and no other action was taken. He clarified that ILS ambulances are used only for inter-facility transfers, and there are some cases where they are called as a second resource to scene. For example, the last one occurred when their ambulance was damaged on scene by another motorist, and they could not transport in that ambulance. An ILS ambulance came in, and a paramedic crew got on and transported to the hospital. Sometimes they are called in on those very unusual circumstances, and ILS is not doing primary response to 911 calls.

At the April 7, 2016 EMS Advisory Board meeting, REMSA was asked if they were supplanting or removing ALS unit hours and replacing them with ILS. He stated they are not doing that. On April 17, 2016, REMSA added five additional ALS shift lines at 240 hours a week, as well as two additional ILS lines at 96 hours a week. The system is growing 8% to 10% a year, so REMSA is always increasing the unit hours to keep up with this growth. He reiterated that REMSA does not take away ALS unit hours and replace them with ILS. They have actually considered the ALS to be the 911 emergency side and the ILS to be a kind of separate business as inter-facility non-emergent. At the communications center, it is actually separated out for efficiency.

Mr. Driscoll asked Mr. Vonarx about the financial impacts to the community. Since the ILS units use lesser-qualified individuals, theoretically at a lesser cost, is the transport rate at a lesser rate than what it is currently, which is assumed to be ALS rates? Mr. Vonarx explained that it is somewhat driven by the level of certification or care of the ambulance, but

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mostly by the medical necessity of the patient. The majority of these inter-facility transports would meet what is called the Medicare EMT basic non-emergent rate, which is paid at a lower rate than the ALS rate. Dr. Michelson asked Mr. Vonarx if in the cases when they have an ILS step in, yet there may be advanced paramedics doing the transport in an ILS rig, do they bring their paramedic bags or stock in the same way. Mr. Vonarx replied that the three primary pieces of equipment that a paramedic brings are the cardiac monitor, the first-out bag with ALS drugs and an airway kit. The ILS ambulances have the cardiac monitor too, but they would use it in the AED mode, as they do not do cardiac monitoring. Dr. Michelson asked him if it is all portable, and Mr. Vonarx responded that it is, by design.

Mr. Clinger moved to accept the update on the progress of the implementation and utilization of Intermediate Life Support (ILS) ambulances in the REMSA service area. Mr. Driscoll seconded the motion which was passed unanimously.

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10. Presentation, discussion and possible acceptance of a presentation regarding the conferences attended by the EMS Program staff.
Staff Representatives: Ms. Conti, Ms. Dayton and Ms. Kerwin

Ms. Conti provided a presentation on the EMS Today Conference that she and Ms. Dayton attended in February. They each attended 15 different trainings over a three-day period. There were 150 trainings available, so they selected those that would be beneficial for EMS oversight and educational for upcoming topics in the region. She highlighted several of the trainings:

- Data usage session. The premise of the session was to look at something over a long period of time, which allows one to see what is really happening in the process, rather than picking out one single data point and reacting to it. The speaker was advocating for the entire process improvement. The EMS Oversight program is of the opinion that a regional implementation of this may be possible.
- Active bystanders. This is not a new concept, it is just being formalized. The concept is that bystanders are going to act if they happen to be at an incident and can help if they are trained and provided with the tools. This is an initiative coming out of ASPR stating goals for becoming resilient and healthy communities and for being a prepared nation. EMS Oversight staff is of the opinion that an active bystander program could be implemented in this region, and they recommend starting a program in the rural areas of Washoe County where bystanders could be critical for a response. Ms. Conti stressed that the bystanders would be there by circumstance and not deployed in any way.
- Terror attacks in Paris. Paris has a two-tiered system with BLS and ALS, but their BLS includes firefighters and first aid workers, and their ALS includes nurses and doctors. They also have private ALS resources in the system. Paris has a call center like the one in Washoe County, but it is staffed with doctors and a nurse. Paris encompasses three different regions, and they have an expectation of seven minutes from the time the call comes in to be on scene. The attacks happened on November 13 in seven different locations with 130 fatalities and 352 casualties of which 100 were critical. Ms. Conti noted that the challenges included things she had not thought about before. For example, victims hid in surrounding buildings, so that resulted in a search and rescue component. The hot zones where people could not go in or out included SWAT team members and medical personnel. It helped them to have two multi-casualty incident plans. They have the red plan, which is the normal mass casualty plan and the Alpha plan which is for

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multiple locations and triple the normal number of casualties. They have damage control kits, but not on units. The kits are placed throughout the city, which ended up really helping them when they could not get in or out of those zones. They utilize businesses as triage centers to get people out of the cold and off the street. They also focused on the evacuation of patients, which is part of their Alpha plan. They do not do much on scene and maximize the evacuation to get patients to the hospitals. The presenter stressed the psychological health of EMS responders, especially in a large disaster.

Ms. Conti advised that for regional implementation, the EMS Oversight Program would like to build out the region's current plan exponentially to be more like an Alpha plan. The Program also thinks it is critical to fund the bar code tracking for patients. Also for possible regional implementation, the Program recommends creating damage control kits ready for an emergency that can be placed around the community in fire stations, law enforcement substations and other static locations.

Ms. Dayton reported on several sessions she attended at the EMS Today Conference:

- Navy Yard shooting that occurred in September 2013 in Washington, DC. There were 12 fatalities and several severely injured. The presenter was one of the incident commanders. He reported on lessons learned, including staging for EMS, having specific areas for EMS and responders and communication issues. The ten agencies responding were filtering up information through their agencies, but it was not getting back to the Unified Command, which prevented the Incident Commander from making quality decisions. Afterwards, the presenter implemented triage days for first responders to practice their communications and have more experience using the MCI tags. Ms. Dayton noted that this region is fortunate to have an MCIP where first responders are required to have continued training. She recommended having triage tag days and creating an MCI scenario where responders would have the opportunity to communicate with other agencies and use the tags more frequently.
- Standardized scenarios. Ms. Dayton attended a presentation given by the coordinators of a paramedic program from a community college in Boston. These coordinators promoted a program using standardized scenarios, because they thought that would lead to long-lasting knowledge and improved performance once students get out of school. The students wrote the scenarios. There were preceptors who had the setting controlled, and they went through the entire process, including being dispatched as if they were on a real call. Ms. Dayton presented their example of a heat stroke incident where the person has a seizure and goes into cardiac arrest. Ms. Dayton recommended standardizing the scenarios in our existing Fire/EMS training and having the students write the scenarios so that they have buy-in into the system.
- National protocols. The Medical Director of Utah presented the idea of national protocols for care and establishing uniform measures. Several medical directors in the country developed national guidelines for care. Regional protocols are a potential EMS Strategic Plan objective, so the Program presented to the PMAC the possibility of their group developing regional protocols for the agencies in this region, and these guidelines could be used in situations where the protocols may differ.

Ms. Kerwin presented highlights of her attendance at the Council of State and Territorial Epidemiologists Conference in Anchorage, Alaska. She attended over 60 presentations over 2-1/2 days. Some of the sessions were related to the national opioid epidemic. One of the major recurring themes of sessions she attended was that this jurisdiction could improve in developing or expanding syndromic surveillance.

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Syndromic surveillance is very useful in monitoring non-infectious conditions. Monitoring is done to find trends that will result in action to improve public health. The region's syndromic surveillance software program in use since 2007 has the capacity to obtain hospital and emergency room patient data including ICD-9 and 10 diagnostic codes to evaluate what a patient was seen for and/or discharged with. It does take the chief complaint and includes basic patient demographics. This would look at connecting annual aggregate data of certain conditions that are impacted by response times, having the full feedback loop, and linking that dispatch and responding agency information with the hospital outcome side.

Mr. Dick made a motion to accept the presentation regarding the conferences attended by the EMS Program staff. Mr. Driscoll seconded the motion which was passed unanimously.

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11. Presentation, discussion and possible acceptance of an update regarding the regional fire partner EMS data and provide direction to staff regarding the content of future data reports.

Staff Representative: Ms. Kerwin

Ms. Kerwin stated she would present the fire partner EMS data update and topic of moving forward with the data. She reported the presentation would include two major sections, the first being the update on the data since the last Advisory Board meeting and the second on how the Oversight Program would like to move forward with the data in the report's content.

Since the last meeting, the Oversight Program held a regional data meeting with their partners, including IT, Dispatch and Fire personnel. She believed that all of the Board members received summaries of those regional data meetings. The first meeting resulted in the agreement that the CAD data was the best source of data and that the CAD data would be reported to the EMS Program.

A CAD data report was developed by the Washoe County Sheriff's Office for all three fire jurisdictions and was sent to the jurisdictions. The CAD data for April 2016 was then compared to Fire RMS data to determine the usability of those CAD data reports. The jurisdictions the forwarded the CAD report to EMS oversight. The jurisdictions did report back some findings, and Ms. Kerwin outlined some additional anomalies found when she reviewed the CAD to the Fire RMS.

The first anomaly she found was also found by their partners who came to the same conclusion that there are certain pockets of calls in the CAD; CAD does contain all the data. The CAD reports were created to filter EMS calls only. Ms. Kerwin noted that when she refers to the CAD data report, that was the preliminary and only filter used on the CAD data. 88.6% of Fire RMS calls for April match to a CAD call across the region. The explanations and recommendation related to that is that this first set of calls, those CAD EMS calls that were not in the RMS data reports, include call types 550 (public assistance call) and 554 (lift assist). The CAD does designate that as an EMS function, however they have been receiving 300-series calls and 600 are cancelled en route, 611 calls from RMS, so that was not a pocket of calls they typically receive. Another reason cited for some of those EMS calls not being in those RMS data that they typically receive is because of cross-jurisdictional changes. For

example, if a call initiates in TMFPD's jurisdiction and it is determined later that Sparks Fire Department will be responding, the CAD references then two separate jurisdictions with their own incident numbers and it might be an issue of the CAD programming, the interface language, not knowing what to do with the null or an exception, or what happens when there are two incident numbers referenced. CAD might not know whether to deliver that data or dump that data into both jurisdictions' RMS. Ms. Kerwin noted she was unable to speak to what happens to that call data at that point. For the other set of calls, there were Fire RMS calls that were not in the CAD RMS report, because primarily there are other functions that when a fire department is dispatched, their primary function might be extrication, or an accident or injury, or handled by another jurisdiction, etc. Those are the categories that were outside the filter that was applied to the CAD data. The recommendation would be to submit all fire calls from both the CAD and Fire RMS to ensure a complete representation of the EMS system.

Ms. Kerwin reported on the second issue. Her presentation showed an illustration of how the variables align from the CAD to the RMS. The initial time stamp was 100% match across the board. The CAD does have the ability to provide the entered date time stamp, which has not been available in Fire RMS, so that was not available for comparison. The dispatch time stamp in the CAD was 100% match with the alarm time stamp in Fire RMS. When you compare the dispatch time stamp from the CAD to the dispatch time stamp in Fire RMS and the subsequent variables after, there is less than a 100% match. She noted they are not as concerned with the closed or the clear times. This has been an issue that was identified by the Washoe County Sheriff's Office and they are pursuing a resolution of that. For the other areas that are highlighted there circled in red, when those do not line up 100% to one another, they are not sure what is being pulled into Fire RMS every time. The overall issue would be that the CAD and Fire RMS data should reflect identical incident level time stamps to ensure that valid data are being utilized to make the data-driven decisions. Jurisdictions do submit CAD data for the ISO accreditation, and those are just fire calls, not necessarily EMS. They also do submit Fire RMS data to NFIRS, and they utilize the Fire RMS system to provide data and information back to their Councils and the general public. The regional fire jurisdictions have the upgrade or switched CAD systems to Tiburon. She noted that it might be time to evaluate that interface between the systems used to query that Fire data. That is the Oversight Program's recommendation for that second issue.

The third issue in their findings is the calls cancelled en route. Half of the calls shown to be cancelled en route in Fire RMS were reflected as having an arrival time in CAD. There are absolutely legitimate scenarios for when this might occur. One of the possible explanations is that the arrival time can be logged into the CAD by either dispatch or Fire, but then that Fire Captain has the ability to change the final call disposition as cancelled in RMS. Another example of when this might occur is that if a different jurisdiction was the first to arrive on scene, the CAD would capture that as the initial arrival time, but the RMS for the other jurisdiction would not necessarily contain that line of information. The recommendations for this would be to standardize dispatch and Fire personnel across the jurisdictions. Ms. Kerwin reiterated the recommendation to submit all fire call data from both the CAD and fire RMS with the purpose of the Oversight program being able to identify, what the final disposition on that call was for the jurisdiction.

Ms. Kerwin reported that their next steps are that they are still recommending that the CAD data be submitted. Their change to this initial recommendation would be to include all

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Fire calls, not just the filtering of EMS only. However, utilizing CAD data will limit the types of analyses available. Ms. Kerwin noted that her presentation slide showed a basic high level of the analysis previously conducted and whether or not they want to continue including those in their reports. She wanted to illustrate with using only CAD data, on the next slide, the analyses that are impacted, without being able to append Fire RMS data. The Oversight Program's recommendation is to submit all Fire RMS calls, which allows Ms. Kerwin to take those incident level Fire RMS variables that are not available in the CAD reports and append them to what she would call the master data set, which would include the time stamps from the CAD and other variables, such as what the final disposition of the call was, the fire priority (Sparks has a priority 1 and 3; the CAD reports did have fire priorities, but it showed 1a all the way down for all jurisdictions, so it is not very telling), land use codes, and eventually the EPCRs.

Ms. Kerwin reported that in terms of their future report contents, the Oversight program would like to organize the report into three sections pertaining to the functional groups. In the EMS system, this would include the dispatch, the response agencies and, in addition, the emergency department data. As a reminder, without an identified metric, performance measurements are challenging to assess. Again, there is a limitation on measuring overall response times and/or response times by call priority or land use with just the use of CAD data. She noted that she would pause there to allow the Board time to discuss and direct either jurisdictional staff or her in terms of resolution of the data, because this will impact the second part of decisions.

Mr. Driscoll thanked Ms. Kerwin, noting that obviously she is getting into the detail and that the analysis that she is providing is wonderful. He stated he understands the difficulty between trying to link some things up. He noted that as they talk about going forward and looking at performance data, one of the things that has been discussed is that performance for each of the three major jurisdictions could be potentially different based on what their jurisdiction is kind of holding themselves accountable to. One may be a certain set of response times, based on definition by that organization. Others may be based on standards of care. With the Program's proposed going forward, he asked would each jurisdiction be able to have, because the data is the data, but as far as analyzing the data and coming to performance metrics, would there be basically a triad of information where Sparks' data would be measured against what they define Reno or TM, so each jurisdiction can do what their elected body is holding their fire providers as a standard. Ms. Kerwin responded that is absolutely fine to measure each jurisdiction according to the parameters that they have and their performance measures that they have adopted. The challenge then becomes when they want to make a regional assessment and a regional decision based off of performance, and okay, we want to reach this goal, how do they then measure that across the region. The Program is more than willing to measure agencies against the performance measures that they have set, but the challenge does remain with measuring a regional benchmark.

Mr. Clinger noted he appreciated the work they have done, and that the data and analysis is phenomenal, especially compared to a year ago. He asked Ms. Kerwin if they have worked through these recommendations with each of the jurisdictions. Because seeing this presentation for the first time and seeing their recommendations, it seems to him, if there has not already, that there needs to be some discussions with the jurisdictions as to these recommendations, maybe a working group to look at these things and bring back some recommendations. He guessed that his first question was have they worked with the different

jurisdictions on these specific recommendations. Ms. Kerwin responded in the affirmative, explaining that the second data meeting they had after the initial decision to use the CAD data, and after they and the jurisdictions had a chance to review it, it was expressed at that meeting that the partners thought there would be value in exploring the interface mapping. As far as what has happened after that meeting, jurisdictions may have conducted further analyses that would result in a different opinion, but that was the consensus from that second data meeting. Mr. Clinger opined that some of these decisions are easier than others, as far as providing the CAD data and providing the RMS data. Some of the other ones are a little more complicated, and he expressed to the Chair that he was not sure he was in a position to make a decision on those, without potentially hearing from the different jurisdictions, but maybe even it would be a working group, working through some of these issues.

Ms. Conti explained that one of the things for part one is that they are recommending the continuing of looking at the interface, because all the analysis was on the reports from the agencies against itself. They do not feel like it is a best practice for it to not be at 100%, from wherever you pull it, that it should always match itself for that agency's decisions. The CAD data and the RMS data allow the Oversight staff to continue in what the Board has asked them to do, as four of the eight ILA duties are data associated. This is sort of a workaround from that part of allowing the Oversight staff to have all calls to be able to continue to do their jobs for the Board. For the first part, she would say, if the Board is not comfortable with making a decision right now, it can be pushed back down to the jurisdictions.

Mr. Clinger said he had a follow-up question that maybe was for both staff and the Board as well. He asked if the goal is to have a 100% data match. He asked how much resources they want to spend trying to chase down that last eight to three percent. He asked if the goal is 100% data match or are they satisfied at 97%. Ms. Kerwin clarified that this was not a data match to the REMSA calls. It was a data match to their own, just two different software systems, basically to themselves. Ms. Conti noted that it is a decision that the Board needs to make, but obviously their recommendation to the Board from a jurisdictional perspective and to the public that wherever you pull your data should always match, where you pull it from somewhere else, if it is the same call. These were incident-level calls, so it is the same call, just pulled from two different software systems. The EMS staff believes that a best practice is that for its own data, it should match 100% to itself. Again, the call closed with something that was identified a long time ago by the Sheriff's Office and the Tiburon work ticket is in there. But the staff believes a best practice is 100% for its own data to match itself. However, they will defer to the Board on what they find to be an acceptable percentage.

Mr. Dick followed up on Mr. Clinger's comments. He stated that from his understanding of this and from what he heard Mr. Clinger say, it sounds like they have a solution that is available as far as the data analysis goes, of providing the CAD data and the Fire RMS data, and they can put that together and get a pretty comprehensive picture between the two of those. He agreed that is a decision they could make to move forward. He shares the concern, though, that has been expressed about if they have data coming in to the Fire RMS and they know it is not pulling properly from the CAD data, it is something that should be worked on and should be fixed. He also wanted to comment on what Mr. Driscoll was speaking to regarding the different standards that various jurisdictions may be measuring their performance against. Mr. Dick noted he thinks it is possible to show how they are doing against those standards as well as looking at how they are doing against other national standards, perhaps, if they want to look at how they continue to improve the performance. He

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wanted to remind the committee members that the Interlocal Agreement does task the regional EMS Oversight Program and the committee with developing and making recommendations about regional performance standards. While they may have some different standards that exist within the various jurisdictions, he opined that their goal going forward needs to be how they develop some regional standards, so that the care that somebody has in an emergency incident is consistent throughout the region, whether they are on one side of the Reno-Sparks border or the other. He noted he does acknowledge that there are different areas within the County that are far flung from urban areas, and he thinks they need to be looking and considering those within the response. While they need some consistency at looking at how the standards are regionally, that does not mean he is saying there should be one uniform standard that covers the entire geography of Washoe County. He stated that those are his comments.

Chair Slaughter noted he was seeing some reaction from some of the regional partners, and requested that maybe just one of the fire chiefs represent the group to give some input and observation. Dennis Nolan, EMS Division Chief of the Reno Fire Department, requested that Ms. Kerwin go back to her first presentation slide that demonstrates the actual call times, so they can understand this, because sometimes he thinks that this can get a lot more confusing than it really is. He noted that first of all, he would like to acknowledge on behalf of the fire agencies, the work that the staff has been doing, and the mission that they have, they share. He opined that, although he is a newcomer, he knows that the EMS and fire agencies strive to provide the highest level of care in the most expedient amount of time. That is what they do, that is what drives the agencies, and that is what they are here for. That has been a function of them since their inception. The data is absolutely essential. He stated they would love to have 100% matching data across the board, in all instances. He opined that it would make everyone's job a lot easier, especially as they internally look at their own data in order to try to drive improvement within their agency. When a call comes in, the times that are seen on the left is date stamped into the CAD system by the PSAP operator as the incident created. The call then goes on to have notification made to crews. Crews then go in service and are dispatched. They arrive on scene. All those times are date and time stamped, including the time on scene, the time that they are done at the scene and return to their stations. So these are identical times which are all stamped into the CAD with each of the agencies. The Fire RMS is separate software that the agencies use, which the CAD downloads those times into. There is an interface between them. They currently are using Tiburon, although the Reno Fire Department is shifting to a Zoll hosting service with their new electronic patient care reporting that is going to change some of this data. There has been a variance that has been identified between the CAD numbers and the Fire RMS numbers, and that is anywhere between a 1-9% difference in numbers at different parts of this time. What has been identified, and they all agree that there has been this difference that has been noted, this variance that has been noted, and they started sitting down to try and analyze the data.

Chief Nolan continued by stating that the fire partners have been involved in discussions with the staff all along, and what they have determined is that there is an almost infinite number of combinations of variances or exceptions that can occur that are responsible for this percentage in differences between the CAD data and Fire RMS data. He stated we could stand up here all day and tell you why these different things occur, but there are so many potential exceptions that happen, at some point in time they can really get into the weeds and try to correct all these variances or sit back and take a look at the big picture, what are we collecting the data for. Ultimately, in emergency medical service, the data should be collected for

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improving patient care and patient outcomes and improving the response times of what services and what resources we have for those patients. That is something that they have been doing maybe not to the degree that their staff has developed, but collectively and individually, the agencies have been doing this, again, since their inception. So, the big question comes is, how much does this percentage or this variance really make a difference. Is it a driving factor in the response times of our agencies to the patient, or is it something that would drive improved patient care? Their assessment is that it would not; this 1-9% difference between CAD and Fire RMS really is not making a difference in their response times. You can take the CAD times, which are true incident times, those are the actual times that things happen, and they can take a look and can say how long did it take for them to get paramedics, or EMTs or whatever resources they have to this patient and how long were they on scene with this patient. So they can take a look at the CAD times and get that data. He noted he was not sure how much the Board had been made aware of, but the fire agencies had recently collectively submitted a letter to Mr. Dick and to the staff and had indicated that they are spending such an inordinate amount of time and resources. He knows the City fire department has seven people who are working on this issue between IT and EMS in various capacities to try to correct this mismatch of 1-9%, and ultimately, their feeling is that if they just use the CAD data, that is enough data to tell them what their response times are and what their resources are getting to that patient. They think they can use the CAD data as opposed to trying to correct this problem with the Fire RMS. So he thought that going back to the drawing board, sitting down with staff again, and maybe taking that approach is the best approach to resolve, at least in their opinion, in how to resolve this issue.

Mr. Clinger stated he just had a quick question for the Chief. He noted that Chief Nolan had stated that he would recommend using the CAD data, but he guessed the question, because in the part one of this would be to submit not only the CAD data but the RMS data, not necessarily match it up, but at least submit both data sets. He just wanted to make sure Chief Nolan felt there was value in submitting both data sets. Chief Nolan began to respond, but Ms. Conti interjected that they would match it based on the incident number but use the time stamps from CAD and the other valuable information from RMS that is not available in CAD. Chief Nolan agreed, and Ms. Conti stated it would match, but the CAD time stamps would be used. Chief Nolan responded that they have no problem with providing them with any of the data that they are looking for. They can provide them with the CAD data and the RMS data, the raw data to create the analysis that they are looking for. He did not think they are proposing to have them add additional man hours or staff. This is something that they would like to do. He stated he did not think they had a problem with the Fire RMS data, but at this point in time, trying to correct the mismatches is what has been causing a lot of consternation amongst the fire services. Mr. Clinger stated he wanted to follow up on the data matching. He thought that as all of them sit there, they would all like to have a 100% match. But for him, where you can fix what he would call the sort of systematic errors where they can identify that there is this systematic glitch that is causing them not to match up, he thought where they can fix those, obviously they would want to do that. But where they have these one-offs, and he believed Chief Nolan said there were an infinite number of possibilities of why the data may not match, he did not know if it was worth it to chase down every single one of those. But if there are systematic issues that they can identify, they would want to correct those. Chief Nolan stated they would agree with that.

Mr. Dick stated he guessed he agreed with what Mr. Clinger was saying that they do not want to throw infinite resources at something if the value is diminishing returns. But he

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expressed some confusion in that in a few meetings ago, they did not finalize a report because they were told that the data was bad. Mr. Dick asked Chief Nolan if that is the same bad that this 1-9% is that he was telling them today they do not need to worry about. It was a whole different picture a few months ago, he thought. Chief Nolan responded that he thinks bad is kind of a nebulous term. The data as stated today, is not necessarily bad, but there is a mismatch. Initially, at the last meeting they had, they were not as tuned in to where that mismatch was occurring. He thought that initially all of them were saying there was a potential problem there, that they were getting Fire RMS data that was not marrying up with the CAD, and why was that occurring. So, there was a lot of analysis done since then. One example might be a call that any location, XYZ, you dispatch a resource and on the way, a close resource becomes available that was on a call, and now says "Engine 1, we are now free, we are right around the corner from that call, we can respond." They say "Go ahead and take the call" and that same information is relayed. The dispatcher will say, "Okay, copy that, Engine 1 you are returning, Engine 3 is now assuming the call." So, that information is going to be entered into Fire RMS and there is going to be a new call signal for the second unit dispatched to the same original call. You can probably understand, that because now you are using two different data systems, how that would look initially confusing. Although the response time was improved, the initial time from the time the patient called to the time the rescue unit or fire engine, or whatever resource was dispatched, is actually better than it would have been. But that is one very simple example of how some of the data becomes mismatched between CAD and Fire RMS. Like they said, there are dozens and dozens and dozens of different examples like that. So, it is not that the data was really bad, it is just that they could not really identify, and still cannot identify, all the different causes of that, let alone some of the CAD-to-CAD interface IT issues that might occur.

Mr. Dick asked Chief Nolan if moving forward with pulling both the CAD data and the RMS data, those both being provided to the Program, and the Program matching them, was he satisfied that this would give them a good picture. Chief Nolan said he was unable to say 100%; there is nothing 100% today in this, that it would completely satisfy everything they were going to need. A lot of that is going to be coming from staff and exactly what they feel they need to accomplish their mission. And it is really not just their mission. It is all of their mission to improve better response time, better patient care. He stated they will continue to provide them additional data that they need, and continue to have discussions with them with what works. In this one particular example, they have sort of hit a wall with the amount of data they can provide the Program and in what fashion they would like it provided. At this particular time, they would be happy with giving the CAD data and then giving whatever raw RMS data they are asking for.

Mr. Driscoll asked Chief Nolan, and noted this may be for staff as well, if since the amount of data that is linking up has such a small variance, are there any statistical variations in the data collection that is causing concern on the ability to provide proper patient care, or is that information causing us to not change protocols that would properly change outcomes to the region's patients. Chief Nolan believed he could answer that question by saying no, and explained that the data that they are collecting right now, when they look at response times internally, and the data they are providing them, they are trying to get within the national standards which, at least in talking with Reno Fire Department, match up with the NFPA standards and with national response time standards with getting medical resources to a patient within 6-8 minutes 90% of the time. They monitor those response times very closely. They monitor the types of calls they are responding to, the level of priority, and, of course,

they want to try to match the right resources, the advanced medical care with those patients that are Priority 1s and Priority 2s. The data they are collecting, they are doing their best to match the resources they have to those patients. They think the data they are getting is giving them the ability to do that.

Ms. Kerwin said from where she stands now, she would not be able to answer Mr. Driscoll's question. She stated she would not be able to speak to whether or not these discrepancies are going to ultimately impact patient care at the end of the day. She noted that regarding his comment about protocol standardization across jurisdictions, this mismatch may be, there are instances that have been identified, and Chief Nolan was talking about that there are a multitude of instances that were identified with these different discrepancies. But there might be protocol-related instances that could be improved upon. She asked Mr. Driscoll if that answered his question. Mr. Driscoll thanked her.

Chair Slaughter noted he was not quite comfortable yet, because last meeting they thought they would be here at this meeting with a solution, that, at least, not all of the partners maybe did not necessarily agree with or were there, but they were at a point where they could say we can move forward. He said he was not hearing that yet. Ms. Kerwin asked if he was referring to the mapping, because there are multiple areas of that. Chair Slaughter responded yes. She asked him whether it was the interface mapping or related to the data receipt. Chair Slaughter responded that it was the data. Mr. Dick said he was prepared to make a motion for discussion. Ms. Conti noted that what she thought she heard Chief Nolan say was that there is consensus on them giving them the data. She believed the point of would the jurisdictions continue to evaluate the interface is where the uncertainty comes in. From the Oversight Program perspective, they recommend to the jurisdictions that it is something worth looking at, but they have identified the workaround, and it appears that those partners, based on what Chief Nolan said, are comfortable with that workaround.

Mr. Clinger asked the Chair, at least for the City of Reno, if staff could come up to maybe address the question of the interface mapping. He noted he thought they are in agreement with the second two bullet points and thought it is just the first one they are getting hung up on. He stated he is just curious where they are for the mapping.

Rishma Khimji, Assistant Director of IT at City of Reno, reported that they looked at the data matching based on the four criteria that were provided to them by the Health Department at the June 14 data meeting. What they found is that there are multiple causes that allow the interface not to provide a 100% match from CAD to RMS. The percentage to us is a small percentage. Those were due to training issues, institutional issues, maybe the way the calls are entered, dispatch close situations where it is a human element in part of that interface. She asked if the interface is going to match 100%. She responded absolutely not and there are going to be exceptions. She suggested maybe they need to build an exceptions report that can then be evaluated. But being such a small percentage, they are not sure it actually relates to the entire regional view or picture of response times, close times, times that the firefighters and EMS are on site with the patient. She stated that when they look at the mismatches, a lot of it, again, is due to, could have been the dispatcher closing up call inappropriately or ahead of time before they are told to go ahead and close the call. It could be due to different agencies responding to the call. And so you have Agency 1 taking the call transferring it to Agency 2. That separate agency then has their own call times, situations like that. It could also be due to the fact that the RMS call times can be changed once the firefighters are in the

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RMS system. They have absolutely seen evidence of this. It is when the EMS provider feels that they left a call a little earlier or a little later than what was reported to dispatch. So they will go in based on their paperwork and change that EMS time. If they cancel the call en route, they will go ahead and remove that on-scene time, because dispatch will clear the call and then close the call. But in Fire RMS, those call times are transferred over, the EMS provider saying, no, they were not really there, so they are going to remove that time from Fire RMS, because it does not accurately reflect their response to the situation. So there are these small institutional issues, training issues that they feel are present, they understand they are present. Maybe they could do more training to alleviate some of these exceptions, but with the human element, putting in the data, actually recording the data, there are going to be mismatches. Either they can account that there are these exceptions and they can look at what to do to make those exceptions better, but they have to allow for the system to have their exceptions so that they can then look at the regional picture as a whole without saying they need a 100% match. She didn't know if they would ever get that, or did not think any institution in the world is ever going to say they have a 100% match on any types of data collecting they do. That is why statisticians use samples. They look at different issues that happen to the data. So she would ask the Board what can they do to either evaluate the exceptions on its own and then come back with recommendations, or to say these exceptions are outliers that have no representation of the regional view of what we are doing on the EMS side, and then look at that picture itself. She stated that they are absolutely comfortable with the interface. A 90% match of data shows that the interface is working 9 out of 10 times. There is that one time where there is an exception, and they can either acknowledge it or say it is not relevant to their regional view.

Mr. Dick stated he had a motion for discussion. **Mr. Dick moved that they have the jurisdictions provide all fire call CAD data and all fire call RMS data to the Oversight Program for their utilization, and that they allow the jurisdictions to evaluate what they think is a reasonable approach as far as any changes to the interface or training programs, etc., as have been discussed. And as far as a standard, he proposed that they move forward with presenting the data with how that performance compares to any local standard established by the jurisdiction as well as national program standards, but also recognize they need to move forward as the Advisory Board with a recommendation on the regional standards.**

Mr. Clinger mentioned to the Chair that he had a question on the motion, just to clarify. He said Mr. Dick stated on the CAD data, all fire data. He asked Mr. Dick if he meant all EMS data, or did he mean all. Ms. Kerwin responded it would be all. The initial CAD report that they did this comparison of had the initial filter of EMS. She pointed out in her presentation slides three of the second set of fire RMS calls, not in CAD, that is because that CAD report was filtered with the primary function as EMS, however, they realized through reviews with the jurisdictions that there can be other primary functions selected, and not EMS, so it would be all for both. She asked Mr. Clinger if that clarified for him. Mr. Clinger replied yes, it did. Ms. Conti noted that that is also where the use of RMS comes in, because RMS is what the final disposition of the call was. So that was something that their partners had found, that RMS more accurately depicts what the call is. When the call comes in, its chief complaint by the citizen, and so they have in the CAD just a small number of things that they can choose, whereas RMS then gives them the ability to have it be what the call truly was. By making that master data set, they can drop all those that would not be relevant to regional analysis.

Mr. Driscoll seconded the original motion. Chair Slaughter noted that the motion has been made and seconded.

Mr. Driscoll noted that the clarification on all the data and having the filters make more sense to him. He said he also appreciates wanting to move to some agreed-to regional standard. However, he thought it will be very important, that while that may be the ultimate goal, and it may take them awhile to get to an agreed-to standard for certain things, that because the data is the data, and each jurisdiction has performance standards that they are relating themselves to as far as response and some other things, that by defining those standards by the jurisdiction, measuring those, that is just math. He noted that he understands that. He noted that he appreciates that is a little more work for them; actually, it is a lot more work for them in a lot of ways. But he stated he thinks it is very important until they have a consensus that they are working under different policies from their different elected officials that they have developed standards on. So if they are going to do performance measures for at least awhile, it should be individual, and then an ultimate goal of having some measurement that they would look at regionally is not unreasonable. But it should not conflict with the elected officials' policy and directions to the individual jurisdictions.

Mr. Clinger requested that City of Reno staff speak. He said that based on their reaction to the submittal of all fire data, it appears there may be some concerns, and he would like to hear what those concerns are. Chair Slaughter agreed, that he would also like to hear from City of Reno staff.

Ms. Susie Rogers, Assistant Director of Public Safety Dispatch for City of Reno, opined that the concern with providing all fire CAD data is that not all fire calls have anything to do with EMS. She stated she thinks a more appropriate request might be all EMS calls and then any other calls where there is a patient, because they can go on a fire hydrant service call and end up with a patient. She thought that maybe any time a patient becomes involved, that those calls be sent over. They would have to figure out a way to do that, but she did not think it would be too hard to do with the technologies they have now. She opined there is just a concern that while medicals are the vast majority of what Reno Fire Department does, it is not all of what they do. She also noted that they talked a lot about the 1-9% discrepancies in those calls. She opined that it is important to note, so that the Board is aware, of that 1-9%, 100% of that 1-9% of those calls has been confirmed or has been verified with Reno on why the exception has occurred. While there are hundreds of different options/exceptions that could have occurred, the vast majority have to do with REMSA cancelling them as they were arriving on scene, or the first unit was dispatched but the second unit was closer so they took the call in turn, or those types of things, or they got cancelled while en route or cancelled after marking arrival on scene. So she just thinks it is important to note that 100% of those discrepancies have been accounted for, looked in to, evaluated, and accounted for, and understandably so.

Mr. Driscoll requested clarification. He stated he did not understand why dumping all the data into the system is an issue when they are going to filter it for certain things, and then understanding that if there is a secondary code that they can filter to that is EMS related, that would seem to him to be a reporting mechanism on the back side versus just having all the data available up front versus screening the data before you dump the data in. He reiterated that he does not understand, and someone would need to educate him a little bit on his

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difference. He asked if dumping the data is just pushing a button. Ms. Rogers replied that for them, it is not even pushing a button; those are reports that are automatically written and already exist. Ms. Khimji opined that the issue is really, they would like to do the filtering to provide… Chair Slaughter interrupted and asked Ms. Khimji to identify herself. She replied she was Rishma Khimji, City of Reno Assistant Director of IT, and opined that for them, the issue is that the agencies would prefer to do the filtering of the data and then providing it to the Advisory Board, instead of the other way around. It just gives them knowledge that they are sending EMS data, patient data, and then they can maybe meet up again with the---they have these data meetings with them anyway--- and say ok, what else are the outliers that they are not receiving, and then make that report available and construct it that way instead of dumping it all to them. She opined that it is just an agency preference to say they want to be able to control the data that they are sending out based on the filters that they need.

Chair Slaughter stated he would like to hear from Chief 1 on this issue. Chief Moore, Truckee Meadows Fire Protection District, stated he was in complete agreement with his colleagues that he does not think there is a problem with the data; the problem is in the analysis, which is very complex. He stated he favors the ability to redact some calls where they are simply confusing, not to get into the weeds again, but it is very, very difficult to get to 100%. He noted he wanted to take them back to the Tri Data stuff where Dr. Cohen said that the real problem in trying to understand the EMS performance is that REMSA's time clock and software is different from most of the fire providers. So they had an extremely difficult time in trying to match REMSA's response to Fire's response. He stated that is really what the issue is here. The Health District staff has been very diligent in this, but he opined it is an impossible job to get to 100%. He stated he was asking for the ability to redact some of these calls, and he would provide a list of what was redacted. But there are some calls within their data that are not applicable. His objection has been that some of those calls have not been redacted. He stated he would ask that the Board would table this and allow the fire partners to give a more cogent response and provide the Board with perhaps a better way to proceed going forward. He noted that ultimately, what needs to happen, again back to Tri Data, is there needs to be a unique identifier between the REMSA call and the Fire call so they can get a 100% match. He added that in conversations he has had with Dean Dow, Mr. Dow is equally concerned with how they do this analysis, because his [Chief Moore's] staff has spent hundreds of hours and he has spent thousands of dollars of staff time trying to get to 100%. He noted he does not know what the return on investment on that is. They are spending a lot of time and he cannot afford to spend that much time on trying to get to 100%. He believed he would like to have some conversations directly with REMSA and see if all four agencies cannot get to some sort of consensus on how to move this forward.

Chair Slaughter asked Chief Cochran if he had anything to add or any differing view. Chief Cochran, City of Reno Fire Department, noted that he may as well weigh in, as everyone else has. He stated that it has been mentioned a couple of times the volume of work that this is generating. He said he knows that for his part, it is imposing a heavy burden on his staff, IT and dispatch, and his concern is two-fold with the all-data approach. He stated that they have been going down this road of trying to reconcile 100% and his view, while he could be wrong, is that if they add more data they are going to add more work. That reconciliation is going to mushroom into even more staff time, and he has an issue with that, obviously. That is what is generating the pushback. If they could just provide the data, that they would be fine, that would be great. But it is the reconciliation component of that creating an issue. He said the other idea it raises, as Mr. Dick pointed out, the ILA dictates the eight

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recommendations, the eight guidelines, for what staff should be doing. It does not include delving into Fire data. Again, we are mushrooming what the mission is instead of focusing on EMS. He noted that he would not reiterate on the goals that everybody has identified. He opined they are laudable goals--they want to improve service and want to improve response times. He opined that they should focus on them. They should focus on the goal and work backward with that, rather than just accumulate all the data and figure out where that takes them. He noted there was one issue he wanted to clarify. Chief Nolan mentioned the NFPA standard and that their goal was to meet that standard. Discussions have been had about that before and you have seen it in the reports. They have not, for the City of Reno's part, adopted that as their standard. He noted that is a goal, that is a good discussion point, a benchmark, if you will, but wanted to make it clear that it is not the City of Reno's standard. He stated he wanted to make that clear for the record.

Chair Slaughter said he would like to have all three chiefs up, if he could. He asked Chief Maples if he had anything else to add, but that he did not have to speak if he did not want to. Chris Maples, Division Chief for City of Sparks, noted he could not speak to this directly, because Chief Garrison had been handling this. However, he did agree with what both Chief Moore and Chief Cochran said. He thought they needed to add, in fact Ms. Conti in her presentation talked about the Seward report where they are looking at the big picture and not spending so much time on outliers or at the end of the bell curve. He noted it seemed that was what they were doing here. Sparks does not have a problem providing the data. He opined that if the Board allows them to--he didn't want to use 'redact' some of it--so what they were getting is true EMS data, then the EMS staff is not wasting a lot of time trying to reconcile it all with the CAD data, and then figure out what it is they want to do with the data rather than just taking a shotgun approach to it.

Mr. Dick noted he has heard everybody say this data stuff is just taking everyone too much time and it is a resource zap, etc. He just wanted to remind everyone how they got there. It is the objection they had from the fire agencies on the data that was being presented in their reports and their concerns that the data was not correct. All of this work has been delving into what is wrong with the data based on the objections we were getting from Fire. The idea that this program is driving this huge consumption of resources about data needlessly, he just does not buy that. He opined they went down this path because of concerns that were raised, that we now understand are because of the interface that exists. Those concerns were raised by Fire. He noted that as far as the amount of work, it seems to him that the easiest thing to do is provide the data for all the Fire calls, and let the Oversight staff, as they can very readily do, pull the EMS out of those. What Fire is proposing is more work in screening that data. He stated he did not understand what the concern is of all the redactions, and maybe he needs to be educated on all the confidential information that resides in there. He opined they had a ready solution that they could move forward with that would not be a burden on anybody. He then requested that Ms. Kerwin might respond and inform them on the experience that the Oversight Program has had when they look at all Sparks Fire data.

Ms. Kerwin reported that as far as the CAD filtering and including those calls that are EMS or patient contact, from what she understands from Karen Burch of the Research Development Unit at the Washoe County Sheriff's Office who developed the reports, that is not a capability of her report generation. It is only able to filter by the call type EMS, extrication, accident, injury, or handled by other jurisdictions. Those are the call types that she

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has expressed she has the ability to filter on. Ms. Kerwin noted that additionally, she knew that a lot of the outside of these deep dives into the data as a result of the data discrepancies pointed out or brought to concern in January, the additional review that a lot of the fire partners are referring to is a feedback when she provides that these are the calls that were unmatched. She stated she would be more than happy to drop that process from how she conducts the match to REMSA data. If that is a concern, that is absolutely not an imperative part in that process of data matching, and they can drop that. She knows that it was causing some concerns in jurisdictional time. In terms of filtering or pre-sending the data to the Program and that is also adding time on the fire partners' part. One of the benefits of sending all calls to the Oversight Program from both software systems would be that she can then apply the same filters across the board for all three jurisdictions without adding a burden or processing step to those fire partners. She does hear their concerns and some of those processes that they are referring to are in terms of when she sends back the initial unmatched calls to them for review. That is time consuming, recognized it, and can be eliminated from the Program's process.

Chair Slaughter stated he was still not comfortable, as this is a partnership, and he is hearing from partners that they are not quite there yet. He stated that is where he is. He added that if they cannot get there, they cannot get there, but he is hearing that there are still openings to get to resolution.

Mr. Clinger agreed with Chair Slaughter and stated he would not be able to support the motion on the floor, because there have been concerns raised by the different jurisdictions. He knows that they are not agendized on this item to give direction other than the report, but opined that the staff needs to get together. It seemed to him that there needs to be a working group, if it is not already happening, to decide what is best for the region. He noted he is not a data expert when it comes to EMS data and CAD data, so must rely on his staff, and when his staff is raising concerns on these issues, without him having further information on it, he has to heed those warnings. He stated to the Chair that he would like to see more work done on this as well before he can support a motion on this.

Dr. Michelson stated that his only reservation here that he perceives is if they are to, as a community and then this committee, make decisions solely on CAD data, would that then result in potentially those decisions having situational rebuttal, which is then not very efficient either, and then all of a sudden, the insignificant not matching up and then becomes significant, then they are right back there again. He opined they need to figure out what they are all going to trust together once and for all and then move forward.

Ms. Conti opined that Dr. Michelson said it, that at some point we need to do a leap of faith, and with all due respect to Mr. Clinger, stated that they have tried in the last three months to come up with solutions together, and so that is why they are proposing this workaround. They are certainly not proposing to take all data and then they decide in a vacuum which call types. They had a jurisdiction send the Program every one of their calls for the entire month to say take a look and let us see. There was an almost 7% higher inclusion rate of call types that for the past two years when the region together identified these calls as being EMS specific, that they actually did have a patient component because they were labeled as something different. She noted that they have tried, and she opined that they are at the time and place where they need the Board to make an uncomfortable decision

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whether it is to change for us or change for the jurisdictions, but she did not necessarily think another three months will do that. Besides, how the data is then used...

Chair Slaughter noted that at their last meeting they discussed that they would be at a point where they either have a special meeting or were here today with resolution, and they are not here today with resolution. Ms. Conti noted that they are. She stated we are not here today with a consensus resolution. Chair Slaughter said he was not hearing that they are there with a resolution and stated he would just ask for a vote at this point in time.

Chair Slaughter stated they had a motion on the floor and requested a vote. The motion failed with Mr. Dick in favor and the remainder opposed.

Chair Slaughter stated he would entertain an additional motion for correction. Mr. Clinger stated he would make a motion that the jurisdictions provide the CAD EMS data as well as the RMS EMS data, which he thought they were currently doing. He requested confirmation of this. Ms. Kerwin responded that it would be dependent on how they would classify EMS, as having an EMS component or the series of calls identified as EMS over about a year ago now, the 300 series. Mr. Clinger stated he was looking to his staff for help now, was it EMS data or EMS-related data. With input at that time from the meeting attendees, he stated that it was EMS and EMS-related.

Mr. Clinger moved for the different jurisdictions to provide both the CAD and RMS data for EMS and EMS-related calls. Mr. Driscoll seconded the motion. Chair Slaughter asked if there was discussion. As there was no discussion, Chair Slaughter requested a vote. **The motion was approved unanimously.**

Chair Slaughter asked if there was anything else on this item. Ms. Kerwin mentioned part two in moving forward with their data reports in terms of what and how shall they measure performance in lieu of adopted standards, either at the regional or jurisdictional level. The Oversight Program's understanding is that TMFPD is the only fire agency who has adopted officially the Standards of Cover in addition to what the reports should contain. Knowing that their previous reports were to answer these anecdotal circumstances, and now that they have a solid baseline of two years of data, she asked how they are proposed to move forward in evaluating.

Mr. Driscoll explained that the Sparks Fire Department has defined performance standards for various data points that they are collecting. If those have not been presented so that they can do that, they can take a very short period of time to define those to the ones that they have defined, and then those can be shared with the Oversight staff for the performance report. He stated he is prepared to do that offline.

Mr. Dick noted he had previously proposed in his motion and would make it again, to the extent that there are the local performance standards, that they include that in the report for measurement, but they also include as a benchmark the NFPA standards. Chair Slaughter asked Mr. Dick if that was a motion. Mr. Dick responded in the affirmative. **Dr. Michelson seconded the motion. Chair Slaughter asked for discussion.**

Mr. Clinger commented that it feels like, and he understands where staff is coming from and thinks the idea of having a regional standard is a good one, but to him, it feels like they

are sort of trying to force and hurry this. He stated he feels like they need to have more discussion on this. He opined that the idea of having a goal that they should have a regional standard makes sense as they sit there today, but he did not feel they were at that point. He noted that his fear is that if they start putting the NFPA standard in a report, it is guaranteed people will start comparing to that and saying, well, and he would use his jurisdiction the City of Reno, you are not meeting the NFPA standards when it comes to response time, for example. He reiterated that he does not know how the NFPA standards are developed, but it gives him concern to put a benchmark in there that for whatever reason, the uniqueness of their department, the uniqueness of their geography, may be very difficult for them to meet. He noted he would have some concerns with that. He opined that as a Board, it makes sense for them to move towards the idea of some regional standards, and maybe it is different for different areas, but to force this today and just say they are going to adopt this as their benchmark and that is what they are going to report, he cannot support that.

Mr. Driscoll noted that he feels similar to Mr. Clinger from the standpoint, that they have not really, with the data they have, they have not taken a hard look at the individual jurisdictions and their performance to their defined standard. To him, it would seem they need to do that for at least a short period, and then they could look at how that would relate to NFPA and determine whether or not those are associable, because right now, they may not be. He opined that defining the jurisdictional layer first, understanding that they are trying to get to a regional and start to understand the differential, maybe they are there and do not know it and it will be okay, but he would like to start with the lower level first and move to the higher level second. He stated he would not be able to support the NFPA standard part of the discussion at this time.

Dr. Michelson asked if the NFPA standards are in the report, can that not just be used as reference though, while recognized that it is not part of a department standard or what they determine as their performance-based criteria. He asked if it could be a second addendum and could it be accessible in the report, or maybe not, judged next to the data right above in the chart. He opined it should be something they look at for time ahead. He commented that, apparently, it is an ideal standard, and he agreed that maybe in this community not be so easily attained in any immediate time period, but he still feels it is important to look at it as a standard, maybe not one that is adopted or a true benchmark. He guessed he supports the data itself being accessible in the report, but maybe not put into the pie chart next to the data.

Mr. Dick asked if that was a proposal to amend his motion. Mr. Driscoll noted that it sounded fairer. Mr. Dick said he would entertain that. Chair Slaughter asked who seconded it. Mr. Dick said he seconded it. Chair Slaughter requested that the amended motion be restated.

Mr. Dick moved that as a performance measure, we use any jurisdictional standards but that we do include data in the report on the NFPA standard, but not presented in a way as it is a performance measure within the report. Dr. Michelson seconded the motion.

Chair Slaughter stated that, again, he is where he was before and wants to hear from all sides, so would like to hear from at least one of the chiefs and their response to that.

Dave Cochran, Reno Fire Chief, said he would just echo the concern that Manager Clinger raised. That is what Reno's concern is, being measured against a standard that they have not

adopted, creating the implication that they are not living up to that standard, when that would not be accurate. He opined that Dr. Michelson's suggestion is well taken, that to have that maybe as a point of reference, that here is the data and here is what it shows, and in a separate section, here are different standards, the Standards of Cover, the NFPA standard, so that with some examination, the reader of the report could have a means of comparing them. He apologized if he had not stated that accurately, but that is what he understood. That would be valuable, but to have that pie chart, as he said, that shows they are compliant 30% of the time, that is a judgement that they as the jurisdiction need to make, what their standards will be. And when they do, then it should be included in the report.

Mr. Clinger requested quick clarification on the motion and the second. He asked if they are talking about in the report that this is an appendix of here are national standards. He also asked if that is sort of what they are talking about, so he can have clarity? Mr. Dick responded that he believes so, that he thinks what he was grappling with as they are having this discussion, is that there was also some previous talk of they should be looking at how they are doing against their local standards and how does that stack up against the NFPA standard. If they do not have some data somewhere that just says how that does stack up against the NFPA standard, how are they going to have that conversation. He opined that if they were to have some appendix that contains that information about the different standards, that would be suitable. Chief Cochran noted that this would be satisfactory for Reno.

Chief Charlie Moore, Truckee Meadows Fire Protection District, suggested that they perhaps refocus on the entire data collection process and where they are going, because it is not just response time that they want to understand. They want to understand arrival of Fire and REMSA, of course, but they want to know patient acuity, how long it took to get the patient to the hospital, they want to know patient outcomes. He reiterated that they are spending a lot of time just trying to analyze response time, which is just a very, very small component of this. He stated that the thing too, again, is he respects each jurisdiction's right to be able to set its own response standards and would say that every jurisdiction should be able to establish that and not use a national standard, because, quite simply, in downtown Sparks and downtown Reno, it is different than rural Washoe County and they cannot take one national standard and apply it throughout the entire County.

Chair Slaughter asked if there was more discussion. Hearing none, he asked if the Board was prepared to vote for the motion that is on the floor. **The motion was approved unanimously.**

Chair Slaughter asked if there was anything else on this item. Ms. Kerwin responded that was it for now.

Mr. Clinger left the meeting at 11:03 a.m.

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12. Discussion, possible approval and recommendation to present the clarification of the northern border of the Washoe County REMSA ambulance franchise service area to the District Board of Health

Staff Representative: Ms. Conti

Ms. Conti presented a map of the proposed northern boundary to the Board. She reported that in March, Dr. George Hess from the District Board of Health requested some clarification on the northern boundary, because the previous map went in line with what Chief Gooch had requested a while ago for trying to define the Gerlach response boundary. The staff report shows that where 911 calls go is a boundary and there is also a rural fire boundary. There is a community with large plots of land with houses and citizens that is not included in the REMSA response area that would require Gerlach to come all the way down through the Pyramid Paiute Tribe property to get there. Through discussions, they are proposing that the top boundary would follow Grass Valley Road which crosses the highway. On Pyramid Lake highway, it would match up with where the tribal lands begin, wrap around, and then all communities out there would have a REMSA or franchisee ambulance response, even though their fire partner might be through a mutual aid agreement. They would get a REMSA ambulance rather than having Gerlach come through or handle that area through mutual aid agreements. She requested the Board's thoughts on this and approval to bring this to the District Board of Health to define this northern boundary of the franchise area.

Mr. Driscoll requested clarification on the E zone. He asked what the response time standard would be for that zone if REMSA is providing that service. Ms. Conti responded that there is no time on E. Mr. Driscoll asked if would be best effort. Ms. Conti replied that it is frontier. Chair Slaughter noted that they have had this discussion with Washoe County staff, and the discussion actually dates back to the original discussion on the Interlocal Agreement and the County Commission's desire to identify what the Gerlach area was. He opined that this helps them get there a little more. From his perspective, he is supportive and the County is supportive. Chair Slaughter introduced and welcomed Mr. Pat Irwin, new Community Fire Services Outreach Coordinator. He reported that Washoe County has entered into a new model in the Gerlach area with their Gerlach Volunteer Fire Department and now a combination department, and Mr. Irwin will be leading that effort up there. Mr. Irwin is initially charged with getting the volunteer force in Gerlach back to a very heavy force that will be responding in the Gerlach area. The new model in Gerlach began on July 1, 2016. Chair Slaughter asked for any other questions and entertained a motion.

Mr. Dick moved to approve the clarification of the northern border of the Washoe County REMSA ambulance franchise service area to the District Board of Health. Mr. Driscoll seconded the motion which was approved five in favor and none against.

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13. Presentation and possible acceptance of an update on Emergency Medical Services Mutual Aid Agreements within the region.
Staff Representative: Ms. Dayton

Ms. Dayton reported that Reno Fire Department requested an update to the EMS Advisory Board on REMSA's mutual aid. Through staff discussion, they felt it would be more appropriate to include mutual aid for all transport agencies in Washoe County. Mutual aid is an agreement between agencies that essentially drops the jurisdictional lines to share resources. It is a shared process of giving and receiving and is the most frequently and commonly used agreement in Fire and EMS. There are currently four EMS transport agencies in Washoe County: Gerlach Volunteer Fire Department, North Lake Tahoe Fire Protection District, Pyramid Lake Fire and Rescue, and REMSA. She contacted each agency to ask what their current mutual aid agreements are as well as any mutual aid agreements in draft form.

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- Gerlach Volunteer Fire Department currently has four mutual aid agreements with agencies in California: Eagleville, Cedarville, Fort Bidwell, and Surprise Valley Healthcare. They are currently drafting a mutual aid agreement with Pyramid Lake; it is currently in the legal review process.
- North Lake Tahoe Fire Protection District has current agreements with North Tahoe Fire Protection District, Tahoe Douglas, Truckee Fire, and Carson City. They also have a Nevada master mutual aid agreement, a Lake Tahoe Regional Fire Chiefs Agreement, and an agreement with the California Office for Emergency Management for strike teams in the Tahoe basin. They are currently in communication with REMSA in drafting an update to their mutual aid agreement, and it was identified that even during this process, they would honor any request during the process, even though it is in draft.
- Pyramid Lake Fire and Rescue has current agreements with Truckee Meadows Fire Protection District, Bureau of Land Management, Bureau of Indian Affairs, North Lyon, Storey County, Hungry Valley, and the Washoe Tribe. They have a draft agreement with Gerlach Volunteer Fire Department and are in the process of drafting an agreement with REMSA.
- REMSA has current agreements with Carson City, North Lyon, SEMSA, Storey County, Truckee Fire, and most recently, Truckee Meadows Fire Protection District. In draft form are agreements with Pyramid Lake Fire and Rescue, Reno Fire Department, and North Lake Tahoe Fire Protection District. They are honoring any requests during the drafting process.

There are also mutual aid agreements between the governors of California and Nevada which authorizes mutual aid across state lines, and a Nevada intrastate agreement authorizing mutual aid across county lines within Nevada.

Mr. Dick moved to accept the report. Mr. Driscoll seconded the motion which was approved five in favor and none against.

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14. Presentation and possible acceptance of the EMS Program's FY15-16 Annual Report template.
Staff Representative: Ms. Kerwin

Ms. Kerwin asked if anyone had questions on the template that was included in the board packet. Chair Slaughter asked if there were questions for staff.

Mr. Driscoll moved to accept the template as presented by staff. Mr. Dick seconded the motion which was approved five in favor and none against.

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15. Presentation, discussion and possible acceptance of an update on the CAD-to-CAD interface between the Public Safety Answering Points and REMSA dispatch.
Staff Representative: Ms. Dayton

Ms. Dayton noted this item was on the April agenda, but due to time constraints, the Board did not get to hear it. The District Board of Health requested an update on the status of the CAD-to-CAD project, and Ms. Conti provided a presentation to them in May. During the May meeting, Division Chief Nolan reported that the City of Reno requested an enhanced scope of work from Tiburon. Ms. Dayton apologized for a typographical error in her staff

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report, that listed the name as TriTech, but it should be corrected to show Tiburon. Reno anticipated receiving that enhanced scope of work in mid-June. She followed up with Fire Department personnel on June 16 and was told there was no update. At the time of the report, they were notified by Reno Fire Department that there was progress being made and they would be circled back in once they had more details.

Mr. Dick asked if anyone from Reno Fire was still at the meeting and if there was any additional information. He asked Chief Nolan if there was any additional information.

Rishma Khimji, Assistant Director of IT for City of Reno, reported that they recently had a meeting with TriTech/Tiburon so the name was not in error on Ms. Dayton's staff report. She explained that TriTech bought Tiburon. They had a meeting with TriTech/Tiburon executives with their Fire Chief, City Manager, Mayor, and REMSA to talk about the progression of their scope of work. Reno is in the final stages of getting an updated scope of work from TriTech. They are working on getting more information on their side to make sure all their needs are taken care of in regards to the mapping of data between CAD at City of Reno and the CAD at REMSA. They want to make sure that data mapping is available, they know what those elements are, so they are going to get that to them so they can prepare their data mapping as they work on the scope of work. They are also looking into having other agencies join with the City of Reno and partake in the CAD-to-CAD, and as soon as they get back word on that, whether they are paying one price for all three agencies, which includes Washoe County and City of Sparks, then Reno will be able to proceed further saying this is a regional CAD-to-CAD instead of just a City of Reno to REMSA CAD-to-CAD. As soon as Reno hears back and this is clarified, they will approach the other entities and let them know this is available as a regional CAD-to-CAD.

Mr. Dick asked Ms. Khimji if they have a timeline for when she expects to have the scope and contract for the City to be able to move forward with executing something. Ms. Khimji responded that TriTech/Tiburon told them they would get back to them at their earliest. They are looking into the regional aspect, and they have not given Reno an ETA for when they get back to them. She contacted them last week, and they are in the final stages of making sure their ducks are in a row. TriTech is looking at their resources to make sure that their resources are in line with a timeline, so they can give Reno an entire project timeline, rather than piecemeal timelines.

Chair Slaughter asked if there was any other discussion and if there was a motion for acceptance. **Mr. Driscoll moved for acceptance. Dr. Michelson seconded the motion which was approved five in favor and none against.**

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16. Presentation, discussion and possible direction to staff regarding the five-year Strategic Plan, a requirement of the Interlocal Agreement for Emergency Medical Services Oversight.

Staff Representative: Ms. Conti

Ms. Conti noted that the Board has the most current draft of the Strategic Plan. Since the last meeting, there is more filled in on the front. Items in red are those that the group either has not discussed or reached consensus on yet. Items in black have been agreed upon by the group. The new ones are Goal 3 and 4. Goal 5 was sent out to the partners that she is

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working with, however she needed to cancel the appointment and they were unable to reschedule before this Board meeting. The next meeting on July 19 will focus on Goals 5 and 6. Chair Slaughter asked Ms. Conti if Goal 6 includes detail. Ms. Conti responded that it is just a goal. As a reminder, in the beginning of the process, they took the SWOT analysis and did high-level goals. The partners thought it important to have a goal about the Oversight Program and the EMS Advisory Board.

Mr. Dick asked if the goal was to have this come back as the strategic plan for approval at the October EMS Advisory Board meeting. Ms. Conti responded in the affirmative. Mr. Dick asked her if she thought they were on track to be able to come back with a draft report that everybody is in agreement on at that meeting, or are there any areas that she wanted to highlight that the Advisory Board needs to be aware of, progress that needs to be made, and particularly, if any members of the Board could help in the progress there. Ms. Conti responded that she did not anticipate there being any problem bringing a solid draft for approval back to the October meeting. At the next meeting in July, they will talk about the final goal, and then in August and September, they would work through the introduction and then circle back on anything that did not reach consensus the first time. In Goal 1, Objective 1.3 was a new objective through discussion. There may come a time when ambulance is not necessarily how transport happens. She cannot say that might be met, that consensus might not be able to be reached, because that has not been discussed yet, because it was asked for that to be built out. That has been built out, but they have not yet been able to circle back yet. On Goal 2, Objective 2.4, she does not know if that one will reach consensus through the group, just because the preliminary discussions indicated that. So that might still come to the Board in red for a Board decision on whether to eliminate it or adopt it. Those are the only two that she cannot really speak to as to when it comes back to the Board.

Chair Slaughter asked if there was any direction the Board wanted to give. Mr. Driscoll asked from a direction standpoint, at least for his jurisdiction, that Ms. Conti advise him if there seems to be some impasse, so he could have some detailed conversation with his staff, as he would obviously hear from them too. Ms. Conti agreed.

Mr. Driscoll moved to approve the presentation with the understanding that the final draft is proposed to come back to the October EMS Advisory Board meeting. Dr. Michelson seconded the motion which was approved five in favor and none against.

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17. Board Comment

Mr. Dick requested that an agenda item be included for the next EMS Advisory Board meeting for staff to present any recommendations on updates to the Bylaws, particularly with regard to the election of the Chair, that with four Board meetings a year, it may not be necessary to transition as often in that role.

Mr. Driscoll announced that Chief Garrison of Sparks Fire Department is retiring on September 16, 2016, and welcomed Division Chief Maples who will be his successor. Mr. Driscoll commented that Chief Maples will do a great job. Chief Maples will begin a transition period next week with Chief Garrison. He also noted that Sparks Fire Department always promotes from within.

Mr. Dick congratulated all the fire agencies on their excellent response throughout the year so far in the wildfire incidents. He has been pleased to see that everything has been

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responded to so well and controlled so far. Chief Maples reported the current Sparks Fire was up to 2,500 acres.

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18. Public Comment

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

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19. Adjournment

At 11:25 a.m., **Mr. Driscoll moved to adjourn the meeting. Mr. Dick seconded the motion.**

Respectfully submitted,

____
Jeanne Harris, Administrative Secretary
Recording Secretary

Approved by Board in session on ______________, 2016.

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WASHOE COUNTY
HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

STAFF REPORT
REGIONAL EMERGENCY MEDICAL SERVICES ADVISORY BOARD
MEETING DATE: October 6, 2016

TO: Regional EMS Advisory Board Members

FROM: Christina Conti, EMS Program Manager
775-326-6042, cconti@washoecounty.us

SUBJECT: Program and Performance Data Updates

Meetings with Partner Agencies:
On July 12, 2016 the EMS Coordinator facilitated the Mid-Term Planning meeting for a full-scale evacuation exercise that will be held in October. This exercise will test the patient evacuation and tracking process as well as the medical surge capabilities of several healthcare facilities in the county.

On July 14, 2016 PSAP and REMSA Dispatch personnel met to follow-up on the newly implemented policy regarding calls for service that have a law enforcement component. Per meeting attendees, no issues have been identified with the new protocol and it has been utilized. A quarterly meeting has been established for this group.

The EMS Program Manager and EMS Coordinator presented at a regional law enforcement meeting on July 19, 2016. EMS staff facilitated a discussion about a possible "scoop and run" planning element in the Multi-Casualty Incident Plan (MCIP), which could allow law enforcement personnel to transports victims during large scale MCIs.

On July 21, 2016 the EMS Coordinator conducted the first MCIP executive training. There were approximately 20 attendees from Washoe County agencies, state departments and boarder county agencies. The training provided a high-level summary of MCIP operational elements, the Mutual Aid Evacuation Annex (MAEA) and the Family Service Center Annex (FSC).

July 27, 2016 was the scheduled meeting to review the direction of the EMS Advisory Board to send EMS and "EMS-related" calls to the Oversight Program for analysis. No fire partner was able to attend so the meeting was not conducted.

On August 5, 2016 the EMS Coordinator met with staff from Carson City and Douglas County to provide training information on the hospital evacuation system. As part of the regional planning process several hospitals in Northern Nevada are implementing the same patient tracking system from the MAEA.

The EMS Coordinator and REMSA personnel conducted a hospital evacuation training at SMRMC on August 9, 2016. The training included a presentation and tabletop where participants were able to walk through the evacuation process of 10 patients.

The EMS Coordinator and EMS Statistician participated in a Great Reno Balloon Race tabletop exercise on August 10, 2016. The exercise included important discussion about the response from fire, law enforcement, EMS and event staff/volunteers and their coordinated efforts for preservation of life safety, mass evacuation and fire suppression.

The EMS Statistician conducted a ride along with Reno Fire Department's Station 1 crews on August 16, 2016. The ride along allows EMS staff to have firsthand experience with the fire responder's daily duties as well as response to both fire and EMS calls.

Regional fire partners and REMSA met with the District Health Officer, Oversight Program staff on August 18. This was the meeting the Fire partners requested on June 28, 2016, but due to scheduling couldn't occur sooner.

The EMS Coordinator participated in the annual Reno Air Racing Association tabletop discussion on August 23. The exercise involved an active assailant incident where the individual was shooting into the vendor and grandstand areas. Attendees were asked to discuss their agency role/response to the incident and the plans that would be activated during this type of disaster.

The Program Manager attended a briefing by the National Weather Service on August 24th to discuss a new program and presentation for heat waves. A new method is being used by NWS to predict health impacts from heatwaves.

On August 24 the EMS Coordinator traveled to Gerlach to attend a meeting and tabletop discussion hosted by Burning Man staff. The meeting was well attended by numerous local, state and federal agencies and allowed for discussion about the various types of incidents and responses that could occur during Burning Man.

The EMS Coordinator held a final planning meeting on September 6 for the full-scale hospital evacuation exercise that is scheduled for October 2016. Personnel from the participating agencies met to finalize the scenario, timeline and exercise documents. The results of this exercise will be used to determine any necessary revisions to the Mutual Aid Evacuation Annex (MAEA).

The EMS Coordinator met with the REMSA Education Manager on September 8 to discuss the quarterly Fire EMS trainings. REMSA provided an update on the changes to the scheduling process and upcoming trainings while the EMS Coordinator presented ideas for possible training enhancements based on a presentation by the Mass Bay Community College at the 2016 EMS Today conference.

On September 9 the EMS Coordinator conducted a WebEOC refresher training for hospital representatives. Since this is not a system used on a regular basis, the EMS Coordinator developed a user guide with step-by-step instructions for hospital staff. The training also included demonstrations on inputting information into the MCI and hospital evacuation boards.

On behalf of Washoe County Health District, the EMS Statistician submitted the HeartSafe application for approval by Nevada Project Heartbeat on September 13. If the application is approved, the County will be a HeartSafe Community, which is a system which helps to strengthen the Chain of Survival for victims of sudden cardiac arrest.

Mass Gatherings:

- Reno Air Balloon Races, September 9 – 11
- Reno Championship Air Races, September 14 – 18

Investigations conducted by the EMS Oversight Program:

Date Received	Individual/Organization Requested Investigation	Reason for Request	Investigation Outcome

Inquiries made agency to agency: ***(as known by the EMS Oversight Program)***

Date Received	Agency Requesting and to Whom the Request was Made	Reason for Request	Inquiry Outcome

Legislative Information Relating to EMS:
NAC 450B and NAC 629 are still being revised and recommended to be approved by the Nevada State Board of Health. The next State EMS Advisory Committee is scheduled for October 6 at 2pm.

Other Items of Note:

In mid-August the EMS Coordinator participated in a three-day training for EOC operations and planning for all-hazards events. The course offered insight and practical experience with emergency management and decision-making skills necessary to effectively manage an EOC response to a large-scale incident. The training culminated with a full-scale response where all participants were assigned an EOC position for a simulation incident.

The EMS Statistician conducted a ride along with Reno Fire Department’s Station 1 crews on August 16. The ride along allows EMS staff to have firsthand experience with the fire responder’s daily duties as well as response to both fire and EMS calls.

The EMS Coordinator attended the Reno Fire Department (RFD) Station 7 ceremony on August 29. All RFD stations are now open; station 7 will be staffed with a two-person crew that can respond to medical calls.

DATE: 8/29/2016

TO: 911 Emergency Response Advisory Committee

FROM: Rishma Khimji, Asst. Director, City of Reno Department of Information Technology, khimjir@reno.gov, 775-334-2026

THROUGH:

SUBJECT: REQUEST FOR APPROVAL FOR FUNDING for the CAD-TO-CAD Interface between REMSA TriTech CAD application and City of Reno PSAP TriTech CommandCAD (formerly Tiburon) including regional participation by City of Sparks PSAP and Washoe Co. PSAP not to exceed $65,600.00. Yearly maintenance in year two not to exceed $14,400.00.

SUMMARY

Currently, the three Public Safety Answering Point (PSAP) agencies in Washoe County utilize a manual transfer process to connect 911 callers with REMSA for all medical related calls. This interface will allow the system to automatically push data such as location and chief medical complaints from the TriTech (formerly Tiburon) CommandCAD system into REMSA's dispatching system alleviating the 911 caller from repeating information and reducing time delays. This interface also allows for data to be pulled from REMSA's dispatching system into the TriTech CommandCAD allowing for a seamless process of data; this would allow for faster and enhanced processing, handling and information sharing for 911 calls involving medical emergencies.

This interface was also recommended by the EMS Advisory Board based on an evaluation of EMS services between the PSAP agencies and REMSA.

NRS APPLICABLE:

NRS 244A.7645 Provides approval of costs associated with maintenance, upgrade and replacement of equipment necessary for the operation of the enhanced telephone system.

The following is a complete definition of the NRS 244A.7645, with applicable sections highlighted:

NRS 244A.7645 Establishment of advisory committee to develop plan to enhance or improve telephone system; creation of special revenue fund; use of money in fund.

1. If a surcharge is imposed pursuant to NRS 244A.7643 in a county whose population is 100,000 or more but less than 700,000, the board of county commissioners of that county shall establish by ordinance an advisory committee to develop a plan to enhance the telephone system for reporting an emergency in that county and to oversee any money allocated for that purpose. The advisory committee must consist of not less than five members who:

(a) Are residents of the county;

(b) Possess knowledge concerning telephone systems for reporting emergencies; and

(c) Are not elected public officers.

2. If a surcharge is imposed pursuant to NRS 244A.7643 in a county whose population is less than 100,000, the board of county commissioners of that county shall establish by ordinance an advisory committee to develop a plan to enhance or improve the telephone system for reporting an emergency in that county and to oversee any money allocated for that purpose. The advisory committee must:

(a) Consist of not less than five members who:

(1) Are residents of the county;

(2) Possess knowledge concerning telephone systems for reporting emergencies; and

(3) Are not elected public officers; and

(b) Include a representative of an incumbent local exchange carrier which provides service to persons in that county. As used in this paragraph, "incumbent local exchange carrier" has the meaning ascribed to it in 47 U.S.C. § 251(h)(1), as that section existed on October 1, 1999, and includes a local exchange carrier that is treated as an incumbent local exchange carrier pursuant to that section.

3. If a surcharge is imposed in a county pursuant to NRS 244A.7643, the board of county commissioners of that county shall create a special revenue fund of the county for the deposit of the money collected pursuant to NRS 244A.7643. The money in the fund must be used only:

(a) In a county whose population is 45,000 or more but less than 700,000, to enhance the telephone system for reporting an emergency, including only:

(1) Paying recurring and nonrecurring charges for telecommunication services necessary for the operation of the enhanced telephone system;

(2) Paying costs for personnel and training associated with the routine maintenance and updating of the database for the system;

(3) Purchasing, leasing or renting the equipment and software necessary to operate the enhanced telephone system, including, without limitation, equipment and software that identify the number or location from which a call is made; and

(4) Paying costs associated with any maintenance, upgrade and replacement of equipment and software necessary for the operation of the enhanced telephone system.

(b) In a county whose population is less than 45,000, to improve the telephone system for reporting an emergency in the county.

4. If the balance in the fund created in a county whose population is 45,000 or more but less than 700,000 pursuant to subsection 3 which has not been committed for expenditure exceeds $1,000,000 at the end of any fiscal year, the board of county commissioners shall reduce the amount of the surcharge imposed during the next fiscal year by the amount necessary to ensure that the unencumbered balance in the fund at the end of the next fiscal year does not exceed $1,000,000.

5. If the balance in the fund created in a county whose population is less than 45,000 pursuant to subsection 3 which has not been committed for expenditure exceeds $500,000 at the end of any fiscal year, the board of county commissioners shall reduce the amount of the surcharge imposed during the next fiscal year by the amount necessary to ensure that the unencumbered balance in the fund at the end of the next fiscal year does not exceed $500,000.

(Added to NRS by 1995, 1056; A 1999, 1686; 2001, 621, 2125; 2007, 561; 2009, 641; 2011, 1124)

STAKEHOLDER REVIEW(s)

Stakeholders are the primary PSAP agencies including City of Reno Emergency Communications, City of Sparks Emergency Communications and Washoe County Emergency Communications.

PREVIOUS ACTION

No previous action has been taken on this specific item. However, previous purchases of software to enhance PSAP communications has been approved by the board on various occasions.

FISCAL IMPACT

The Enhanced 911 Fund is a special revenue fund which receives revenue pursuant to NRS 244A.7643 in the form of telephone surcharges collected to support the emergency reporting system. Budget authority exists within the E911 Fund to support the CAD-TO-CAD interface to integrate the PSAP agencies TriTech CommandCAD and REMSA dispatching applications. The total cost for the interface, including project management, remote training and first year's maintenance is $65,600.00. Yearly maintenance, which is also requested for approval, is $14,400.00 (subject to any increases by the vendor, TriTech).

Year one amount requested is: $65,600.00

Year two maintenance amount requested is: $14,400 (Subject to vendor increases; any changes will require new approval.)

RECOMMENDATION

It is recommended that the E911 Emergency Response Advisory Committee approve the request for funding of the CAD-TO-CAD Interface between REMSA TriTech CAD application and City of Reno PSAP TriTech CommandCAD (formerly Tiburon) including regional participation by City of Sparks PSAP and Washoe Co. PSAP not to exceed $65,600.00. Yearly maintenance in year two not to exceed $14,400.00.

POSSIBLE MOTION

Motion to approve funding for the CAD-to-CAD interface in an amount not to exceed $65,600 and to approve funding for the year two maintenance in an amount not to exceed $14,400, and to allow the City of Reno's Department of Information Technology to move forward with the purchase and implantation of said interface.

A TriTech Software Systems Company

Proposal Sales/Quotation

Quotation #	3638	Quotation Date:	12/8/2015

General & Client Information

Client Name:	Reno, NV	**Bill To:**
System Description:	Total Command CAD	City of Reno
Great Plains ID:	TBD	1 East 1st Street
Sales Order #	TBD	Reno, NV 89502
Client Purchase Order #	TBD	
Client P.O. Date	TBD	
Client Contact:	Rishma Khimji	
Contact Phone:	775.334.2026	**Ship To:**
Contact Email Address:	khimjir@reno.gov	City of Reno
		1 East 1st Street
		Reno, NV 89502
Credit Terms:	TBD	
Account Executive:	Steve Angell	
Project Manager	TBD	

Project Products & Services

Qty.	Item Description	Unit Price	Qty*Unit $	Discount	Extended Price
1	Advanced CAD-to-CAD Interface	$ 80,000	######	$40,000.00	$ 40,000
1	Project Management	$ 11,200	######		$ 11,200
				Subtotal:	$ 51,200

Annual Maintenance & Recurring Fees

Annual Maintenance		
Advanced CAD-to-CAD Interface		$ 14,400
	Subtotal:	$ 14,400
	Total Payments:	**$ 65,600**

Project Payment Terms: Net 30 days from date of invoice

Quote valid for 60 days after date of issue.

Payment Schedule

- 50% Upon Tiburon's delivery of a Statement of Work.
- 50% Upon achievement of the completion criteria set forth in the SOW.

Note: No scheduling of resources will occur until after the first payment milestone is paid and all outstanding accounts receivable payments have been made. This Proposal may be cancelled at Tiburon's discretion upon written notice to Client if the first payment milestone is not paid when due.

Assumptions

This Quotation does not include:

- Warranty
- Documentation or training
- Hardware or third party products or services

Summary Information & Project Notes

Quotation Issued by:	Send Purchase Orders to:
Ron Lovejoy **Contact info:** (951) 315-2644 Ron.Lovejoy@tritech.com	**Tiburon** **Attn: Ann Conway FAX: (858) 799-7015** Ann.Conway@tritech.com
	Remit Payments to: **Tiburon** **9477 Waples Street, Suite 100** **San Diego, CA 92121**

By signing below, you are indicating that you are authorized to obligate funds for your organization. To activate your order, check the appropriate box below and, either, (I) attach a copy of this quotation to your purchase order when it is remitted to Tiburon, or, (ii) if no additional authorizing paperwork is required for your organization to accept and pay an invoice, sign below and fax this quotation to (925) 621-2799 or email to kelley.chavez@tritech.com to indicate your acceptance.

- ☐ **Purchase Order required and attached, reference PO#____________________ on invoice**
- ☐ **No Purchase Order required to invoice**

Please check one of the following:

- ☐ I agree to pay any applicable sales tax.
- ☐ I am tax exempt. Please contact me if Tiburon does not have my current exempt information on file.

Accepted for Client

____

Client Agency/Entity Name

____

Print Name & Title
Client Authorized Representative

____

Signature **Date**
Client Authorized Representative

Terms & Conditions

Software License Terms:

The Tiburon Software is licensed for use by Client in accordance with the software licensing terms of the Tiburon license agreement currently in effect between Tiburon and Client. Acceptance for the Tiburon Software may be defined in the applicable Statement of Work ('SOW'), if not, the Software licenses shall be deemed accepted on delivery.

The annual Software Support Services for the Tiburon Software licenses are provided for a period of twelve-months from the Installation date and shall be governed by the existing Support or Maintenance Agreement currently in effect between Tiburon and Client. Support fees will be prorated at renewal of the existing support term to adjust the term to be co-terminus with the existing Support or Maintenance Agreement annual term.

Sales Tax:

Any estimated sales and/or use tax has been calculated as of the date of quotation and is provided as a convenience for budgetary purposes. Tiburon reserves the right to adjust and collect sales and/or use tax at the actual date of invoicing, at the then current rates. Your organization must provide Tiburon with a copy of a current tax exemption certificate issued by your state's taxing authority for the given jurisdiction, when your order is placed, if you are exempt from sales tax.

General Terms:

The items in this quotation are based upon meetings and communications with the Client and unless attached to a contract form the entirety of the deliverables from Tiburon.

The Tiburon Software license price does not include any services for installation. Services, if applicable are listed as separate line items.

The scope of Deliverables for this order will be limited to the Tiburon Software, Services, and Support, and if applicable third party items (collectively the "System") that are explicitly listed herein for the listed quantities.

This order provides Tiburon Software licenses as well as required deployment services only for the environments that are explicitly listed herein (Production, Test, Training, Disaster Recovery, etc.). These software licenses do not apply to any other existing environments, or environments that may be implemented in the future.

Changes in the scope of certain components of the System may impact the cost and timelines for other areas of the Project.

All services will be performed during normal business hours, unless otherwise stated in this quotation for specific service deliverables.

Deployment and implementation of Tiburon Software and Services are based upon Tiburon's standard processes and procedures.

Tiburon reserves the right to adjust this Quotation as a result of changes including but not limited to project scope, deliverables (TriTech Software, or third party software or hardware, including changes in the hardware manufacturer's specifications), services, interface requirements, and Client requested enhancements.

Travel and out-of-pocket expenses will be invoiced as incurred, at actual cost, unless specifically itemized in the quotation.

Tiburon reserves the right to assess $1,000 cancellation fee for the training classes that are cancelled any later than 5 business days prior to the first day of the class, plus any additional fees or charges associated with the cancellation and rebooking of the airline tickets and other travel arrangements.

Tiburon reserves the right to assess 25% of the services fee, up to $1,000 as cancellation fee for any remote, or onsite installation services work that are cancelled by the Client at no fault of Tiburon any later than 5 business days prior to the date of performing the work. This may include the services that are cancelled or rescheduled due to the client's infrastructure not meeting the minimum requirements for the installation, lack of preparation of the site based on Tiburon's documentation, issues with remote connectivity, or other barriers that result in the work being cancelled.

Scope Description

This SOW describes the tasks and responsibilities for Tiburon, Client and REMSA in the deployment of the CAD to CAD (C2C) interface.

Any Interagency Agreement or Memorandum of Understanding between Client and REMSA are solely the responsibility of the Client, and must be executed prior to the scheduling of any work related to this SOW.

Any infrastructure costs related to the communications between Reno and REMSA for the implementation of the C2C interface are not included in this SOW, and must be in place prior to the scheduling of any work related to this SOW. In addition, the Client is responsible for procuring and installing the equipment to support the C2C interface if required.

The following list details the scope of the C2C implementation. Tasks may not follow the order as outlined and may include some overlap of tasks. Task completion will be acknowledged by the Client's signature on the Task Completion Letter.

All work will be completed during Tiburon's normal business hours Monday through Friday (0800 - 1700).

Assumptions:

This interface supports Reno CAD to REMSA CAD via an API. **Because Washoe County and Sparks are part of the Reno CAD (one CAD), they are also supported as part of this interface and will have access to the features and functionality.** If additional agencies want to be added, a Client provided external Hub may be required to support CAD communications beyond the Reno to REMSA CAD API.

Client will designate a person to be the principal point of contact for all technical questions and administrative arrangements relating to this Proposal.

Client will provide VPN access to Tiburon.

Client will coordinate the participation of non-Tiburon provided third parties and outside agencies.

Client's TotalCommand CAD must be 2.9 or higher.

Task 1 – Project Initiation Teleconference

Task Description:

A remote project initiation teleconference meeting will be scheduled and conducted on a mutually agreed-to date. The objectives of the meeting include:

- Client, Tiburon and REMSA personnel introductions;
- Review scope, objectives and process;
- Review Client environment (network connections, servers, infrastructure requirements)
- Review information gathering needs (mappings of units and codes between Reno and REMSA)

- Determine an initial Deployment Schedule;
- Review site layout/network configuration;
- Confirm/Test Interagency Connectivity between Reno and REMSA

Tiburon Responsibilities:

a. Coordinate with the Client's Project Manager to establish a schedule and agenda for the meeting.
b. Conduct the project initiation teleconference.

Client Responsibilities:

a. Coordinate with Tiburon's Project manager to establish a schedule and agenda for the meeting.
b. Ensure that all appropriate Client and REMSA personnel attend and actively participate in the project initiation teleconference.
c. Provide site layout/network configuration information one week prior to teleconference.
d. Provide Interagency connectivity information and test results.
e. Lead the review of the mapping of units and codes with REMSA. Client will have final approval on the mapping.

Completion Criteria:

This task is considered complete when the project initiation teleconference has been held and the mapping of units and codes have been defined.

NOTE – Project will not proceed until Interagency connectivity is installed and tested.

Task 2 – Interface Deployment

Task Description:

Remotely, Tiburon will install and configure the software components necessary for the successful deployment of the C2C Interface.

NOTE – installation of the C2C Interface may require the installation of a new CommandCAD build and COLD restart to implement required configuration settings.

Tiburon Responsibilities:

a. Install software components on Client Test servers necessary to support the C2C interface.
b. Configure, provide, and install any updated CommandCAD builds necessary to support the C2C interface.
c. Coordinate any required COLD restarts of the Test system with the Client.

Client Responsibilities:

a. Procure, inventory, and install any Client procured hardware required to support the C2C interface, at least two weeks prior to the scheduled work of Tiburon.
b. Provide Tiburon with server and third-party information necessary to provide support of the system.

c. Provide a site adequate for the installation, operation, and maintenance of the C2C interface.
d. Provide all communication lines, modems, hubs, routers, cabling, or any other infrastructure components necessary for C2C interface operation and maintenance. This includes the Test and Production environments.
e. Assist with the installation and verify operation of the interface to any Client-provided networks.
f. Provide TCP/IP communications support for any existing networks, servers, or workstations that access Tiburon applications.
g. Modify and update necessary Client specific data elements (i.e. units, status codes) in CommandCAD File Maintenance.

Completion Criteria:

This task is considered complete when connectivity between agencies has been established and can be demonstrated through server level logs (i.e. heartbeat acknowledgements).

Task 3 – Remote Training

Task Description:

Remotely, Tiburon will provide a single 4-hour WebEx training session outlining the File Maintenance and End User changes related to the C2C Interface.

Tiburon Responsibilities:

a. Provide reference material necessary to complete training
b. Conduct remote WebEx training session

Client Responsibilities:

a. Attend remote WebEx training.
b. Update all necessary File Maintenance tables to support C2C Integration Training.
c. Provide internal End User training to support Integration Training and Cutover.

Completion Criteria:

This task is complete at completion of the 4-hour WebEx training session.

Task 4 – Integration Testing

Task Description:

Tiburon, Client and REMSA will conduct up to a maximum of three two-hour integration testing sessions. Integration testing must include REMSA and will include the testing of sending and receiving data. Test scenarios will be jointly created and documented prior to this task occurring. Any test scenarios must be approved by all parties a minimum of two-weeks prior to Integration Testing. This testing will be done on the Test systems.

Upon successful completion of the joint Integration Testing, Client will have two weeks to conduct additional testing. During this period, there will be two one-hour meetings to review results and answer questions.

Client will log any discovered issues during testing in a Tiburon Support Request (TSR), and a mutually agreeable resolution plan will be developed by all parties.

Tiburon Responsibilities:

a. Test system integration in accordance with the agreed upon test scenarios.
b. Resolve any discrepancies discovered during this task as agreed upon in the resolution plan.
c. Ensure that all appropriate personnel attend and actively participate in the project initiation teleconference.

Client Responsibilities:

a. Test system integration in accordance with the agreed upon test scenarios.
b. Document any discrepancy discovered during testing.
c. Coordinate test windows with REMSA.

Completion Criteria:

This task is complete when joint integration testing is complete and at the end of the two week period for Client's additional testing. Completion of Client's additional testing is not required for this task completion. If Client requires additional testing beyond the two weeks, then this task will be considered complete two weeks after the joint integration testing is complete.

Task 5 – Interface Cutover

Task Description:

After Integration Testing has been completed, Tiburon will notify the Client in writing that the C2C Interface is ready for LIVE status and assist the client in placing the system in operational status. A cutover readiness call will be scheduled with all involved parties to review the tasks and assignments for cutover.

Cutover will occur during Tiburon's normal business hours. Tiburon will provide remote support of the cutover with a Project Manager and a technical staff person.

NOTE – installation of the C2C Interface into the LIVE environment may require the installation of a new COMMANDCAD build and COLD restart to implement required configuration settings.

Tiburon Responsibilities:

a. Notify the Client when the C2C interface is ready for live production status.
b. Conduct a cutover readiness teleconference.
c. Install C2C on the Production environment.
d. Remotely monitor the operation of the C2C application for up to two business days.
e. Assist Client staff with utilizing and supporting the system.

Client Responsibilities:

a. Coordinate any necessary communications with REMSA.
b. Update Production File Maintenance for C2C.
c. Participate in the cutover readiness teleconference.
d. Begin operational use of the system.

Completion Criteria:

This work will be considered complete ten (10) business days after Tiburon has provided the Client with written notification that the Tiburon C2C interface has been placed into production. If Client does not confirm completion with a sign off letter presented by the Tiburon project manager within ten (10) business days of submittal of such letter, or otherwise notifies Tiburon in writing why completion sign-off has not been provided any final invoice(s) will be issued and will be payable in accordance with the payment terms of this Quotation.

WASHOE COUNTY HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

STAFF REPORT
EMS ADVISORY BOARD MEETING DATE: October 6, 2016

TO: EMS Advisory Board Members

FROM: Christina Conti, EMS Oversight Program Manager

775-326-6042, cconti@washoecounty.us

SUBJECT: **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.**

SUMMARY

The purpose of this agenda item is to discuss and possibly provide direction to staff on the progress of developing the five-year strategic plan, as required in the Inter Local Agreement for Emergency Medical Services Oversight.

PREVIOUS ACTION

During the EMS Advisory Board on June 4, 2015, the Board approved the development of the five year strategic plan.

A regional SWOT (Strength, Weaknesses, Opportunities, and Threats) Analysis was conducted on August 31, 2015 during an EMS Advisory Board meeting.

During the EMS Advisory Board on April 7, 2016, the Board approved the update on the development of the five year strategic plan

During the EMS Advisory Board on July 7, 2016, the Board approved the update on the development of the five year strategic plan.

BACKGROUND

The EMS Oversight Program was created through an Inter Local Agreement (ILA) signed by the City of Reno (RENO), City of Sparks (SPARKS), Washoe County (WASHOE), Truckee Meadows Fire Protection District (FIRE), and the Washoe County Health District. Within the ILA there are eight duties specifically outlined for the EMS Oversight Program. One of the items explicitly tasked the EMS Oversight Program to "Maintain a Five-Year Strategic Plan to ensure the continuous improvement of Emergency Medical Services in the area of standardized equipment, procedures, technology training, and capital investments to ensure that proper future operations continue to perform including Dispatching Systems, Automated Vehicle Locations Systems, Records Management Systems, Statistical Analysis, Regional Medical Supply and Equipment, and other matters related to strategic and ongoing Emergency Medical Services and approved by RENO, SPARKS, WASHOE and FIRE."

Public Health
Prevent. Promote. Protect.

At the June 4, 2015 EMS Advisory Board meeting, through discussion with the Board, the purpose of the strategic plan was identified as a document that would create milestones, furthering the EMS system in Washoe County. It was determined that a workshop should be held with the Board members to kick off the discussion and might provide some specific deliverables and desired outcomes.

On August 31, 2015 an EMS Advisory Board meeting was held with members of the EMS Working Group in attendance. The primary focus of the meeting was to hold the SWOT analysis. Manager Steve Driscoll facilitated the process and representatives from the Board, jurisdictional dispatch centers, fire partners, REMSA, and communications discipline participated.

The EMS Program Manager then began working with regional partners to develop the regional strategic plan. The stakeholders participating in the developing of plan included representatives from each jurisdiction and REMSA from dispatch and operations, as well as a regional communications representative. Over the course of 11 months the workgroup identified the components that would be included in the strategic plan. The first meetings were used to review the SWOT analysis and to identify goals for the region. Subsequent meetings reviewed the individual goals and the objectives within.

To ensure the process was efficient, each meeting had an identified objective to accomplish. All items drafted by the EMS Oversight Program remained in red and turned to black once the group has discussed and reached consensus on the draft.

The attached final draft of the strategic plan shows the efforts of the region in taking the SWOT analysis results and creating a path forward to improve the EMS system within Washoe County.

FISCAL IMPACT

There is no fiscal impact to the Board on this agenda item.

RECOMMENDATION

Staff recommends the Board to approve the presentation and recommend staff present the five-year Strategic Plan, a requirement of the Interlocal Agreement for Emergency Medical Services Oversight, to the District Board of Health

POSSIBLE MOTION

Should the Board agree with staff's recommendation a possible motion would be:

"Move to approve the presentation and recommend staff present the five-year Strategic Plan to the District Board of Health."

WASHOE COUNTY EMERGENCY MEDICAL SERVICES

2017-2021: Five-Year Strategic Plan

2017

Washoe County EMS Oversight Program

The Washoe County EMS System

The Washoe County Emergency Medical Services (EMS) Five- Year strategic plan was created with EMS Advisory Board support and reviewed by:

Contracted Ambulance Provider:
REMSA

Fire Service Agencies:
Reno Fire Department
Sparks Fire Department
Truckee Meadows Fire Protection District
Gerlach Volunteer Fire Department

Stakeholder Organizations and County Departments:
North Lake Tahoe Fire Protection District
Pyramid Lake Fire Rescue
Reno Dispatch
Airport Authority Fire Department
Sparks Dispatch
WC Shared Communication System
Washoe County EMS Oversight Program
Washoe County Communications

Approved by:
District Board of Health
EMS Advisory Board

Document Distributed to:
Contracted Ambulance Provider
Fire Service Agencies
Incline Village Community Hospital
Northern Nevada Medical Center
Renown Regional Medical Center
Saint Mary's Regional Medical Center
Stakeholder Organizations and County Departments
Veterans Affairs Sierra Nevada Health Care System

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Strategic Planning at a Glance

The Washoe County EMS system will provide high quality patient care through collaborative efforts and integrated healthcare providing evidence based prehospital medicine exceeding the expectations of the community.

RESPECTFUL

CUSTOMER SERVICE ORIENTED

PROFESSIONAL

RESPONSIVE

QUALITY IMPROVEMENT/ ASSURANCE

ACCOUNTABLE

COLLABORATIVE

It is the mission of the WC EMS System to coordinate the delivery of efficient and effective emergency medical services to the citizens, businesses and visitors of Washoe County through collaboration with EMS providers.

Enhance the regional EMS resources utilization matching the appropriate services as defined by the call for service through alternative protocols, service options and transportation options.

Improve pre-hospital EMS performance by reducing system response times through the use of technology and the development of regional response policies.

Improve communications between EMS partners through enhanced usage of technology and the development of regional guidelines.

Improve continuity of care through regional processes that ensure patient information transfers from the scene to the hospital.

Design an enhanced EMS response system through effective regional protocols and quality assurance.

Continue collaborative models with regional EMS agencies, health organizations and public safety stakeholders.

- Service Levels for Omega Calls
- EMD process for low acuity calls
- Alternative Transportation Options
- Automatic Vehicle Locator
- Ambulance Franchise Area Map Review
- Mutual Aid Agreements for EMS services
- Tier 1 response measurement
- Enhance radio communication systems
- CAD to CAD Interface
- Prehospital patient information flow
- EMS system annual report
- Regional set of protocols
- Regional quality improvement process
- Strategic plan implementation
- Reporting structure to ILA signatories

Executive Summary

Washoe County is the second largest EMS region in the state of Nevada. It is 6,551 square miles in size and has approximately 433,000 residents. Washoe County is diverse geographically in its mountainous, urban, suburban, rural and wilderness/frontier terrain.

There are many EMS system stakeholder organizations including police and fire agencies, dispatch centers, healthcare organizations, and a contracted ambulance provider. The current ambulance contractor provides service to Washoe County; excluding the Gerlach Volunteer Fire Department service area and the North Lake Tahoe Fire Protection District.

The Washoe County EMS Five-Year Strategic Plan was created between August 2015 and October 2016 to guide the future direction of the Washoe County EMS System. The assessment process evaluated the strengths and weaknesses, as well as the opportunities and threats facing the EMS system from national, regional and local influences. The information obtained through the analysis created goals to optimize the structure, processes, and outcomes of the EMS Five-Year Strategic Plan, focusing on: 1) maintaining or improving clinical care and patient satisfaction; and 2) improving operational efficiency and collaboration across the region.

The best EMS systems are based on collaborations among the diverse organizations that comprise the EMS system. When these organization's strengths are emphasized by system-wide integration and a culture of trust, the EMS system can more effectively capitalize on new opportunities and mitigate threats to the system. The planning process for Washoe County was supported by and involved EMS stakeholder leadership.

The strategic planning process was collaborative and included consensus building processes within the region and provided periodic updates to the EMS Advisory Board and District Board of Health. The results of this process were the EMS System's Mission, Vision, Values, Goals and Objectives. The EMS Five-Year Strategic Plan was approved by the EMS Advisory Board on October 6, 2016 and approved by the District Board of Health on October 27, 2016.

The six goals within Washoe County EMS Five-Year Strategic Plan are most relevant to the EMS system's ability to adapt to the changing healthcare environment, specifically focusing on pre-hospital care. There are three goals within the strategic plan to ensure maintenance and improvements related to clinical care and patient satisfaction. The remaining three goals focus on improving operational efficiencies within the region, both internally and externally through collaboration. These include proposed changes to existing processes that will positively impact the EMS System in its entirety.

Emergency Medical Services Regional Mission, Vision and Values

It is the mission of the Washoe County EMS System to coordinate the delivery of efficient and effective emergency medical services to the citizens, businesses and visitors of Washoe County through collaboration with EMS providers.

Vision:

The Washoe County EMS system will provide high quality patient care through collaborative efforts and integrated healthcare providing evidence-based prehospital medicine exceeding the expectations of the community.

The values of the Washoe County EMS System are:

- Respectful: To be open-minded of all stakeholder's views and ideas.
- Customer Service Oriented: To be responsive to our customers' needs striving to provide high quality services in a respectful and courteous manner.
- Accountable: To be responsible for our behaviors, actions and decisions.
- Professional: To be dedicated in our service to the region and ourselves through adherence of recognized policies, rules and regulations. This includes maintaining the highest moral and ethical standards.
- Responsive: To rapidly identify emerging issues and respond appropriately.
- Quality Improvement/Assurance: To continuously evaluate operations, procedures and practices to ensure the EMS system is meeting the needs of our patients and stakeholders.
- Collaborative: To work together towards delivering efficient and effective emergency medical services to the citizens, businesses, and visitors of Washoe County.

Emergency Medical Services Authority

Washoe County is comprised of three political jurisdictions, the City of Reno, City of Sparks and unincorporated Washoe County. In addition to the political bodies and their operational policy decisions, the State Division of Public and Behavioral Health also oversees EMS licensing and certifications within Washoe County.

There are multiple regulations that impact how the EMS system operates in Washoe County. At the State level, Nevada Revised Statute 450B is the overarching legislation that identifies minimum requirements for EMS services. In addition, the Nevada Administrative Code also includes codified regulations for EMS personnel and agencies.

At the local government level, by the authority established through Nevada Revised Statute (NRS 439.370 et seq.) and the 1986 Interlocal Agreement (last amended 1993), the Washoe County Health District has jurisdiction over all public health matters in Reno, Sparks, and Washoe County through the policy-making Washoe County District Board of Health (DBOH). Through this authority the DBOH established an

exclusive ambulance franchise in August 1986 in Washoe County, excluding Gerlach and the North Lake Tahoe Fire Protection District. This Franchise was awarded to the Regional Emergency Medical Services Authority (REMSA) in May 1987. Through a regional process, the agreement was amended, restated and approved by the DBOH in May 2014. As part of the regional process, one recommendation for improvement of the delivery of patient care and outcomes and the delivery of emergency medical services was the creation of a Regional Emergency Medical Oversight Program through an Inter Local Agreement (ILA).

The ILA was fully executed in August 2014 and is an agreement between five political jurisdictions; City of Sparks[1], City of Reno[2], Washoe County Board of County Commissioners[3], District Board of Health[4], and Truckee Meadows Board of Fire Commissioners[5]. The ILA establishes an Emergency Medical Services Advisory Board (EMS Advisory Board).

The EMS Advisory Board is comprised of the following members:

a. City Manager, Reno
b. City Manager, Sparks
c. County Manager, Washoe County
d. District Health Officer
e. Emergency Room Physician (DBOH Appointment)
f. Hospital Continuous Quality Improvement (CQI) Representative (DBOH Appointment)

The purpose of the EMS Advisory Board is to review reports, evaluations and recommendations of the Regional Emergency Medical Services Oversight Program and to discuss issues related to regional emergency medical services. The function of the EMS Advisory Board is to thoroughly discuss changes within the regional EMS system prior to making recommendations to the respective Board(s), of the five signatories, and placing items on an agenda for possible approval and implementation.

Additionally, the EMS Advisory Board can make recommendations to the District Health Officer and/or the District Board of Health related to performance standards and attainment of those standards, medical protocols, communication, coordination, and other items of importance to a high performing Regional Emergency Medical Services System, and providing for concurrent review and approval by the Managers of the City of Reno, City of Sparks and Washoe County, striving to have a uniform system maintained for the region whenever possible.

The ILA also established the Regional Emergency Medical Services Oversight Program (Program). The purpose of the Program is to provide oversight of all emergency medical services provided by the EMS personnel within the signatory jurisdictions, as well as REMSA. Additionally, the Program is expected to achieve the duties outlined within the ILA. The program consists of a Program Manager, Program Coordinator and Statistician.

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[1] Referred to as "SPARKS" within the ILA
[2] Referred to as "RENO" within the ILA
[3] Referred to as "WASHOE" within the ILA
[4] Referred to as "DISTRICT" within the ILA
[5] Referred to as "FIRE" within the ILA

The eight duties specifically detailed within the ILA are:

1. Monitor the response and performance of each agency providing Emergency Medical Services and provide recommendations to each agency for the maintenance, improvement, and long-range success of the Emergency Medical Services;

2. Coordinate and integrate provision of Medical Direction for RENO, SPARKS, WASHOE, FIRE and REMSA providing emergency medical services;

3. Recommend regional standards and protocols for RENO, SPARKS, WASHOE, FIRE and REMSA;

4. Measure performance, analysis of system characteristics, data and outcomes of the Emergency Medical Services and provide performance measurement and recommendations to RENO, SPARKS, WASHOE, FIRE and REMSA;

5. Collaborate with REMSA, RENO, SPARKS, WASHOE, FIRE and DISTRICT on analysis of EMS response data and formulation of recommendations for modifications or changes to the Regional Emergency Medical Response Map;

6. Identify sub-regions as may be requested by RENO, SPARKS, WASHOE, FIRE or the DISTRICT to be analyzed and evaluated for potential recommendations regarding EMS response services in order to optimize the performance of system resources;

7. Provide a written Annual Report on the State of Emergency Medical Services to RENO, SPARKS, WASHOE, FIRE and REMSA covering the preceding fiscal year (July 1st to June 30th), containing measured performance in each agency including both ground and rotary wing air ambulance services provided by REMSA in Washoe County; the compliance with performance measures established by the District Emergency Medical Services Oversight Program in each agency, and audited financial statements and an annual compliance report by REMSA as required in the exclusive Emergency Medical Ambulance Service Franchise;

8. Maintain a Five-Year Strategic Plan to ensure the continuous improvement of Emergency Medical Services in the area of standardized equipment, procedures, technology training, and capital investments to ensure that proper future operations continue to perform including Dispatching Systems, Automated Vehicle Locations Systems, Records Management Systems, Statistical Analysis, Regional Medical Supply and Equipment, and other matters related to strategic and ongoing Emergency Medical Services and approved by RENO, SPARKS, WASHOE and FIRE.

The ILA also outlines the duties of the signatories, which support the expectation that the strategic planning objectives will be achieved. Those duties are:

a. Providing information, records, and data on Emergency Medical Services dispatch and response from their respective Public Safety Answering Points (PSAPs) and Fire Services for review, study and evaluation by DISTRICT.

b. Participating in working groups established by DISTRICT for coordination, review, evaluation, and continuous improvement of Emergency Medical Services.

c. Participating in establishing and utilizing a Computer Aided Dispatch (CAD) – to – CAD two-way interface with REMSA which provides for the instantaneous and simultaneous transmission of call-related information for unit status updates;

d. Working cooperatively with DISTRICT to provide input to the development of the Five Year Strategic Plan and to ensure consistent two-way communication and coordination of the Emergency Medical Services System between RENO, SPARKS, WASHOE, FIRE, and REMSA in the future as technologies, equipment, systems, and protocols evolve;

e. Participating on the Regional Emergency Medical Services Advisory Board;

f. Striving to implement recommendations of DISTRICT, or submitting those recommendations to their governing bodies for consideration and possible action if determined necessary and appropriate by the respective managers; and

g. Submitting recommendations regarding the Emergency Medical Services System to DISTRICT for implementation or for consideration and possible action by the District Board of Health if determined necessary and appropriate by the District Health Officer.

Regional Strategic Plan
Process, Objectives and Implementation

Washoe County has a two tiered system response to emergency medical calls. When an individual dials 9-1-1 the call routes through one of three Public Safety Answering Points (PSAPs): Reno, Sparks or Washoe County. Jurisdictional fire departments are dispatched to a medical call by PSAP personnel. If appropriate, the caller is then transferred to REMSA’s communications center for Emergency Medical Dispatch (EMD). EMD allows REMSA dispatch to prioritize the caller's chief complaint to dispatch appropriate resources and provide pre-arrival instruction to the caller.

There are several agencies and organizations involved in the response to an emergency medical call. The EMS Advisory Board recognizes the need to provide optimal emergency care under the varied conditions throughout Washoe County. Therefore, the EMSAB strives to influence the coordination of all stakeholders as it develops and sustains a system to ensure appropriate and adequate emergency medical services. With this in mind, the Five-Year EMS strategic plan was constructed.

To ensure the objectives of the entire region were considered, the EMS Working Group convened and participated in a SWOT analysis. The SWOT analysis looks at the strengths (internal), weaknesses (internal), opportunities (external), and threats (external) for the regional EMS system.

Representatives from both dispatch and operations for the EMS agencies provided input and feedback on the development of the strategic plan. The EMS Oversight Program frequently met with the representatives to review the goals, objectives, and strategies while discussing realistic timelines for implementation. These meetings were an integral part of the process to ensure the regional planning goals mirrored the jurisdictional strategic planning goals of the individual EMS agencies. This culminated in the development of a regional strategic plan for the EMS Advisory Board's consideration.

The Five-Year EMS strategic plan includes goals, objectives and strategies. The six goals of the strategic plan are broad statements to identify future achievements of the Washoe County EMS system. Each goal includes objectives designed to measure progress towards the attainment of the goal. The strategies for each goal describe a major approach or method for attaining the objectives.

Additionally, the strategic plan outlines the method to achieve effective and efficient solutions to system-wide challenges. The strategic plan calls for maximum collaboration to achieve the objectives and strategies within the five year planning period (2017-2021). Through continued collaboration, the strategic plan can be updated to capitalize on new opportunities or to mitigate threats to the system. This process will ensure key stakeholders remain involved in regional emergency medical services planning activities.

Goal #1 – Enhance utilization of EMS resources by matching the appropriate services, as defined by the call for service, through alternative protocols, service options and transportation options by October 7, 2021.	
Objective 1.1 Develop appropriate protocols to determine service level for Omega calls by January 5, 2017.	**Strategy 1.1.1** Resolve legal issues impacting fire partners by March 30, 2016. **Strategy 1.1.2** Develop regional Standard Operating Procedures to address response to Omega calls by June 21, 2016. **Strategy 1.1.3** Approval by the EMS Advisory Board of protocols determining service levels for Omega calls by July 7, 2016. **Strategy 1.1.4** Determine data elements required for process verification by September 30, 2016. **Strategy 1.1.5** Analyze, interpret and report data elements to EMS Advisory Board and partner agencies quarterly beginning January 5, 2017.
Objective 1.2 Implement appropriate protocols to determine service level through EMD process to low acuity Priority 3 calls by February 5, 2017.	**Strategy 1.2.1** Resolve regional concerns (operational, legal, and patient care) relating to protocols to determine service level through EMD process to low acuity Priority 3 calls by June 30, 2016. **Strategy 1.2.2** Develop Standard Operating Procedures to determine service level through EMD process to low acuity Priority 3 calls by October 28, 2016. **Strategy 1.2.3** Determine data elements required for process verification by December 16, 2016. **Strategy 1.2.4** Review by the EMS Advisory Board of the protocols that determine service levels through EMD process to low acuity Priority 3 calls by January 5, 2017.

- Goal #1 Continued - Enhance utilization of EMS resources by matching the appropriate services, as defined by the call for service, through alternative protocols, service options and transportation options by October 7, 2021.	
Objective 1.3 Develop standardized procedures for eligible patients to receive funded alternative transportation to obtain medical care at an alternative destination by October 7, 2021.	**Strategy 1.3.1** Conduct research on alternative transportation options utilized across the United States by October 31, 2020. **Strategy 1.3.2** If applicable, develop processes for dispatch centers to select eligible patients to receive funded alternative transport to facilities that accept patients who meet alternative destination criteria (e.g. urgent care, physician's office criteria) by August 31, 2021. **Strategy 1.3.3** If applicable, obtain approval by the EMS Advisory Board of standardized procedures for patients to receive funded alternative transportation to obtain medical care by October 7, 2021.

- Goal #2 - Improve pre-hospital EMS performance by reducing system response times through the use of technology and the development of regional response policies by December 21, 2022.	
Objective 2.1. Implement regional usage of Automatic Vehicle Locator (AVL) technology to dispatch closest available unit by December 31, 2022.	**Strategy 2.1.1.** Complete a regional assessment to identify and understand existing AVL capabilities to dispatch the closest EMS responder by June 30, 2021. **Strategy 2.1.2.** Approval to utilize AVL to dispatch the closest available unit to EMS calls by individual Councils/Boards and EMS Advisory Board by December 31, 2021. **Strategy 2.1.3.** Develop regional dispatching process that will utilize the AVL technology to dispatch the closest unit to EMS calls for service by June 30, 2022. **Strategy 2.1.4.** Purchase and install additional AVL equipment to increase capabilities in region by December 31, 2022.
Objective 2.2. Establish ambulance franchise response map review methodology by September 30, 2016.	**Strategy 2.2.1.** Develop standardized methodology for the annual review of the ambulance franchise response map by June 30, 2016. **Strategy 2.2.2.** Develop standardized methodology for the five and ten year review for the ambulance franchise response map by September 30, 2016. **Strategy 2.2.3.** Approval by the EMS Advisory Board of the standardized methodology for the annual, five and ten year reviews by October 6, 2016. **Strategy 2.2.4** Analyze and report franchise map reviews annually including any recommended modifications to the EMS Advisory Board, beginning July 6, 2017.
Objective 2.3. Increase depth of resources able to respond to EMS calls for service in Washoe County by December 31st annually.	**Strategy 2.3.1.** Identification of operational opportunities by WC EMS agencies through a review of mutual aid agreements (MAA) and/or memorandum of understanding (MOU) that include EMS services for Washoe County by June 30th annually.

- Goal #2 Continued - Improve pre-hospital EMS performance by reducing system response times through the use of technology and the development of regional response policies by December 31, 2022.	
Objective 2.3. Increase depth of resources able to respond to EMS calls for service in Washoe County by December 31st annually.	**Strategy 2.3.2.** Enter into or modify MAAs/MOUs with partner agencies as necessarily by December 31st annually. **Strategy 2.3.4.** Provide an update to EMS Advisory Board on all MA/MOU process changes or additional agreements being utilized in region by January 31st annually, beginning in January 2017.
Objective 2.4. Define a measurement for EMS Tier 1 response agencies, to support recommendations for system improvements, by ________.	**Strategy 2.4.1.** Determine jurisdictional fire response measurement by _____________. **Strategy 2.4.2.** Review defined jurisdictional measurement with EMS Oversight Program by December 31, 2016. **Strategy 2.4.3.** Monitor and report to the EMS Advisory Board the performance of the regional EMS system utilizing the jurisdictional fire measurement and ambulance franchise response map by the 15th of the month, following the fiscal year quarter. **Strategy 2.4.4.** Provide recommendations for improvements based on defined performance measures to EMS Advisory Board as needed.

- Goal #3 - Improve communications between EMS partners through enhanced usage of technology and the development of regional guidelines by June 30, 2021.	
Objective 3.1. Enhance radio communication systems within Washoe County by June 30, 2021.	**Strategy 3.1.1.** REMSA will ensure interoperability between UHF and 800 MHz through a gateway connection between REMSA and Washoe County Regional Communication System by December 31, 2016. **Strategy 3.1.2.** Obtain clarification from District Board of Health regarding Amended and Restated Franchise section 5.1 by June 30, 2017. **Strategy 3.1.3.** Develop a comprehensive migration interoperability plan for WCRCS that outlines the enhancement of the radio communication system to include completion of upgrades, maintenance of REMSA gateway connection and identified equipment needs by December 31, 2018. **Strategy 3.1.4.** REMSA and regional public safety partners will develop a plan to upgrade system based on jurisdictional analysis, in alignment with WCRCS target date of June 30, 2021.
Objective 3.2: Establish a CAD-to-CAD (computer aided dispatch) interface between the primary PSAP and REMSA dispatch center by December 31, 2017.	**Strategy 3.2.1.** Create a regional workgroup to design the elements of the CAD-to-CAD interface increasing interoperability between dispatch centers by January 31, 2016. **Strategy 3.2.2.** Complete configuration process that includes development of the data exchange overview document and implementation by December 31, 2017. **Strategy 3.2.3.** Provide process updates to EMS Advisory Board quarterly, beginning April 7, 2016.
Objective 3.3: Establish a two-way interface to provide visualization of AVL for all EMS vehicles for the primary PSAPs and REMSA dispatch center by December 31, 2017.	**Strategy 3.3.1.** Complete a regional assessment to identify and understand AVL existing capabilities by December 31, 2016. **Strategy 3.3.2.** Develop regional process that will utilize the AVL technology to visualize EMS vehicles in both the primary PSAPs and REMSA dispatch center by December 31, 2017. **Strategy 3.3.3.** If applicable, purchase and install additional AVL equipment to increase capabilities in region by December 31, 2017.

- Goal #4 - Improve continuity of care through regional processes that ensure patient information transfers from the scene to the hospital by December 31, 2018.	
Objective 4.1. Develop a process to improve the flow of patient information throughout the prehospital setting by December 31, 2018.	**Strategy 4.1.1.** Identify the electronic patient care reporting (ePCR) software being utilized or purchased for use in the region by June 30, 2016. **Strategy 4.1.2.** Evaluate how to transfer information between the ePCR from the fire response unit to the REMSA response unit by December 31, 2016. **Strategy 4.1.3.** Evaluate existing processes for transferring all prehospital care information to hospital personnel and implement process improvement by June 30, 2018. **Strategy 4.1.4.** Create and conduct training on regional policy, to include pertinent information required for seamless transfer of patient care from agency to agency by December 31, 2018.
Objective 4.2: Produce an annual report on EMS system performance that includes hospital outcome data by December 31, 2018.	**Strategy 4.2.1.** Collaborate with hospital partners on data available for submission to the EMS Oversight Program for cardiac, stroke and stemi patients by October 31, 2016. **Strategy 4.2.2.** Pilot the annual report with hospital outcome data with one regional hospital by March 31, 2017. **Strategy 4.2.3.** Draft for distribution an annual report with relevant regional hospital partner data included by June 30, 2017. **Strategy 4.2.4.** Review annual report with ePCR implementation and determine enhancements available for hospital outcome data by October 31, 2018. **Strategy 4.2.5.** Draft for distribution of an annual report with enhanced data included by December 31, 2018.

- Goal #5 - Design an enhanced EMS response system through effective regional protocols and quality assurance by December 31, 2018.	
Objective 5.1. Develop a regional set of protocols for the delivery of prehospital patient care by July 2017.	**Strategy 5.1.1.** Review current protocols for each regional agency to determine differences and opportunities for improvement by October 31, 2016. **Strategy 5.1.2.** Coordinate with PMAC[6] to develop regional protocols based on national standards and recent clinical studies, by June 30, 2017, amend as needed with a minimum annual review. **Strategy 5.1.4.** Presentation to the EMS Advisory Board of the regional protocols and conflict resolution procedure for prehospital care by July 2017 **Strategy 5.1.5.** Create and conduct training on regional protocols for prehospital care by December 31, 2017.
Objective 5.2. Establish a regional process that continuously examines performance of the EMS system by December 31, 2018.	**Strategy 5.2.1.** Create a regional team, including PMAC representation, which would work to improve the system through examination of system performance by December 31, 2018. **Strategy 5.2.2.** Determine team goals and identify initial performance measures to be utilized to continuously improve processes by December 31, 2018. **Strategy 5.2.3.** Acceptance by the EMS Advisory Board of the performance initiatives to be used during the review process by January 2019. **Strategy 5.2.4.** Present information from the quarterly meeting to the appropriate entity, beginning April 2019.

[6] PMAC is the Prehospital Medical Advisory Committee for Washoe County

- Goal #6 - Continue collaborative models with regional EMS agencies, health organizations and public safety stakeholders.	
Objective 6.1. Coordinate and report on strategic planning objectives quarterly through June 2021.	**Strategy 6.1.1.** Create a Gantt chart for the regional partners with the details of the goals by October 31, 2016. **Strategy 6.1.2.** Develop structured feedback loops for the current initiatives of the strategic plan goals. **Strategy 6.1.3.** Provide progress reports to the EMS Advisory Board quarterly, beginning January 2017.
Objective 6.2. Promote the EMS Oversight Program through regional education of the strategic plan's goals and initiatives by January 31, 2017.	**Strategy 6.2.1.** Create a reporting structure for the signatories of the Inter-Local Agreement and ambulance franchisee Board to receive updates on the status of the regional EMS system, biannually, beginning January 2017.

Strategic Plan Evaluation and Update

In an effort to ensure the successful implementation of the strategies and objectives of the EMS Advisory Board strategic plan, the EMS Oversight Program will develop a Gantt chart. The chart will be distributed to the regional partners upon approval of the strategic plan by the District Board of Health. The chart will be reviewed semi-annually to ensure all projected timelines remain achievable. Progress on the strategic planning strategies and objectives will be included in the EMS Oversight Program "Program and Performance Data Update" staff report at the EMS Advisory Board meeting.

Every two years, beginning in October 2018, the regional partners will convene to review the status of the current strategies and objectives. During the October 2018 review, the EMS Oversight Program will begin to develop the draft goals, strategies and objectives for years 2022-2023. Upon completion the EMS Oversight Program will bring an updated 5-year strategic plan to the EMS Advisory Board for review, input and approval.

WASHOE COUNTY
HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

STAFF REPORT

ADVISORY BOARD MEETING DATE: October 6, 2016

TO: EMS Advisory Board Members

FROM: Heather Kerwin, EMS Statistician
775-326-6041, hkerwin@washoecounty.us

SUBJECT: **Presentation, discussion and possible approval for distribution the Washoe County EMS Oversight Program FY 15-16 Annual Data Report.**

SUMMARY

The purpose of this agenda item is to present for discussion the EMS Oversight Program Annual Data Report for FY 15-16. This year's Annual Report (FY 15-16) serves as an educational and informational resource highlighting the work performed and achievements of the entire region as it relates to EMS. The FY 15-16 Annual Report is designed to ensure understanding of how the EMS system is designed to work in our community.

PREVIOUS ACTION

The previous EMS Program Annual Report for FY 14-15 was approved on October 1, 2015 and utilized all calls matched and used in the quarterly report analyses for FY 14-15.

BACKGROUND

The previous Annual Report (FY 14-15) served as a baseline document which measured the EMS system's performance relative to National performance standards and was focused primarily on agency response times by month. The format illustrated agency's response times were consistent from month to month.

While response data is important to EMS system performance, the EMS Advisory Board FY 15-16 Annual Report highlights regional achievements and utilizes the quarterly report for sophisticated data analysis. The FY 15-16 Annual Report should be utilized as an educational and informational resource for our community to discuss EMS system performance more effectively. It serves as a true report from the EMS Advisory Board on the status of the EMS system and the achievements from all the partner agencies.

FISCAL IMPACT

There is no additional fiscal impact should the Advisory Board approve the presentation and distribution of the Washoe County EMS Oversight Program FY 15-16 Annual Data Report.

RECOMMENDATION

Staff recommends the Board approve the presentation and distribution of the Washoe County EMS Oversight Program FY 15-16 Annual Data Report.

POSSIBLE MOTION

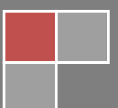
Should the Board agree with staff's recommendation, a possible motion would be: Move to approve the presentation and distribution of the Washoe County EMS Oversight Program FY 15-16 Annual Data Report.

2016

Washoe County EMS Oversight Program

Annual Report FY 15-16

Washoe County Health District
Division of Epidemiology and Public Health Preparedness
EMS Oversight Program



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Acknowledgements

The EMS Oversight Program would like to thank the following for contributing to the FY15-16 Annual Report:

- Washoe County GIS Technological Services/Regional Services for creating all the maps contained within this document.

- The partner agencies for providing their highlights and accomplishments.

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Introduction

The Emergency Medical Services (EMS) Oversight Program Annual Report contains a summary of the Washoe County regional EMS system from July 1, 2015 through June 30, 3016 (FY 15-16). Within the report there are seven sections highlighting the EMS system within Washoe County, to include EMS response agencies and their jurisdictional boundaries, regional performance data, and regional EMS accomplishments and goals for fiscal year 16-17.

Section 1: About the Washoe County EMS Oversight Program

An assessment of the Washoe County EMS system was conducted in 2012 by a public safety consulting firm, TriData; this study resulted in 36 recommendations to the region for the improvement of EMS services, including the establishment of a Regional EMS Oversight Program (Program). On August 26, 2014 an Interlocal Agreement (ILA) for Emergency Medical Services Oversight was fully executed between the City of Reno (Reno), City of Sparks (Sparks), Washoe County Board of Commissioners (Washoe), Washoe County Health District, and Truckee Meadows Board of Fire Commissioners (Fire). The ILA created the Program, the purpose of which is to provide oversight of all emergency medical services provided by Reno, Sparks, Washoe, Fire, and REMSA. The Program is staffed with 2.5 full-time employees; a full-time Program Manager, a full-time Program Coordinator, and a part-time Program Statistician. Additionally, the establishment of the ILA and the Program created specific duties and expectations of the signatories. A summary of the eight duties of the Program, and seven duties of the signatory partners, as designated per the ILA, are provided below.

The Program is tasked with the following:

1. Monitoring the response and performance of each agency providing EMS in the region
2. Coordinate and integrate medical direction
3. Recommending regional standards and protocols
4. Measure performance, system characteristics, data and outcomes for EMS to result in recommendations
5. Collaboration with partners on analyses of EMS response data and formulation of recommendations for modifications or changes of the regional Emergency Medical Response Map
6. Identification on sub-regions to be analyzed and evaluated for recommendations regarding EMS response
7. Provide an annual report on the state of EMS to contain measured performance of each agency and compliance with performances measures established by the Program for each agency

8. Create and maintain a five-year strategic plan to ensure continued improvement in EMS to include standardized equipment, procedures, technology training and capital investments

The signatory partners are tasked with the following:

1. Provide information, records and data on EMS dispatch and response for review, study and evaluation by the EMS Program
2. Participate in working groups for coordination, review, evaluation and continued improvement of EMS
3. Participate in the establishment and utilization of computer-aided-dispatch (CAD)-to-CAD interface[1]
4. Work cooperatively with the EMS Program to provide input on the five-year strategic plan and ensure two-way communication and coordination of EMS system as future technologies, equipment, systems and protocols evolve
5. Participate in the EMS Advisory board
6. Strive to implement recommendations of the EMS Program or submit recommendations to their respective governing bodies for consideration and possible action
7. Submitting recommendations regarding the MES system to the EMS Program for implementation or consideration and possible action by the District Board of Health

The ILA also created an Emergency Medical Services Advisory Board (EMSAB), comprised of the following members:

a. City Manager, Reno
b. City Manager, Sparks
c. County Manager, Washoe County
d. District Health Officer
e. Emergency Room Physician (DBOH Appointment[2])
f. Hospital Continuous Quality Improvement (CQI) Representative (DBOH Appointment[2])

The EMSAB was established to provide a concurrent review of topics within the EMS system. The purpose of the EMSAB is to review reports, evaluations and recommendations of the Program, discuss issues related to regional emergency medical services and make recommendations to the respective jurisdictional Boards.

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[1] CAD-to-CAD is a two-way interface with allows for call-related information to be transferred between all agencies involved with an incident to have access to live updates and incident status information

[2] DBOH is the Washoe County District Board of Health; the governing board which oversees health-related issues within Washoe County

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Section 2: How Washoe County's 9-1-1 and EMS systems are designed

Washoe County has a two-tiered response system to emergency medical calls. A 9-1-1 call is routed through the Public Safety Answering Point (PSAP), to determine if a caller is requesting police, medical or fire response; and if medical is requested or needed, the caller is forwarded to REMSA for Emergency Medical Dispatch (EMD).

The two-tiered system is designed so that a fire agency is dispatched first to a medical EMS incident in their jurisdiction, since fire stations are located within neighborhoods throughout the region. While fire is being dispatched, the call taker is questioned by REMSA to determine the call priority, and the subsequent dispatching of an ambulance. The performance of the EMS System within Washoe County is dependent on all parties working together.

Figure 1 illustrates how a 9-1-1 call is transferred through the EMS system. Starting from the initial call coming into the PSAP, to the call taker questioning, dispatch of fire, transferring the 9-1-1 call to REMSA, REMSA dispatching an ambulance, EMS (Fire and REMSA) responders arriving on scene, and REMSA transporting the patient to a hospital.

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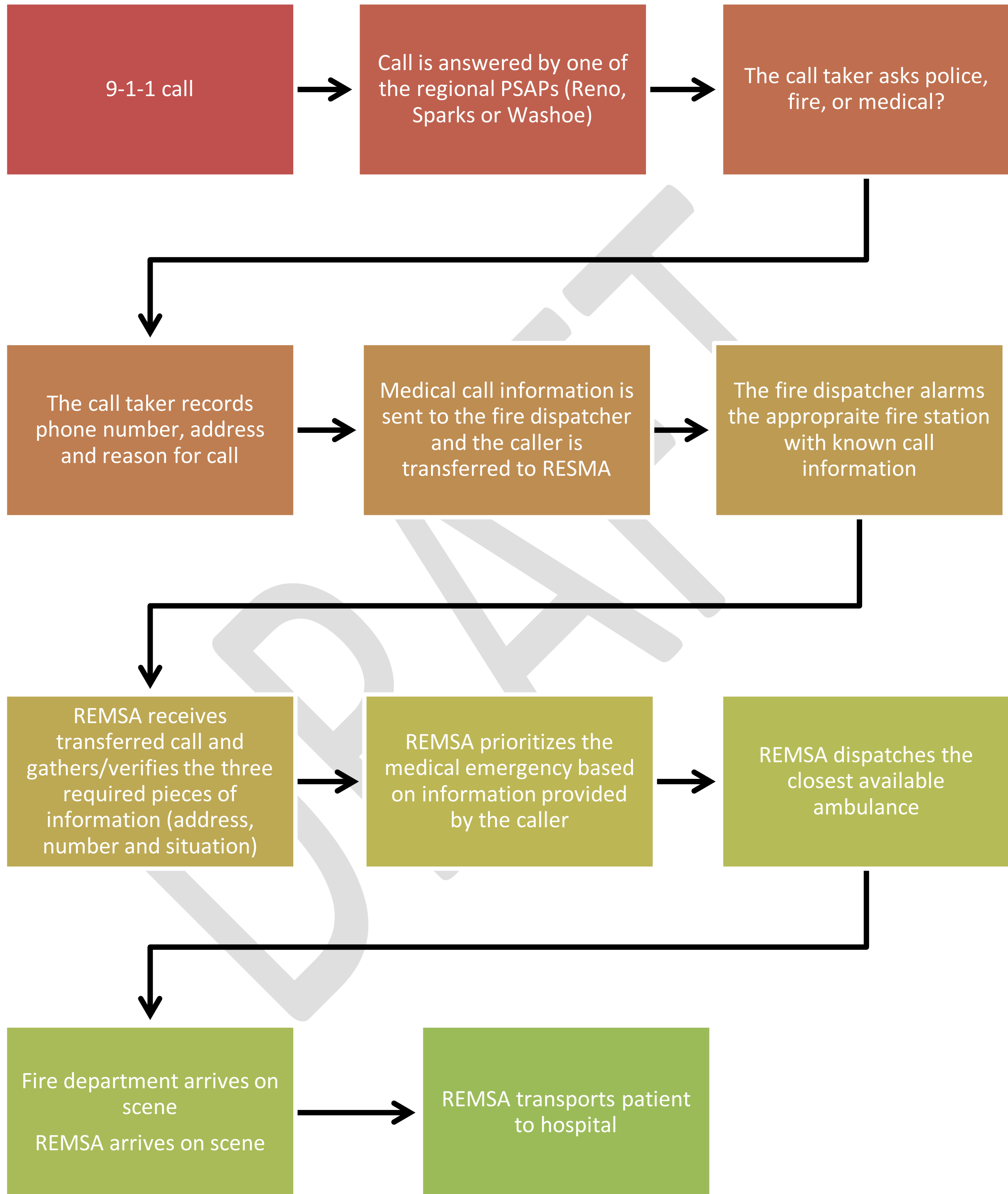
Figure 1: 9-1-1 Call Routing in Washoe County



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Section 3: Washoe County EMS Partner Agencies

The EMS system within Washoe County is comprised of multiple partner agencies. These agencies work together daily to ensure the needs of the community are met. These EMS partner agencies include:

- City of Reno[3]
- City of Reno Fire Department
- City of Reno Public Safety Dispatch (Reno ECOMM)
- City of Sparks[3]
- City of Sparks Fire Department
- City of Sparks Public Safety Answering Point
- Gerlach Volunteer Fire Department
- North Lake Tahoe Fire Protection District
- Pyramid Lake Fire and Rescue
- Reno-Tahoe Airport Authority Fire Department
- REMSA
- Truckee Meadows Fire Protection District[3]
- Washoe County[3]
- Washoe County Health District[3]
- Washoe County Sheriff's Office

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Jurisdictional Response and Station Maps

Emergency Medical Services in Washoe County are provided by the following career fire agencies: Reno Fire Department, Sparks Fire Department, Truckee Meadows Fire Protection District, North Lake Tahoe Fire Protection District and Pyramid Lake Fire and Rescue. The City of Reno and City of Sparks Fire Departments' jurisdictions encompass the city limits of their respective cities (Figure 2), while Truckee Meadows Fire Protection District's jurisdiction encompasses the more rural areas of unincorporated Washoe County (Figure 3) up to the Rural Fire Boundary (Figure 4). The southwest corner of Washoe County falls under the jurisdiction of North Lake Tahoe Fire Protection District (NLTFPD). NLTFPD provides fire and ambulance coverage and transport for the residents of Incline Village, Crystal Bay and surrounding communities. Pyramid Lake Fire and Rescue's jurisdiction includes the Pyramid Lake Tribal Land reservation boundaries.

[3] signatory of the ILA

Washoe County citizens also are served by the following volunteer fire agencies: EMS coverage north of the Rural Fire Boundary is covered by Gerlach Volunteer Ambulance and Fire Department, their jurisdiction includes the towns of Gerlach, Empire, and surrounding rural region. The Red Rock Volunteer Fire Department serves a rural area north of Reno; and the Verdi Volunteer Fire Department serves an unincorporated area west of Reno, near the California border.

The private ambulance company, REMSA, is responsible for the transport of patients within their designated Franchise response area. REMSA's response area extends from the southern border of Washoe County, north to the border of the Pyramid Lake Paiute tribal lands, east to Wadsworth and west to the border of California (Figure 3).

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Figure 2: Jurisdictional Boundaries and Fire Station Locations for Reno Fire Department, Sparks Dire Department and Truckee Meadows Fire Protection District

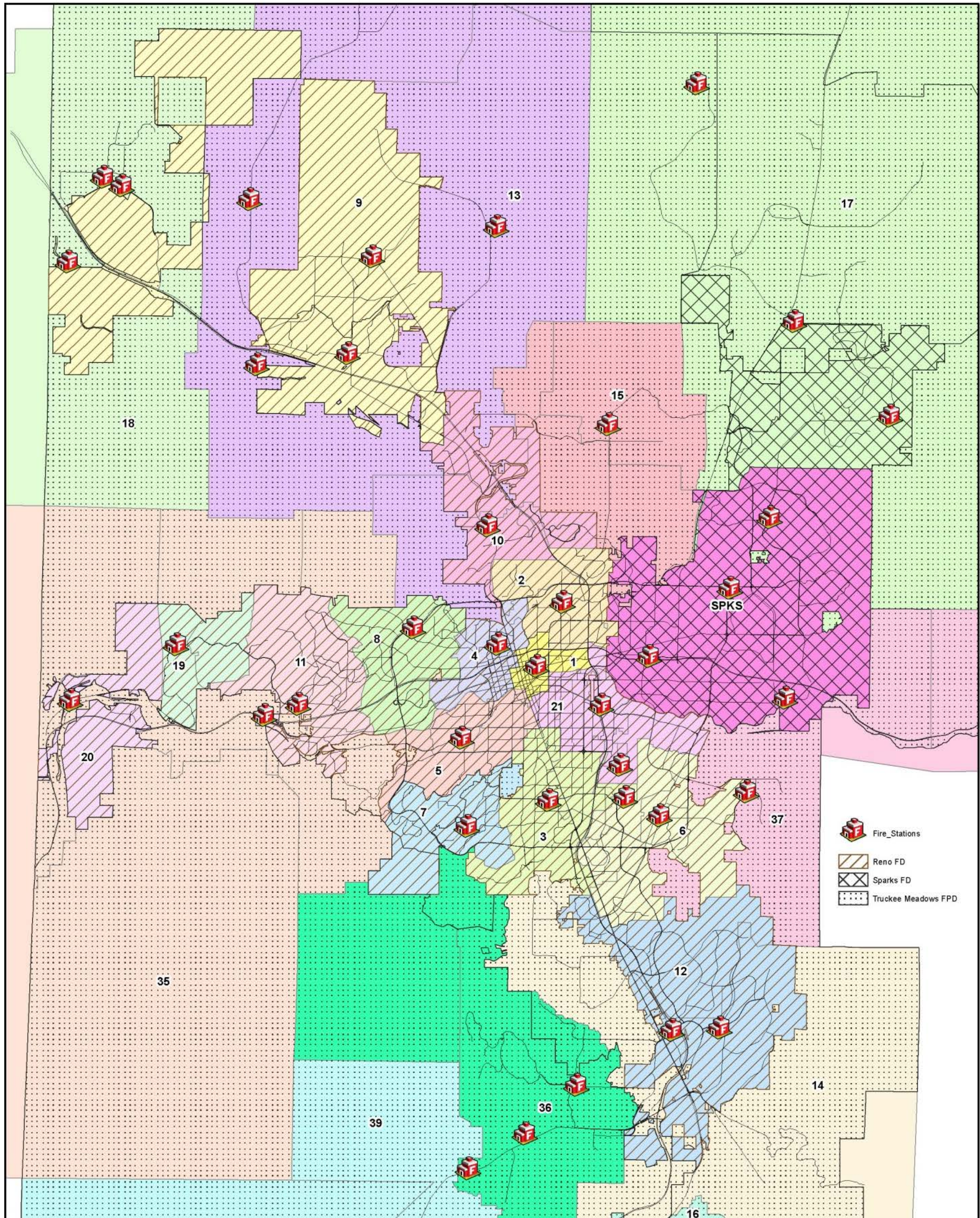
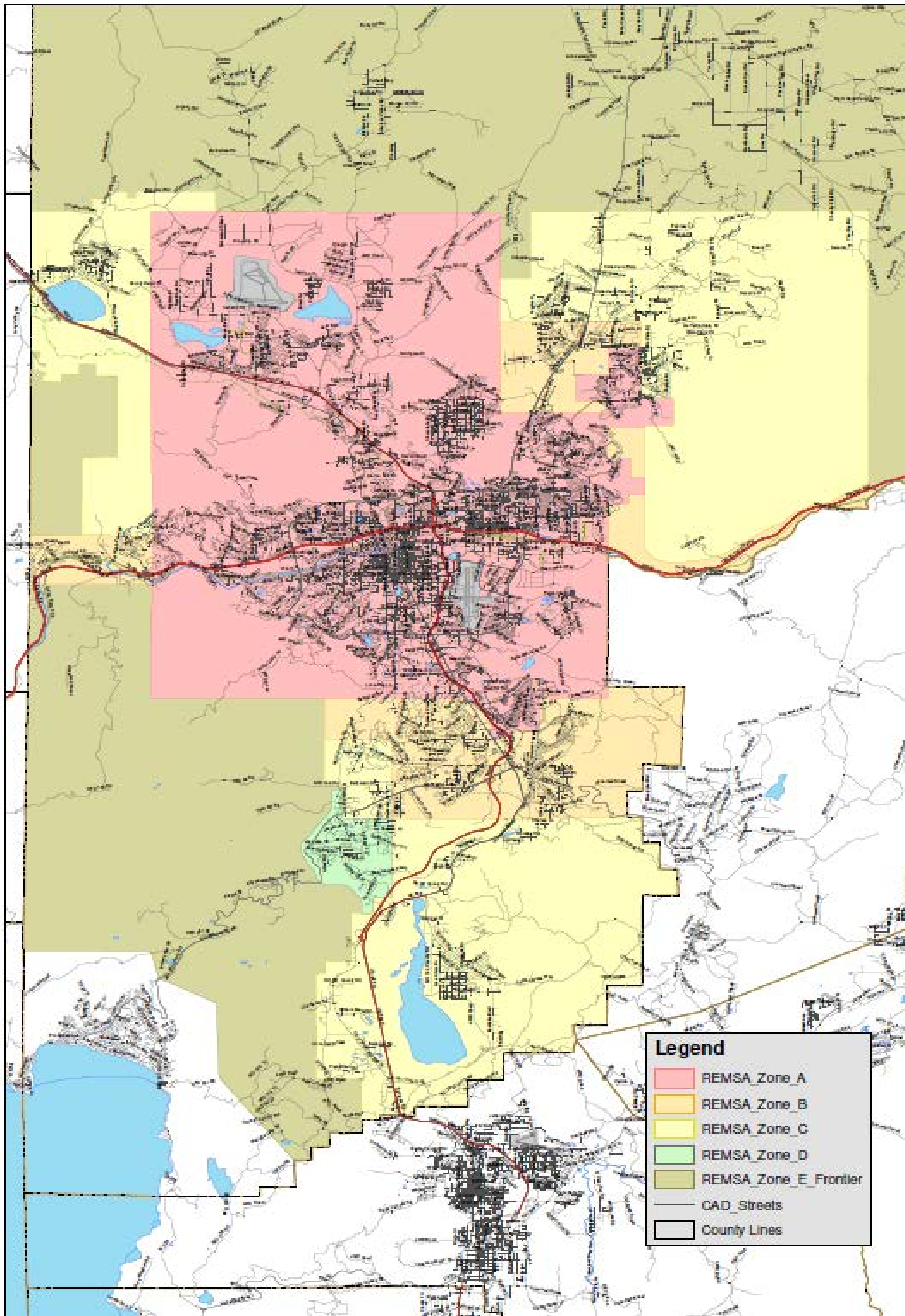


Figure 3: REMSA Franchise Response Map through June 30, 2016



Section 4: Regional EMS Performance Analyses

EMS related calls are reported by three fire agencies in Washoe County: City of Sparks, City of Reno, and the Truckee Meadows Fire Protection District (unincorporated Washoe County), all of which are signatories of the Interlocal Agreement, as well as REMSA. The reported EMS related fire calls are matched to REMSA calls for service to allow for an evaluation of system performance on EMS incident response, from the initial 9-1-1 call through each agency arriving on scene. The purpose of matching fire call data with REMSA call data is to better understand how the EMS system is functioning in our region and determine if implemented protocols are impacting response times and patient outcomes. Additionally it allows the region to review if there are opportunities for improvement.

The analyses presented in this section are representative of the EMS calls for service during July 1, 2015-June 30, 2016. The calls utilized in these analyses are those which matched between fire partners and REMSA.

Table 1 Total number of Fire calls which matched to REMSA calls by REMSA priority. The number used in each analysis is dependent on the time stamp validity for time stamps used in each table.

Priority	#	%
1	21,498	47.5%
2	17,149	37.9%
3	5,954	13.2%
9	693	1.5%
Total	**45,294**	**100.0%**

Table 2 The proportion of calls when PSAP received notification of a 9-1-1 call prior to REMSA. SFD was able to provide PSAP data starting October 26, 2015. Calls which occurred prior to October 26 from SFD do not have PSAP data.

Agency	#	%
REMSA First	5,237	12.4%
PSAP First	36,880	87.6%
Total Matched N =45,294, Used N = 42,117		

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Table 3 The median time intervals from the initial call (IC) to responding agency's dispatch and arrival on scene.

The initial call (IC) time was calculated using either REMSA call pick up time or PSAP Created Time, depending on which was first. Those calls excluded from the analysis were missing PSAP Created Time or did not have an arrival on scene time stamp for either a fire partner or REMSA.

REMSA Priority	Median Time from Initial Call (IC) to Dispatch and Arrival On Scene		
	IC to REMSA Dispatch	**IC to Fire Arrival**	**IC to REMSA Arrival**
1	0:01:12	0:06:46	0:06:56
2	0:01:16	0:07:05	0:07:27
3	0:01:14	0:07:00	0:09:04
9	0:01:17	0:07:15	0:10:03
All	0:01:14	0:06:55	0:07:19
Total matched N = 45,294, Used N = 30,481			

The median time from the initial call to REMSA dispatch (clock start) is 01:14 minutes, to Fire arrival is 06:55 minutes, and REMSA arrives 07:19 minutes after the initial call.

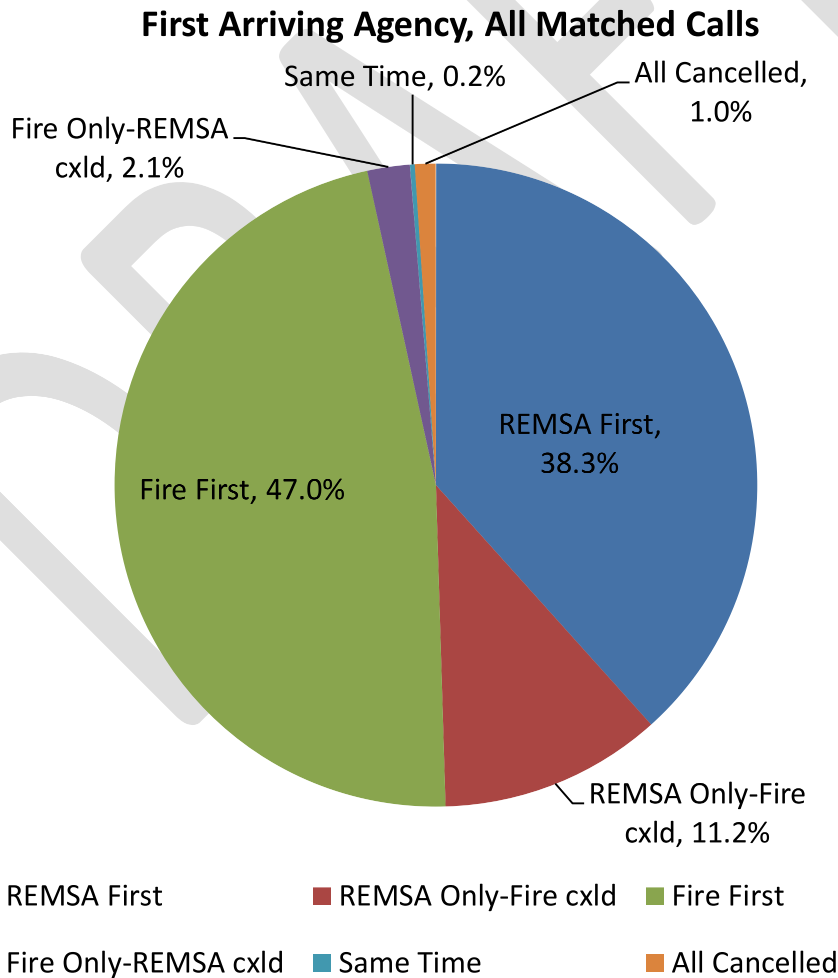
Table 4 The median travel time (time from when fire agency goes en route to fire agency arrival on scene). Median, Mean (average), and 90th percentile.

Fire Travel Time: En route to Arrival		
Median	**Mean**	**90th Percentile**
0:03:57	0:04:27	0:07:22
Used N= 38,980		

Of the 38,980 fire calls with an en route and arrival time stamp, the median travel time was 03:57 minutes, the mean or average travel time was 04:27 minutes and the 90th percentile, meaning 90% of the calls, were 07:22 minutes or less.

Table 5 Regional information that indicates the first responding unit on scene, by priority.

First on Scene	Priority REMSA									
	1		2		3		9		Total	
	#	%	#	%	#	%	#	%	#	%
REMSA First	9,211	42.8%	6,518	38.0%	1,485	24.9%	152	21.9%	17,366	38.3%
REMSA Only-Fire cxld	1,951	9.1%	2,083	12.1%	906	15.2%	125	18.0%	5,065	11.2%
Fire First	9,959	46.3%	7,780	45.4%	3,195	53.7%	374	54.0%	21,308	47.0%
Fire Only-REMSA cxld	185	0.9%	443	2.6%	313	5.3%	29	4.2%	970	2.1%
Same Time	57	0.3%	40	0.2%	12	0.2%	4	0.6%	113	0.2%
All Cancelled	135	0.6%	285	1.7%	43	0.7%	9	1.3%	472	1.0%
Total	21,498	100.0%	17,149	100.0%	5,954	100.0%	693	100.0%	45,294	100.0%



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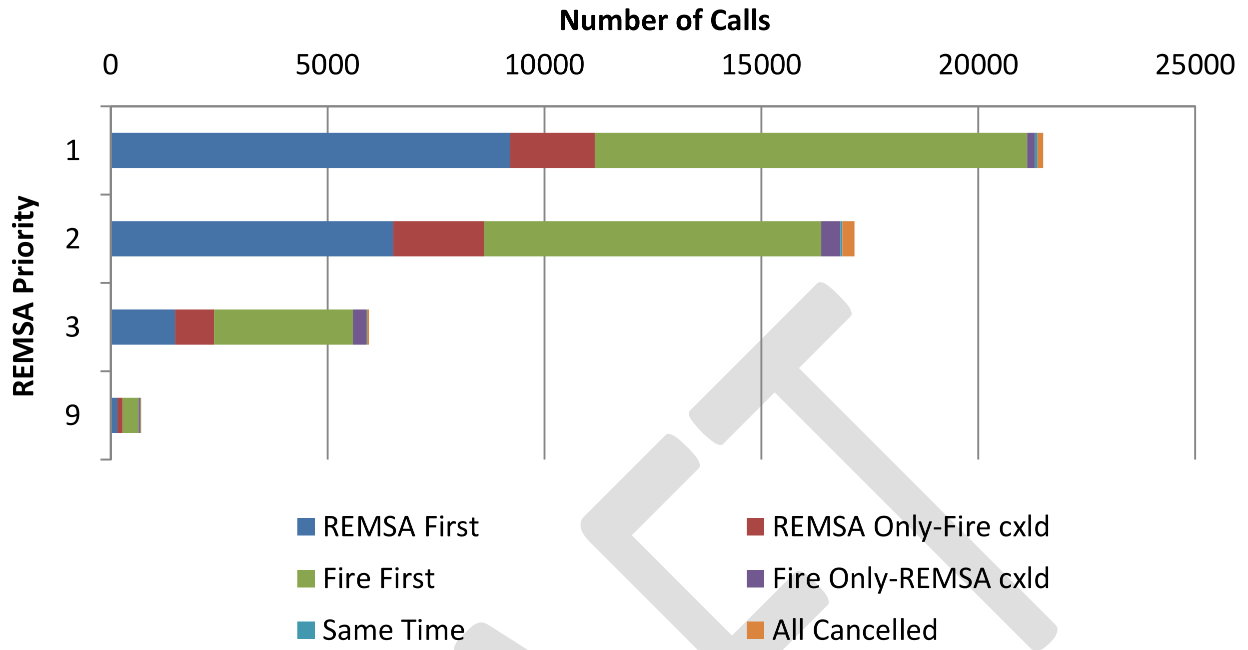

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Section 5: EMS Oversight Program Accomplishments FY 15-16

Regional Omega Protocol

An Omega call is a type of 9-1-1 call which when evaluated through the Emergency Medical Dispatch (EMD) process, is deemed as low-acuity non-emergent and an ambulance response is not the most appropriate level of care. In 2011, the International Academy of Emergency Dispatch (IAED) approved 200 Omega EMD determinant codes, these are calls with a chief complaint such as a spider bite, headache, hiccups, cannot sleep, splinter, or nosebleed without any other life-threatening symptoms present. About 150 of the 9-1-1 calls in this region are categorized as Omega each month. The region recognized this was not best-practice or an appropriate utilization of EMS resources. In June of 2015 the region's EMS agencies met to discuss the response protocol for Omega calls. After additional research, including discussions with other jurisdictions that adopted alternative responses for Omega calls, and multiple revisions to draft policy, the region's Omega protocol was accepted by the EMS Advisory Board on April 7, 2016 and approved by the District Board of Health on April 28, 2016 with an implementation date of July 1, 2016.

The protocol approves 52 Omega EMD determinant codes to be transferred from the 9-1-1 system to the Nurse Health Line (NHL) for further assessment and evaluation to determine the appropriate level of care for the patient. This increases the availability of the region's EMS resources allowing them to respond to higher acuity calls and reduces the burden on emergency rooms, while still providing assessment and recommendations to the patient.

Revised REMSA Franchise Response Map

The REMSA Franchise response map delineates the time expectations for REMSA to respond to 9-1-1 calls in the Franchise service area. The process of reviewing and revising the REMSA map began in February 2015, with regional meetings starting April 2015. EMS staff utilized a contractor to assist the region in the development of a sound methodology and process for developing a new REMSA Franchise response map. The methodology adopted by the region was based on population density models with an overlay of call volume data for a 12 month period of time. After incorporating quantitative data elements and evaluating several map revisions, the regional EMS partner agencies met consensus on the newly developed REMSA response map (Figure 4). The new map was approved by the EMS Advisory Board January, 2016, followed by approval from the District Board of Health February, 2016 effective July 1, 2016.

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Figure 4: REMSA Franchise Response Map Effective July 1, 2016

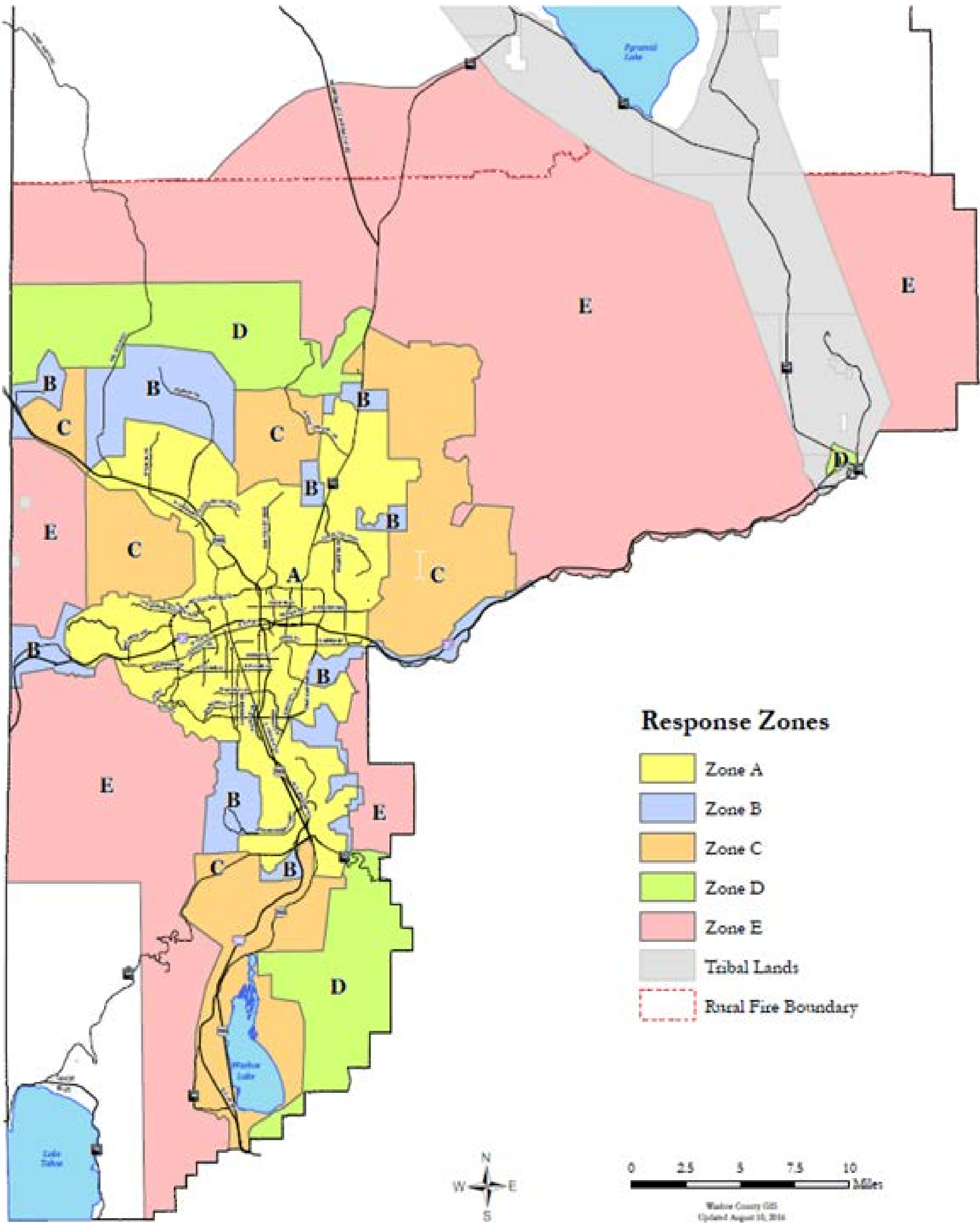
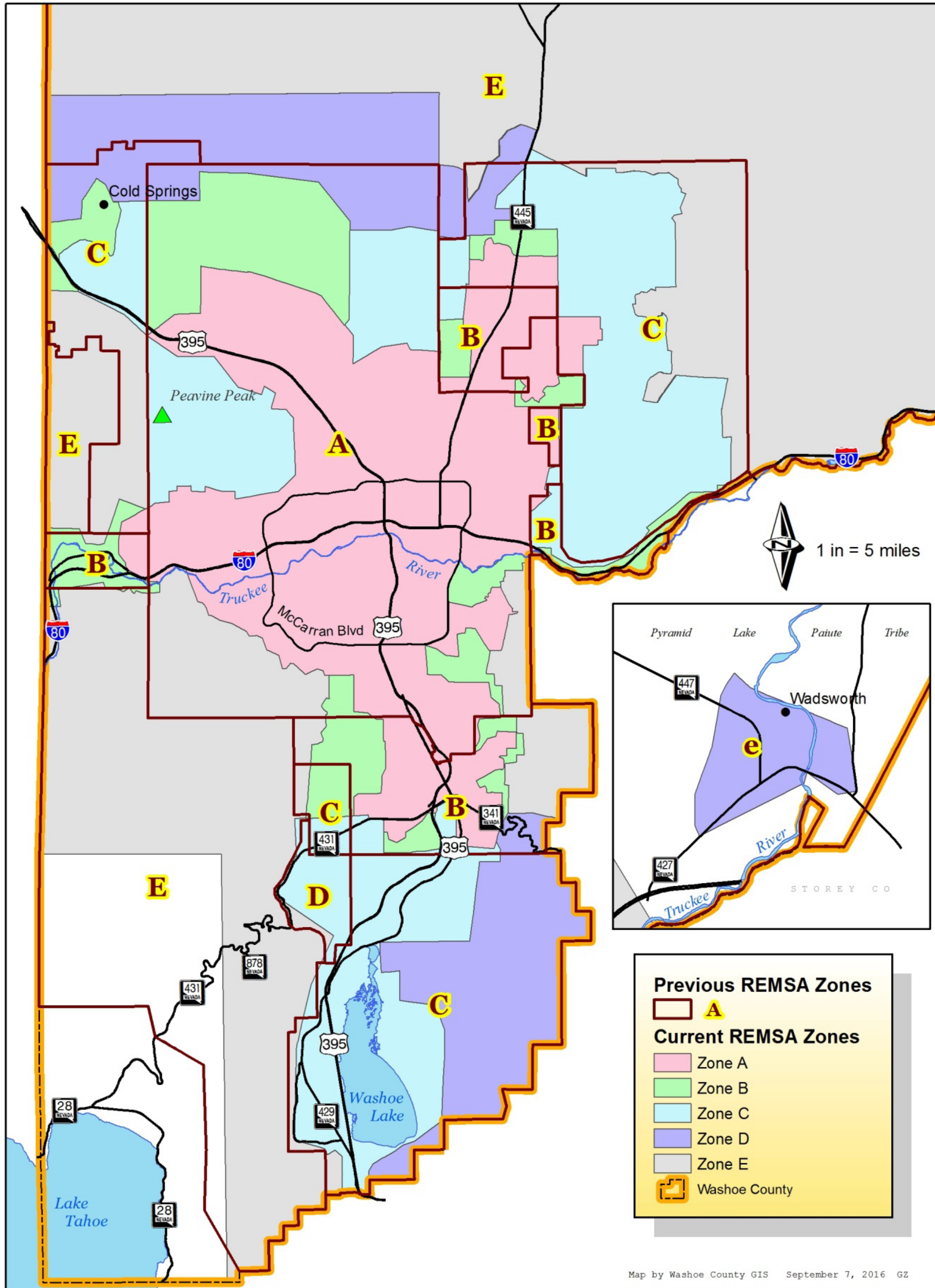


Figure 5: Map of REMSA's Previous and Current Franchise Response Zones



HeartSafe Community Designation

In 1991 the American Heart Association brought forth the concept of “Chain of Survival”, the intention of which was to increase the survival rate of persons who are victims of sudden cardiac arrest. Nevada Project Heartbeat developed a HeartSafe Community Program to recognize the collaborative efforts of organizations and agencies to enhance and improve their pre-hospital system’s response to cardiac events.

The Washoe County EMS Oversight Program has been working with several partner agencies, since November 2015, to develop a HeartSafe program and apply for Washoe County to be a HeartSafe Community. Agencies involved include Renown, Reno-Tahoe Airport Authority Fire Department, Reno Fire Department, Sparks Fire Department, Truckee Meadows Fire Protection District, Washoe County Sherriff’s Office, REMSA, American Red Cross, Reno Police Department, and North Lake Tahoe Fire Protection District. Although Incline Village had previously been recognized as a HeartSafe Community, the partners thought it was prudent to submit an application on behalf of the County.

The process of developing a HeartSafe Program involved assessing the number of and access to automated external defibrillators (AED) and the number of residents who are trained and certified in CPR. The HeartSafe Program works to improve all aspects of the 9-1-1 system, so that pre-hospital care for a sudden cardiac arrest, including the initiation of CPR and defibrillation by bystanders, can begin prior to the arrival of EMS providers.

Multi-Casualty Incident Plan (MCIP) Update

The MCIP was first enacted in 1986 in response to the Galaxy Airlines crash in Reno. The MCIP is designed to provide the community with the District Board of Heath’s polices and guidelines for response to an MCI. Since its inception, the MCIP has gone through seven revision cycles to enhance the plan; the most recent occurred during fiscal year 2015-2016. For several months EMS staff worked with regional agencies to update plan elements. The larger revisions included:

- The development of a section on EMS Coverage for Mass Gatherings as mitigation planning
- The addition of American Burn Association information as an appendix (general location of burn beds and burn bed criteria)
- The creation of a Family Service Center (FSC) Annex
- The development of a pre-built communications plan (ICS 205)
- The enhancement of the section on mental health and stress management
- The creation of an executive level training on the MCIP

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The District Board of Health heard a presentation on the revisions and approved the updates on April 28, 2016 with an effective date of July 1, 2016.

MCIP Executive Training

As part of the MCIP revision process, regional agencies identified a gap in regional training of the MCIP: most executive level personnel are familiar with the MCIP, but could benefit from a brief training that covers the operational details of the plan. Program staff began development of the MCIP executive level training to be offered during Fiscal Year 16-17. This training is intended to be offered on an annual basis.

Nevada Statewide Medical Surge Plan

The Nevada Statewide Medical Surge plan was first written in 2008 and is an all-hazards response plan and applies to all planned and unexpected events that may necessitate a surge of hospital and other healthcare resources within Nevada. During Fiscal Year 2015-2016 stakeholders deemed it necessary to update the plan content as well as add regional/multi-county response annexes. The West region plans include three annexes: medical surge, MCIs and healthcare evacuation.

The West region annexes were developed with the intention of having additional organization when a response requires multiple counties and jurisdictions. The framework of the annexes was based off Washoe County plans, but the content was modified for regional response and coordination. The annex development culminated with a tabletop exercise to test capabilities, strengths and possible improvements.

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Section 6: Partner Agency EMS Highlights & Accomplishments FY 15-16

Partner agencies provided their EMS related highlights for FY 15-16, which include accomplishments such as increased capacity in terms of scope of work, increased staffing levels, newly hired personnel, updates to protocol and equipment upgrades. These are instrumental in assuring the best level of care is provided to the citizens and visitors of Washoe County.

City of Reno Fire Department Highlights for FY 15-16

The Reno Fire Department responds to about 36,000 calls annually. Of those calls about 75% are EMS.

In January 2016 Reno Fire Department hired EMS Chief Dennis Nolan to handle the EMS Division, and was able to establish a standing EMS committee with a Department EMS training center located at Station 11.

On January 8, 2016 Reno Fire Department began delivering ALS service for the first time in the 128 year history of the Department.

The Reno Fire Department hired 32 new recruits spread over two recruit academies. The first academy started on January 4, 2016 and the second academy started April 18, 2016. All recruit graduates are now line firefighters working for the Reno Fire Department.

The Department participated in the National Reading Month in March, reading to over 1,500 school children in the classroom.

The Reno Fire Department continued its participation with local charitable organizations including Muscular Dystrophy Association (the Fill-the-Boot program), Northern Nevada Children's Cancer Foundation with the charitable fundraising dinner we call Natalia's night and Mom's on the Run, a local charitable organization that supports families and individuals impacted by breast cancer.

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The Department raised money for Breast Cancer awareness during October through the sale of pink RFD duty shirts. The shirts were approved uniform shirts to be worn on-duty during October.

At Christmas the Department again delivered the Sam Saibini Food Basket program which provides food, free of charge, to underprivileged families in the region and also held the Children's Christmas Party for homeless children in Reno.

In early 2016, the Reno Fire Department began delivering EMS service utilizing a Medical Response Unit (MRU) which provides an additional resource for the Department and allows for flexible staffing.

The Department put two new fire engines in service during March 2016, with a third scheduled to go into service.

The Department chaplain continued to deliver trauma intervention, resources and spiritual care to employees and the public.

Along with the region, the Reno Fire Department completed the application to become a HeartSafe Community.

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City of Sparks Fire Department Highlights for FY 15-16

REMSA Response Map: the entire City of Sparks is now within the 8-minute response zone after the Response Map revisions.

Implemented the Omega Response Protocols: In conjunction with regional partners, developed the Omega response protocols allowing Ambulance and Fire Resources to discontinue response to low acuity priority 3 medical complaints.

Developed a Refusal of Medical Assistance (RMA): Developed, delivered required training, and implemented a Refusal of Medical Assistance procedure. This provides for better resource management and proper patient refusal in minor vehicle accidents and falls resulting in lift assists.

Completed Protocol Update: Updated protocols to reflect the recent changes in American Heart Association guidelines, scope of practice changes that came with the transition to Advanced EMT and other changes per medical direction.

Acquired and Renewed POD Endorsement for Numerous Personnel: The majority of SFD personnel attended vaccination administration training in conjunction with the Washoe County Health District. This cooperative effort allows SFD personnel to gain an additional endorsement on their EMS license that permits them to assist the County in delivering needed vaccines during public health emergencies. SFD personnel, in addition to other first responders, exponentially expand the resource availability to the Health District during a time of need.

Implemented the NEV CORD Radio Frequency: Programed department radios to include the NEV CORD frequency to be used to communicate with Air Ambulance resources.

Participated in NAC 45OB Workshops and Hearings

Completed Comprehensive Study on the Need for Paramedic First-Tier Resources Within the City of Sparks

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Truckee Meadows Fire Protection District Highlights for FY 15-16

Acquired Chest Compression Devices: Thanks to Commissioner Hartung, a chest compression device was purchased with County funds and placed on the engine in Spanish Springs to enhance cardiac arrest survival rates in that District. The District subsequently budgeted for additional units to be placed on all 11 TMFPD engines in FY 16/17.

Staffed Gerlach and developed EMS transport procedures: Due to the resignation of several volunteers in Gerlach, TMFPD assumed operations of that area on an interim basis until a long-term plan could be developed and implemented. With approximately 2 weeks' notice, TMFPD was able to equip and staff a rescue and ambulance to service the region and provide ALS ambulance transport. The service was successfully transferred to new County staff on 7/1/16.

Approved Division Chief of EMS for FY 16/17 Budget: With a growing demand for EMS services and program support needs, the District created and funded a new Division Chief of EMS & Training, approved May 2016. The District will recruit for the position in mid FY 16/17.

Acquired fiber optic intubation scopes: To enhance success rates during critical, advanced airway placements, the District acquired fiber-optic video laryngoscopes. These tools allow for Paramedics to more easily visualize the placement of advanced airways, leading to better patient outcomes when successful.

Acquired intubation manikins for all stations: To further enhance advanced airway placement success rates, every TMFPD station was provided with an advanced airway training manikin. This allows crews to practice these critical skills on a daily basis.

Trained numerous personnel in vaccination administration: The majority of TMFPD personnel attended vaccination administration training in conjunction with the Washoe County Health District. This cooperative effort allows TMFPD personnel to gain an additional endorsement on their EMS license that allows them to assist the County in delivering needed vaccines during public health emergencies. TMFPD personnel, in addition to other first responders, exponentially expand the resource availability to the Health District during a time of need.

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65 Certified Paramedics now on staff: Over the course of the last several years, TMFPD has continued to hire ALS personnel while existing ALS personnel have promoted to higher rank positions. During March 2016 TMFPD hired six additional firefighter paramedics, bringing the total to over 65 certified Paramedics on staff in various ranks which helps the District in all levels of its ALS EMS service.

Developed a mutual aid agreement with REMSA for TMFPD's ambulance: REMSA and TMFPD have developed a mutual aid agreement that will utilize the TMFPD ambulance stationed in Washoe Valley during MCI's and/or when REMSA needs assistance in providing transport in the South Valley's.

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REMSA's Agency Highlights for FY 15-16

Hours Added: Analysis of demand and implementation of the new response zone map led to the addition of 240 Advanced Life Support unit hours per week. These additional hours have been added to the system to increase the number of shift lines and staff available to the system throughout the week.

Inter-facility System Growth: Growing demand and a dedication to utilizing appropriate resources based on patient condition led to REMSA adding 144 Intermediate Life Support unit hours. This increase ensured BLS and ILS transfers can be completed by an ILS transport staff, increasing the availability of ALS units in the 911 system.

New Dedicated Posts: Two dedicated posts have been added to outlying areas in an effort to provide services to growing and expanding population centers in the region. A 16-hour dedicated post at Wedge Parkway and a 16-hour dedicated post in Spanish Springs were implemented to better serve the expanding geographical population base of the Truckee Meadows

Community Health: Began transitioning CHP programs from grant-based to sustainable models with new Healthcare Partners and strategic relationships.

Omega Protocols: Implemented Omega Protocols with approval from all three jurisdictions as well as the EMS Advisory Board and the District Board of Health. This agreement is part of REMSA's Community Health initiatives to get the right care to the right patients.

Communication Staff: Communication staff added to support the increase of requests specific to handling Inter-facility transfers and to help ensure efficiency of the ILS transport systems.

Communication Center Accreditation: Successful reaccreditation of the REMSA Communication Center by the International Academy of Emergency Dispatch Center of Excellence. This is REMSA's 15th year being an accredited Center of Excellence.

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Mutual Aid: Initiated a new Mutual Aid Review Policy to ensure agreements are reviewed more frequently. A Mutual Aid Agreement with Truckee Meadows Fire Protection District was also completed and signed on June 28, 2016. Additionally, work began on establishing agreements with Reno Fire Department and Pyramid Volunteer Fire and Rescue.

National Visitors: Hosted multiple tours of key external decision makers; Dean Heller, Reid's staff, State Legislators, and representatives from the Center for Medicare Innovation.

New Technology: Implemented Mobile Data Terminals in ambulances and supervisor vehicles for improved routing, information sharing and digital communications. This new technology allows crews access to more information about calls and increased communications with the Communications Center.

Mission Life Line Silver Award: Awarded the Silver Mission Life Line Recognition in 2016 for successfully managing and caring for STEMI patients in collaboration with all local hospitals based on national criteria, see below.

Core Measures	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Overall
Percentage of pts with non-traumatic chest pain $\geq$35 treated and transported who received a pre-hospital 12 lead:	95%	95%	95%	92%	94.7%
Percentage of STEMI pts treated/transported to PCI facility with first medical contact to device $\leq$90 minutes:	100%	90%	80%	95.7%	92.2%

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Gerlach Volunteer Fire Department Highlights for FY 15-16

Gerlach Fire and EMS: The small department remained active in FFY-2016, thanks to assistance from the Truckee Meadows Fire Protection District (TMFPD). Due to a variety of factors, the department was in transition. The first half of the year the station was staffed by volunteers and the second half of the year the station was staffed by TMFPD.

However, it emerged stronger and more sustainable as a Combination Fire Department with two full-time employees and two Intermittent Employees to form the nucleus of the revitalized Department.

Volunteers are being recruited, and regular service calls are being conducted by the two ambulances stationed at the Gerlach Department. The coverage area remains almost 5,000 square miles and the department averages about 50 calls per year, with call spikes during the annual Burning Man festival.

Calls for service: During FFY-2016 the Gerlach Volunteer Fire Department or TMFPD, responded to 71 calls for service within the Gerlach response area, of which 48% (34) were EMS.

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Section 7: Goals for Next Fiscal Year

The following goals are areas which the EMS Oversight Program has been working towards for a several months, however are expected to be in effect within the next fiscal year. The Five-year Strategic Plan is a duty assigned by the ILA and was developed over much of FY 15-16 in collaboration with partner EMS agencies. The Program will also be working with EMS partner agencies and regional hospitals to develop best practice methodology to evaluate patient outcome data for future data reports.

Five-Year Strategic Plan

The Washoe County EMS Five-Year Strategic Plan began in August 2015 to guide the future direction of the Washoe County EMS System. The strategic plan was a collaborative assessment to examine strengths, weaknesses, opportunities and threats facing the EMS System from national, regional and local influences. The information obtained through the analysis helped formulate goals to optimize the structure, processes, and outcomes of the EMS Five-Year Strategic Plan, focusing on: 1) maintaining or improving clinical care and patient satisfaction; and 2) improving operational efficiency and collaboration across the region.

The strategic plan provides Washoe County's EMS System's mission, vision, values, goals and objectives to be accomplished by 2021. The following six goals are outlined in the plan and are as follows:

Goal 1: Enhance utilization of EMS resources by matching the appropriate services, as defined by the call for service, through alternative protocols, service options and transportation options by October 7, 2021.

Goal 2: Improve pre-hospital EMS performance by reducing system response times through the use of technology and the development of regional response policies by December 31, 2022.

Goal 3: Improve communications between EMS partners through enhanced usage of technology and the development of regional guidelines by June 30, 2021.

Goal 4: Improve continuity of care through regional processes that ensure patient information transfers from the scene to the hospital by December 31, 2018.

Goal 5: Design an enhanced EMS response system through effective regional protocols and quality assurance by December 31, 2018.

Goal 6: Continue collaborative models with regional EMS agencies, health organizations and public safety stakeholders.

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Patient Outcome Data

As identified in the Program's FY 14-15 Annual Report, focusing on the relationship between the two-tiered response system is an isolated review of the EMS system performance and patient outcome data should be included for evaluating performance of prehospital care. Promoting a high-quality level of patient care is a priority of all EMS partner agencies. Currently our region's EMS providers are not formally informed of patient's outcomes after the responders are cleared from the scene or complete the patient's transport to the emergency room.

While all 9-1-1 calls are deemed important, there are a few select conditions which national guidelines recommend a rapid response time from emergency responders; these include the following types of calls:

> **Cardiac arrest:** An electrical malfunction of the heart, resulting in an ineffective heartbeat, or complete lack of heart beat. Often occurs without an early onset of warning symptoms. When the heart's electrical pulse is disrupted, the blood flow to the rest of the body stops, this causes the victim to become unconscious, resulting in death within minutes.
>
> **ST-elevation myocardial infarction (STEMI):** Specific type of heart attack in which the blood flow to a portion of the heart is blocked. The heart is a muscle and if an artery providing oxygen-rich blood is blocked for prolonged periods of time that section of the heart will begin to die. Heart attack symptoms may occur suddenly, however many heart attacks occur slowly over a period of days or even weeks.
>
> **Stroke:** Occurs when a blood vessel carrying blood to the brain is blocked or ruptures, resulting in lack of blood to that area of the brain which in turn causes brain tissue and cells to die. Strokes impact people differently depending on which area of the brain the blockage or rupture occurred and the extent of tissue death.

Obtaining patient outcomes from regional hospitals allows EMS providers, including dispatchers, to effectively evaluate dispatch pre-arrival instructions as well as patient care provided on scene and en route to the hospital. This will help to ensure an accurate patient assessment is occurring and the prehospital treatment is appropriate. Measuring patient outcomes is instrumental to evaluate the effectiveness of prehospital protocol and procedures. The Program's goal is to work with the EMS partner agencies and hospitals to further identify patient conditions to analyze and ensure the appropriate data are gathered to effectively assess pre-hospital patient care.

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WASHOE COUNTY
HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

STAFF REPORT
EMS ADVISORY BOARD MEETING DATE: October 6, 2016

TO: EMS Advisory Board Members

FROM: Brittany Dayton, EMS Coordinator
775-326-6043, bdayton@washoecounty.us

SUBJECT: Presentation, discussion and possible approval of updated EMS Advisory Board Bylaws.

SUMMARY

The EMS Advisory Board Bylaws is the governing document for all meetings related to the EMS Advisory Board. The Bylaws may be amended as necessary, but shall be reviewed at a minimum of every two (2) years. Staff reviewed bylaws of EMS Advisory groups in other regions and states and has developed a draft for the EMS Advisory Board is review, provide direction or approve.

PREVIOUS ACTION

On October 30, 2014 members of the EMS Advisory Board directed staff to write and develop draft Bylaws for the body to use as guidelines for organization of the Board and conducting meetings.

On December 4, 2014 staff presented draft Bylaws to the EMS Advisory Board. After discussion of this item there were several recommendations for improvement, including staggering the DBOH appointee's terms, removing the meeting procedures, and adding all Board responsibilities included in the Interlocal Agreement (ILA) for EMS Oversight.

On March 5, 2015 the EMS Advisory heard a presentation on a revised version of the Bylaws that incorporated specific changes from the December meeting. The Board unanimously moved to approve the Bylaws.

During Board comment at the July 7, 2016 EMS Advisory Board meeting, Mr. Dick requested that an agenda item be included for the next EMS Advisory Board meeting for staff to present any recommendations on updates to the Bylaws, particularly with regard to the election of the Chair.

BACKGROUND

The ILA was approved by the Washoe County Health District, City of Reno, City of Sparks, Truckee Meadows Fire Protection District and Washoe County and became effective on August 26, 2014.

Article 2 of the ILA establishes the Regional Emergency Medical Services Advisory Board and the expected administration of the Board, including the adoption of Bylaws or procedural rules necessary to carry out its functions and duties in an efficient and orderly manner.

Staff researched reviewed bylaws of EMS Advisory groups in other regions and states and drafted the following changes to the current bylaws:

- Addition of a cover sheet that tracks revision/review dates
- Minor grammatical changes throughout the document
- Term change for the District Board of Health appointees; 3 years for the ER Physician and 4 years for the Hospital Continuous Quality Improvement representative
- Term change for the Chair and Vice-Chair; 2 year terms with reappointment eligibility for up to two additional terms
- Additional sections including information on voting, attendance and conflicts of interest
- Modification to the bylaws amendment process

Attached is the current bylaws document with proposed revisions in tracked changes.

FISCAL IMPACT

There will be no direct fiscal impact associated with the approval of the updated EMS Advisory Board Bylaws.

RECOMMENDATION

EMS Program staff recommends that EMS Advisory Board approve the updated EMS Advisory Board Bylaws.

POSSIBLE MOTION

Should the Board agree with staff's recommendation, a possible motion would be:

"Move to approve the updated EMS Advisory Board Bylaws."

EMERGENCY MEDICAL SERVICES ADVISORY BOARD

BYLAWS

WASHOE COUNTY
HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

Public Health

Approved
March 2015

Dates of Revision/Review
October 2016

ARTICLE I – NAME AND PURPOSE

Section 1 - Name

The name of this body is the Emergency Medical Services (EMS) Advisory Board (hereinafter referred to as "Advisory Board").

Section 2 - Purpose

The Advisory Board is established to provide for concurrent review of present topics within the Washoe County EMS system by the City of Reno, a municipal corporation in the State of Nevada ("RENO"), and the City of Sparks, a municipal corporation in the State of Nevada ("SPARKS") and Washoe County, a political subdivision of the State of Nevada ("WASHOE").

The Advisory Board is established by the Inter-Local Agreement (ILA) for Emergency Medical Services Oversight, executed on August 26, 2014. The purpose of the Advisory Board is to review reports, evaluations and recommendations of the Regional Emergency Medical Services Oversight Program (the "Program"), discuss issues related to regional emergency medical services and make recommendations to the respective jurisdictional Boards.

Section 3 - Duties

Duties of the Advisory Board shall include:

a. Make recommendations to the District Health Officer and/or the District Board of Health ("DBOH") related to performance standards and attainment of those standards, medical protocols, communication, coordination, and other items of importance to a high-performing Regional Emergency Medical Services system.
b. Strive to implement recommendations of the Program, or submit those recommendations to their governing bodies for consideration and possible action if determined necessary and appropriate by the respective managers.
c. Make recommendations to the respective Boards regarding participating in working groups established by the Program for coordination, review, evaluation, and continuous improvement of Emergency Medical Services.
d. Support the Program in establishing and utilizing a Computer Aided Dispatch ("CAD") – to – CAD two-way interface with Regional Emergency Medical Services Authority ("REMSA") which provides for the instantaneous and simultaneous transmission of call-related information for unit status updates.

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e. Work cooperatively with the Program to provide input to the development of the Five-Year Strategic Plan, as it relates to the continuous improvement of Emergency Medical Services.

f. Support and work cooperatively with the Program to achieve the Program duties as outlined in the ILA.

ARTICLE II – MEMBERSHIP

Section 1 - Board Composition

The Advisory Board shall be composed of the following members:

a. City Manager, Reno
b. City Manager, Sparks
c. County Manager, Washoe County
d. District Health Officer
e. Emergency Room Physician (DBOH Appointment)
f. Hospital Continuous Quality Improvement (CQI) Representative (DBOH Appointment)

~~Consistent and current membership participation is critical to the success of the Advisory Board.~~

Section 2 - DBOH Appointments

Two positions within the Advisory Board are appointed by the District Board of Health and will serve staggered terms to ensure stability of the Advisory Board. The Emergency Room Physician appointment, a representative of the Prehospital Medical Advisory Committee, will be for ~~two~~ three (~~2~~3) years while the Hospital Continuous Quality Improvement (CQI) representative will serve a ~~three~~ four (~~3~~4) year term. Both appointees are eligible for reappointment for up to two additional two (2) year~~s~~ terms.

Section 3 - Resignation and Termination of DBOH Appointees

Advisory Board membership may be resigned at any time to the DBOH in writing.

Upon the resignation or expiration of the DBOH appointee's term, the member shall continue to serve until his/her successor qualifies and is appointed.

Section 4 - Terms/Board Administration

The Advisory Board shall elect a chair and a vice-chair from among its membership to manage the meetings. The chair and vice-chair shall serve for two ~~one~~ (~~1~~2) years. Both positions are eligible for reappointment for up to two additional two (2) year terms.

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The Advisory Board shall be subject to the requirements of Nevada Revised Statutes Chapter 241, Open Meeting Laws. A majority of the Advisory Board constitutes a quorum for the conduct of business and a majority of the quorum is necessary to act on any matter.

ARTICLE III – MEETINGS

Section 1 - Meetings

The Advisory Board shall hold a minimum of one meeting per fiscal year. Additional meetings may be held at the discretion of the chair or as frequently as needed to perform the duties of the Advisory Board.

A quorum of the Advisory Board members must be present to transact business legally – a quorum consists of four (4) Advisory Board members. A majority vote is required for any official action of the Advisory Board unless otherwise specified in the rules of order, which are defined below.

The chair presides over the meetings:

a. The chair opens the meetings.
b. The chair determines that a quorum is present by a roll call vote.
c. The chair calls the meeting to order.
d. Approval of minutes of the prior meeting.
    i. Unanimous consent can be used instead of motions to expedite the proceedings.
e. Every meeting of the Advisory Board shall be conducted in accordance with the adopted agenda.
    i. The written agenda will be approved by the chair prior to distribution and will be distributed to all committee members at least three (3) working days prior to the meeting.
f. The vice-chair shall preside over meetings when the chair is absent.

Section 2 – Voting

Each Advisory Board member will have one (1) vote. Proxy votes are not permitted.

Section 3 - Attendance

Consistent meeting attendance and participation is critical to the success of the Advisory Board. Members who are unable to attend an Advisory Board meeting will notify the Chair of the Advisory Board and Program staff. Program staff will record attendance of all members at each Advisory Board meeting.

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Section ~~4~~2 - Minutes

Minutes shall be kept and recorded of all meetings and forwarded to all members of the Advisory Board as promptly as possible following the adjournment of each meeting.

Section 5 – Conflict of Interest

A member of the Advisory Board may not vote on a matter with respect to which the member has a conflict of interest.

ARTICLE IV – AMENDMENTS

Section 1 - Amendments

These bylaws may be amended as necessary at any Advisory Board meeting, but will be reviewed at minimum every two (2) years. All amendments requests must be indicated at the ~~must first be submitted in writing at the previous~~ Advisory Board meeting as a future agenda item and require an approval of a two-thirds vote for adoption. Amendments take effect immediately upon approval of the Advisory Board.

Approved and adopted this ___________ day of ___________ 20____, by the Emergency Medical Services Advisory Board.

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John Slaughter, Chair

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