WASHOE COUNTY HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

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MEETING MINUTES

Emergency Medical Services Advisory Board

The Emergency Medical Services Advisory Board met on Thursday, January 5, 2017, in the Health District Conference Room B, 1001 East Ninth Street, Reno, Nevada.

1. *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
Bill Thomas, Acting Manager, City of Reno
Dr. Andrew Michelson, Emergency Room Physician, St. Mary's

Ms. Spinola verified a quorum was present.

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

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2. *Public Comment

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

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

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3. Consent Items

Matters which the Emergency Medical Services Advisory Board may consider in one motion. Any exceptions to the Consent Agenda must be stated prior to approval.

A. **Approval of Agenda**
January 5, 2017

B. **Approval of Draft Minutes**
October 6, 2016

Mr. Thomas moved to approve the Consent agenda as presented. Mr. Dick seconded the motion which was approved unanimously.

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

Dr. Michelson; Last meeting I wasn't as prepared as I should have been, and the PMAC is also maybe a meeting behind as far as how prepared we should have been to receive the report from the EMS consultant group. I think that one expectation that maybe was unrealistic was the thought that the PMAC was going to be able to direct the results of this analysis that this EMS Consultant Group did for us. Do we all know about this?

Ms. Conti: everybody out here knows, but you may just want to reinforce.

Dr. Michelson: We made the decision maybe 6+ months ago from the PMAC to go ahead and have this EMS Consultant Group come in and assess essentially all the protocols of all the agencies of the EMS in town. The interest from the PMAC mostly is that we would progress towards a more unified practice. They reviewed everything and put up a big protocol analysis essentially for us, and we are at this point asking that the agencies, somewhat kind of led by Dianne Rolfs of REMSA right now to get all the, well whoever wants to participate from each of the agencies, to start digesting the protocol analysis.

Dr. Michelson: Some of the exciting things from the PMAC perspective, with in mind what I'm hoping that we adopt as our mission statement, so let me just share with you, the PMAC is to be the advocate for the local community and its associated EMS catchment area through continuing to augment and suggest evidence-based recommendations to our EMS InterLocal agency agreement providers to optimize the emergency medical services. It's not to be any kind of, we have no power, essentially, only a number of docs mostly of which are the medical directors of these agencies to come together from a clinical side as far as a receiving hospital side, and if anything, bring recommendations to the agencies.

Dr. Michelson: A number of the recommendations from that clinical side would mostly simplify much of which already overlaps, but in general, making handoffs probably easier from REMSA to fire, or excuse me, fire to REMSA, as well as when we get them in the hospital, similar practice plans as far as what we receive. They also offered a pretty realistic approach; I mean this is by no means there, this EMS Consultant Group with Dr. Barnett, by no means their first project. They have offered continued collaboration as well, and being available to reference. That was helpful, to not just throw a bunch of data at us and then just walk away. Hopefully Dianne is aware of that; I'll make sure she is.

What I mean by one meeting behind is that we, it would have been ideal for us to have had the foresight of encouraging these agencies to be ready to discuss this result. Instead, we came to that at the last meeting, which was just in the beginning of December. We were hopefully going to

come to this meeting and maybe something has developed, unbeknownst to my knowledge, okay, that we would be moving forward with this review. But I've yet to hear that. Again, just that it's not a PMAC decision; we are only here to facilitate recommendations. Some of the limitations that maybe I picked up on is that it's inevitably going to be costly, in regards to some services, expecting to practice similar to others in regards to medical technology, literally the tech that they carry on their rigs and even more so, pharmacology, drugs that go bad, etc., and don't get used. In levels of training, the scope of practices that are expected, or available. Then again, if there is some type of actual, unified protocol that is practiced by, well then that's also going to be costly. The recommendations they had were anything from color-coding these protocols to, and I believe it was Truckee Meadows Fire Protection District already had something that was pretty close to what they were suggesting, but the limitation was mostly money. Questions at all?

Mr. Thomas: I guess before questions just to paraphrase my understanding is, what we're trying to do to make a better emergency response system for our residents is, if I read the literature right, is to try to move the triage, make that more efficient so we don't have people, for example, going to the ER, which is the most expensive solution, we're trying to bring that down, is that the end goal? Or is this more about just like when we pick people up, what are we supposed to do with it?

Dr. Michaelson: More about when they are actually transported. Just another aside, as far as where this would apply, for example, in the setting of potentially an MCI or a situation of a mass number of patients, in that setting it would definitely facilitate overlap of care for those patients and lack of confusion and more efficiency. Not that that is something that is of course ever common, especially in a city of our size, but definitely something that will facilitate efficiency from the PMAC's perspective at least, as far as on the receiving end, what we are getting from the EMS. We could go through a number of examples, but it's essentially to streamline and overlap the care. So not so much applying to triage or keeping patients out of the ER, that might, if anything right now is active in regards to that, it would be more so the REMSA's, what has been a number of years now since REMSA started there, I don't remember what it's called, but they send out paramedics to houses and essentially can do wellness-checks and not necessarily transport. I don't remember what

Ms. Conti: Community Paramedicine.

Dr. Michelson: Thank you, yeah, so they were able to get some grant and then also part of that grant was primarily to decrease transports, decrease ER visits, and the dollars spent on emergency care on that end. So no, this is more so in regards to just overlapping the protocols that each of the agencies utilize in care during transport.

Ms. Conti: In the continuity of care, it doesn't matter who is touching the patient, that there is continuity prior to the hospital.

Mr. Thomas: Each emergency responder, as I understand it, and maybe this isn't true, but I know for Reno it is true, there is a medical oversight person for them, and then REMSA has their own, so you have multiple clinicians making recommendations? This is supposed to be a regional approach to protocol so we are all doing the same thing, is that what this is all about?

Dr. Michelson: Yes, each agency has a medical director, and I don't necessarily know the position of others that interact with the medical directors. However, they at least are there to review the protocols, sign off on the protocols, and be the M.D., if you will for final review.

Mr. Thomas: Is somebody looking at it from the liability standpoint? This is the clinician, the practice, but what about the liability side? In terms of, that is always an issue whenever we deal with anything. Not only is it right from a medical standpoint, but is it the risk-sensitive solution.

Dr. Michelson: That would hopefully fall into the just all-around awareness of the hopeful task force that is developing here between the agencies to review these protocols, and I would hope that that would be on their horizon too. But for the most part I don't think that would play too heavily in, as far as when designing a protocol.

Ms. Dayton: Just as a clarifying point, all of the medical directors for the EMS agencies sit on PMAC, which is why they call it the appropriate avenue to go through, so they are going to be updated throughout the process, and we're not changing the sign-off process for these protocols, so they would still be the ultimate ones signing off, with the liability associated with medical director.

Mr. Thomas moved to accept the report. Mr. Dick seconded the motion which was approved unanimously.

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5. *Program and Performance Data Updates
Christina Conti

Ms. Conti: Good morning, before I start I want to take the opportunity to introduce you to a new member of our team, this is Jackie Lawson, she joined our team a couple months ago and has been participating in the tour that we have been giving for the Regional EMS update for the signatories. Jackie is splitting her time between our program, the EMS program, and the Public Health Preparedness (PHP) programs. We are very happy to have her on board.

Ms. Conti: Just a couple things to point out to you today, and then I'm happy to answer any questions. On the first page of my staff report, it talks about the EMS Coordinator and Public Health Emergency Response Coordinator meeting with Rosewood, and having Rosewood sign on as a member of the Mutual Aid Evacuation Annex (MAEA). From the time that this was submitted and the time period that it incorporated, we had another skilled nursing facility sign, it's a memory care, so we now have an additional facility, Arbors, is now a part of the process in the region, so we're just continuing to grow that so if there is a medical situation where a health care facility has to evacuate, there are pre-designated counts available so we don't have to figure that out on the fly. So we are very happy about that.

Another thing with health care preparedness, the improvement to the 800 MHz radios for health care. It was an action item from that full scale evacuation exercise that we did. So this is more for the whole region, I bring it to your attention that the radios have been reprogrammed so that all the channels listed in the multi casualty incident plan are now on those health care facility radios, so in the event something happens, everybody has the same channels listed, which is a really great thing.

Ms. Conti: I wanted to just highlight the Nevada State Board of Health meeting that was held on December 9. NAC 450b and NAC 629 were on the agenda, both passed. 629 passed with zero changes, 450b had a middle of the meeting workshop where the whole meeting kind of left, it was very interesting to watch, and workshopped a lot of different points. When it came back there were several things in the proposed NAC on the agenda that were actually omitted. I need to get a copy of the final one and when I do then we can make it available to you and all the partners and make sure everybody has the most current.

Ms. Conti: You'll see Rishma's CAD-to-CAD update in here for your review.

Ms. Conti: The last thing, Ms. Dayton, was accepted into The Chambers Leadership Program, so we are really excited for her. She begins that in January and it is a 9-10 month process that is going to be hopefully rewarding for her but then we benefit from it as well.

Ms. Conti: I am available for any questions.

Mr. Dick: On the CAD-to-CAD update information, so as I understand, the work will begin for the interface being established between the City of Reno and REMSA for that CAD-to-CAD, then other agencies can come on after that. Is the contract set up for other agencies to then come in under that contract or is that a new contracting arrangement that needs to be made?

Ms. Conti: I'll defer to somebody from City of Reno. I believe that it's just because Reno is the holder of it, but it then becomes an agreement with Reno and not necessarily TriTech, but I could be completely wrong.

Chief Cochran: Good Morning, Dave Cochran, Reno Fire Chief. The contract is with the City of Reno. It was always contemplated that the City of Reno would administer the contract, whether it was just them or the entire region, so that was always the approach, so the contract is with the City of Reno, if and when the County and Sparks decide to come on, then the City of Reno will facilitate bringing them on into the system.

Mr. Dick: It would be a straightforward process to move forward under your existing contract to bring them on?

Chief Cochran: Yes, and it contemplates that idea that the County and Sparks would come on.

Mr. Dick: Then I've got another question; you may be the person to answer. As far as the funding request going in January to the 911 Committee, is that for funding for the entire thing, Reno and the other partners?

Chief Cochran: That is. The initial request was for funding for the entire project. That was turned down and I don't want to give the reason on the 911 issue, the community's issues. It was brought up again at the last meeting. They still have some questions about their budget and how much money they really have available to fund it, which in my view is progress, because they're not saying no, they are saying we're just trying to find the money, and there is a question as to when they can find the money. I know they are having a budget update meeting next week, which is out of sequence for them; it's a special meeting to address the budget issues. They have some questions about how much reserves they need to hold, need to, want to, those sorts of issues. So they are working, in my perception, toward finding the money. Just to add one more piece, we're looking at about a 6-month time frame, and that is just for Tri-Tech/Tiburon to fit us into their schedule.

Chair Slaughter: Chief, did you mention what that funding request is?

Chief Cochran: It's a little over $60,000. There was a contract amount, a contract might be in your packet, and we've signed the contract, the City of Reno signed the contract, but we have not paid it, because until they put on the calendar to do the work, we don't need to pay it.

Chair Slaughter: Right. So the request to 911 is?

Chief Cochran: The full amount. Mr. Thomas: Dave, before you leave. The $60,000 covers Reno?

Chief Cochran: The $60,000 covers the entire project.

Mr. Thomas: The whole region?

Chief Cochran: Well, it covers the CAD-to-CAD connection, that bridge, if you will. Right now it is set up so that Reno is paying the full amount, obviously Truckee Meadows and Sparks have to pay their share if and when they come on, unless the 911 Committee pays the whole thing, and that's what we are asking for, is for the 911 Committee to pay the whole $60,000.

Mr. Thomas: So who, because I'm the novice on this, who is the 911 Committee?

Chief Cochran: I can't give you a clear, definitive summary, but basically it is a committee made up of 911 users throughout the region. Sheriff's, RPD, and everybody's got a representative on it, and there is a small fee that is collected and put into their budget, and they administer it with the idea of supporting projects that enhance the 911 system and enhance communications.

Chair Slaughter: To further that, there is a surcharge on phones, up to 25 cents I believe and the 911 committee makes recommendations actually to the County Commission which funds, we collect, I don't know how much it is a year, it's quite a bit.

Chief Cochran: Yes, it's quite a bit of money. It's a pretty broad goal, of enhancing communications throughout the system and this clearly does that.

Mr. Thomas: It sounds like Reno's already set as far as the budget, it's just a question of whether the 911 Committee frees up money to pay for that in part or in total. Then what about the other players as far as kicking in? Is that something that we are going to have an answer to for the Health Department and the County and Sparks for their budgets for the next year, because I assume we want to do that this year, right? Do you guys think it would be a small enough number you don't need to show it in your budget? Chie Cochran: Reno's committed to paying that full amount, so the system is going to be online as soon as they can fit us into their work schedule. We're also, I think it's in Rishma's report, working towards getting the full amount funded by 911. If that doesn't happen, then we will have to turn to Sparks and the County and say here's our shortfall, do you want to buy in for your share, that will be at your level to decide what that share is.

Mr. Thomas: I'm just trying to get to the timing to make sure that if there were something that were needed in anyone's budget that they would know, because we are all starting our budget processes now, sooner rather than later, to be able to make that in. Or just be aware of it.

Chief Cochran: yes. And I think realistically, you're not going to have an answer from the 911 Committee prior to committing to a number in your budget.

Mr. Thomas: One last question, do you know how we would break that out in terms of region? Is it by population, is it by, should it be split?

Chief Cochran: The discussion has not been had. Is it 1/3, 1/3, 1/3, is it by population, by call volume, those are all part of the conversation that needs to be had.

Mr. Thomas: One last, last question, does this group need to make that decision as we move into this?

Chief Cochran: No. That would be made at the County Manager, City Managers of Sparks and Reno level, not by this Board.

6. *Presentation to the EMS Advisory Board

Emergency Medical Dispatching Process for Washoe County (Requested Item by Manager Thomas)

- Information on Proxy Representation for EMS Advisory Board (Requested Item by Kevin Dick)

Ms. Conti: At the last meeting, Manager Thomas asked for a presentation on the Emergency Medical Dispatch (EMD) process so that he could get a better understanding about call routing and how it went through our system. This is real brief, but it allows for the discussion points. The objectives (slide 2) would be to discuss the information on how a call routes through the system, and the time associated with that from a citizen perspective. One of the things to let you know is that this is looking at the full fiscal year data, a little over 42,000 matched calls, matched calls between REMSA and a fire partner. What we're going to show you is blind of which partner is knocking on the door; it's the process from the citizen's viewpoint.

Ms. Conti: There are a couple things to take away here (slide 3). You have the EMS call, and this is sort of the routing system if you will. I realize for the Board that it is a little bit tricky to see, but right here, this is where a fire department will get the information they need to dispatch a unit- it's the phone number, the address, and the citizen's identified reason for the call-that information then goes to the fire dispatcher who dispatches out the fire engine. At the same time, or close to the same time, that's when the call is being transferred if the phone is ringing in one of the jurisdictions that does not do EMD. Washoe County Sherriff's Office (WCSO) has the ability to do EMD because they are the dispatch center for Incline Village, and so it is important to note that this isn't mutually exclusive with the partners.

Ms. Conti: (continuing on slide 3) REMSA then receives the call, they dispatch an ambulance with the same information, a phone number, an address and the citizen's identified reason for the call. I want to pause on that is because the EMD process has not begun yet when the dispatching of the ambulances happens. That's happening right here, when they dispatch the ambulance then there is this line right here is actually doing the EMD. We would hope that, especially with the Omega protocol thatthe fire department and REMSA are not arriving on scene before EMD is completed. However, sometimes that happens depending on their proximity.

Ms. Conti: Looking at calls for service for FY 15-16 (slide 4), 88% of the phone calls for emergency care were received in a PSAP first, 12% for the FY show to be received in REMSA first. Taking those two percentages and looking from the PSAP perspective (slide 5 and 6). Again, phone call ring and blind of who's knocking on the door, if the phone call happened in the PSAP first, the initial time, this is just for Priority 1/Priority 2 calls, were only 6:22 from the median time from the minute they pick up the phone until someone is knocking at the door. If REMSA's the one that receives the call first, it's 6:07, so it does go down but not by a significant amount. Taking those two time stamps and actually splitting them, from the notification on the front end, when median times, when PSAP receives it first, there's about a 46 seconds that's accounted for before REMSA then is receiving the call, then you have your 5:36 travel time. On the flip side, if REMSA's receiving it, they would be doing the EMD before doing the notification over to the PSAP unless they had an extra dispatcher to help, so that median time is showing to be 1:26 for the FY, travel time 4:41. Questions?

Mr. Thomas: On that original graphic (slide 3), you had, the 8 or 9 steps, how many dispatches in that 9-step process?

Ms. Conti: Dispatches or dispatchers?

Mr. Thomas: Dispatch actions. Like the person calls, right, they pick up their phone and they dial 9-1-1 I assume, and I guess the second question then, after you answer that one, is, how does a person go directly to REMSA?

Ms. Conti: sGoing with the first one, and maybe sharing the podium with Jen, I believe there to be an action here, so at #1, and here, because it crosses over, (speaking to Jen)-I know that you're Washoe County, but he wants to know how many dispatch steps are happening. Come join me.

Ms. Felter: Jen Felter Washoe County Communications for the record. So from the time of the 911 call and I can answer on the EMD side because my PSAP is the one that does that, from the time of the 911 call, once we know that it is a medical, we roll straight into protocol. There is a little bit of discrepancy there for us, so it's a little bit different as opposed to I can't answer for how Reno does it, I know there's steps, but. The call is answered, the EMS call and the answering would be one step in our PSAP. So then we don't ask police, fire, or medical. Our procedure is: what's the address of your emergency?, By that time we are getting an address, we're verifying an address, so we're already in protocol. We do all three of the protocols but we're already in so that's a verification step. And then we know right around the fourth step if we're going medical, police, or fire. So it's just a matter of seconds and questions.

Ms. Conti: With your knowledge of the other two PSAPs would it be fair to say that most boxes up here (slide 3) do have an action step associated with it from a dispatcher perspective?

Ms. Felter: I think that the EMS call and the first and the second boxes are in my opinion one and the same. The third one would be technically the second one and we do ask police fire and medical and then by the fourth step, or third step, I'm sorry, the transfer to REMSA would start. That of course is if it is a transfer to REMSA based on is it a medical and a police matter, and if that's the case then nine times out of 10 they are going to keep that call before they transfer a medical.

Mr. Thomas: In lay terms, to translate that, you send all the resources and then you back them off based on what you learn, as opposed to a culling of the call through multiple dispatches to figure out who is going to go. Is that a fair characterization?

Ms. Felter: On my side that's an incorrect assessment because Washoe County does EMD, so I can't surmise what the City of Reno and City of Sparks do.

Ms. Conti: My understanding, Manager Thomas, is that yes, which is that each jurisdiction has identified what they will and will not respond to. That comes into play for that fire dispatcher who is going to roll the apparatus. My understanding is that yes, it is more of a dispatch to get the help to the citizen and then through the EMD process if it is determined that it really was a stubbed toe and not a broken leg hanging off, then they would pull back.

Mr. Thomas: There are really two issues. One of them is the customer/client/citizen wants, they don't care, and they just want someone to respond.

Ms. Conti: Correct.

Mr. Thomas: Then there's the public responsibility of the resources, which is, are we spending

a lot of money on resources at the expense of someone else that might need them because we really didn't ascertain before we sent everything what exactly is going on. And then that balance between the timing and figuring that out, and sending the right resources. I mean ideally, if we had the optimal or the best situation, we would have perfect information at the initial dispatch to know exactly who to send, so we would send just the amount of, the right amount of resources and not either under-resource it or over-resource it. That would be the goal, or would it?

Ms. Felter: I want to address the citizen portion of your question first. As a citizen, if I was a citizen calling in, I don't want to be transferred. I want to know that the person who is on the line is going to stay with me on the line the whole time, which in our PSAP, we do. The 911 calls that we get, even within the jurisdictional boundaries that REMSA has right now, they're still contractually our County, so we will EMD that call. And we will call REMSA and let them know, hey we have a cardiac, conscious, breathing, however, you know, we give them all of that information. So we're already rolling our paramedic engines. So they're already in route. It's just the transport and the extended care that REMSA would provide after that. So as a citizen, I don't want to be transferred.

Ms. Felter: On the flip side, I just think that having that EMD call center is the one you are going to be talking to initially and throughout. I'm sure REMSA has the same thing when the 12% that they have come in, they feel the same way. But we're here for the citizens, and it's not safe to transfer, because we could lose it, any transfer, and ultimately that liability remains on the PSAP, the primary PSAP. Not the secondary or the EMS.

Mr. Thomas: So the second question about REMSA, how does someone go directly to REMSA?

Ms. Conti: Heather actually did some analysis on that 12% to find out if there were some commonalities, and there are some things that we believe to be true. I can hand it over to Adam or Don (REMSA) to expand upon. What we have learned is that there are some police departments that do not call back to their PSAPs necessarily, Highway Patrol just call directly to REMSA. We also have identified that there are some health care facilities where there is a physician on staff, and so they don't go necessarily through the inter-facility transport way because there is something that is a little bit more high acuity than that, so they need the ambulance and they need it to be prioritized and get there quickly, and so they feel like since there is a physician on staff that's overseeing it, that they can do a direct call. We have also found out that there are companies within the community that send out little magnets as their own advertisements and there is the business office or a phone number of REMSA on there, and it says ambulance and has that number. Aside from those things, we, there weren't a lot of commonalities that we could identify. Adam I'm not sure if you'd like to add any other options that we have found? Then the Nurse Health Line, which, now that the grant is over, the EMS Oversight program will begin getting that data, 0.5% of their total calls for the last quarter were transferred into 911. So there's a small percent but that does also account for it.

Mr. Dick: I think there are varying opinions about the best way to do EMD. There were extensive discussions when we were working on the franchise renegotiation. I think we heard one opinion here today, but that doesn't mean that that's an expression of all the views around EMD.

Chair Slaughter: Are we going to talk about the proxy representation at this meeting?

Mr. Dick: I don't know if Ms. Admirand would like me to summarize my understanding of this or if you wanted to...

Ms. Admirand: I've got the law here; I can just read it to the Board and explain. There was a law that went into effect in 2013, it was amended in 2015. In the Open Meeting Law that basically states, I'm just going to read it to you: "Unless the designation is expressly authorized by the legal authority pursuant to which the public body was created, the public body may not designate a person to attend a meeting of the public body in the place of the member of the public body, and a member of the public body may not designate a person to attend the meeting of the public body in his or her place."

Ms. Admirand: We were talking about the bylaws and whether the Board members could appoint a proxy to represent them at the meetings, and my belief, in reading this law, is that the proxy is not allowed because the Interlocal Agreement (ILA) that creates this public body, does not provide for the provision of a proxy for the Board member. I think, Mr. Dick, correct me on this, you were asking about acting members, and I don't think this prohibits acting members from serving in the member's position if they are assuming the duties of that position. For the Health Officer, there are provisions within the ILA, when the Health Officer is either absent or has been terminated, for the Health Officer to appoint somebody as an acting Health Officer or for the Board of Health to appoint somebody as an acting Health Officer and that person would assume the position on this body. Likewise with Mr. Thomas, your City Charter allows for the appointment of an acting manager in your absence or if your office is vacant and that would allow that person to serve in your position as well. Does that answer the question that you had about the provisions?

Mr. Dick: I believe it does, does that satisfy the rest of the Board?

Mr. Thomas: I'd just like to say it back so we all understand it, as long as the agency or the entity within their powers makes a designation that's the key to who can be sitting here.

Ms. Admirand: Correct.

Mr. Thomas: Okay, makes sense to me.

Mr. Thomas: Now, I guess, a follow-up question –is there interest on the Board in adjusting the ILA? That's where it sounds like the change would have to be made if there was an interest.

Mr. Dick: If I could. There were discussions around this when the ILA was being established as wanting this to be the Health Officer or the City or County Manager actually be the person at the meeting so I would suggest we not make changes to the ILA in that regard at this point.

Chair Slaughter: Agreed. In part because of the infrequency of our meetings, today also we have two members that aren't here, and the depth of what's been covered in the past.

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7. Presentation and possible acceptance of an update regarding EMS data and content of future data reports.
Heather Kerwin

Chair Slaughter: Introduced item and noted it was an action item.

Ms. Kerwin: EMS Statistician – I'm not going to read the staff report verbatim, but just a few highlights. I've been conducting meetings to determine the contents of future quarterly data reports and I did want to thank the participants of those meetings. Representatives from all the agencies, and that included Dennis Nolan, Adam Heinz, Joe Kammann, and Ed McDonald were the most recent representatives that I was working with, and through the process of those four

meetings, we did come out with three tangible items.

–Ms. Kerwin: The first that I want to discuss with you is that response time map that wasn't included in your packets, it was a product from our GIS department, Jay Johnson actually did a fabulous job on those. You have two maps there, one is a response time heat map and the second is a population density map for reference. What was discussed in those meetings were six topical areas that were identified by our fire chiefs as important areas to measure. That includes response times, patient outcomes, dispatch and prioritization of calls, transport times, quality of patient care in the field, and prevention and community interventions.

Ms. Kerwin: This was our first tangible outcome was that response time heat map, and we would like to be able to make that publicly available, if there's any input on that. Our initial idea was to make this an interactive, clickable map, but our GIS is limited by the license that they have. What they have agreed to do is pre-populate a Google map interface with anywhere between 10-15 different maps that we would like to see. So what you're seeing is all calls for the fiscal year. It's Priority 1 and 2 calls, it's a little over 34,000 calls, and the reason why the number is different from Christina's presentation is that these were geo-located calls, so they had to have an address. What its showing is the response time for that actual incident. So if we were interested in calls that occurred during the day vs. calls that occurred at night, those are two separate maps that we can pre-populate into an interface that you would just select that, and then you would be able to move in and out. We didn't want to violate any HIPAA or get down to the nitty gritty so when you would be able to zoom in the layers would turn off so you can't look at your house and your neighbor's house to see if one is yellow or green or you know, so that was the idea behind that.

Ms. Kerwin: The second item that came out of there, you'll see the template for future data analysis, much shorter, kind of like a brief one-pager, and those were the agreed-upon tables and analysis from previous reports that identified those working by those representatives to be included in future data reports at this time. I'm open to input on that as well.

Ms. Kerwin: Then the third thing that was discussed was having an internal, formalized process for the agencies to request specific data analysis that then be turned around and provided back within their own agency. That can be an ongoing data analysis, a one-time look, and we can also run quarterly checks on turnout and travel times and things like that and provide those back to the agencies if they request things like that. So I'm open to any questions or input.

Mr. Thomas: So if you look at SW Reno, just so I understand this map, there's a red circle, surrounded by an orange circle, surrounded by, whatever that tan is. Which seems kind of bizarre, because the more you move out of the urban area, right…

Ms. Kerwin: So the way that this works, as it was explained to me, every single data point looks at the six closest other addresses that had a response and uses the response times associated with those points to give you an estimate on what the response time would be in a location that currently didn't have an address point, if that makes sense. You'll see, underneath the key there, it says estimated response time analysis is limited to areas within two miles of an actual response. The underlying base layer is white, so that dot that you are speaking of specifically, anything white on the outside just means that there was a call, two miles radius out, there's no other data to input and estimate what that response might look like. Does that answer your question?

Ms. Thomas: For me I think it's very valuable to have this kind of map, the geographic map, maybe annually. And just to my colleagues here, I think where this would be valuable is in

probably more of a regional planning discussion because it's important in terms of the emergency medical system process to know what's going on, but I think in terms of the landform, it's also fair to say and have a regional discussion about what should be the service provision further out. Because generally there's less density, less resource, and I think conceptually, the areas that are green should get the quickest response, and if somebody lives, you know somebody here may live on Red Rock Road, but if you're living way out on Red Rock Road you shouldn't expect to get a four minute, five minute medical response, I mean that's the price you pay for your choices of where you live. I think if we can reflect that to the public, that's the trouble I have with the circle, is that it might give the wrong impression to somebody, which is don't buy that house in the red, but if you buy that house just two away. But I think that something like this going out publicly would help because it also helps people make a decision. So if you had, for example, if you had an illness in your family that you knew was going to require a lot of emergency medical response, the best thing for the region would be to go seek out a residence that was within one of these green areas, not go buy a house out in the orange. Because it's going to cost all of us a lot of money, and we're probably going to fail in providing that response.

Ms. Kerwin: We did consider including, that's why you also have the population density, to try and help communicate that, because we did consider including that in the heat map itself, but there wasn't a graceful, uncluttered way to present all of that information in one image. So that was one of our concerns, is that there are areas that might look like they are not getting as quick a response as you would might hope for if you were a citizen living there.

Mr. Thomas: My only two cents is to get rid of those little tiny circles and maybe making it a more regularized service map just in terms of what you would show to the public for planning purposes to show what's really going on and those are the areas where you get better response. Then I think local governments can decide if they want to expend more resources to change that, I mean that's the value to me of the map.

Mr. Dick: To add to Mr. Thomas' comments, I think that it would be good to couple this with the, if we are providing this on the website or something like that, with the REMSA response zone map. We don't have anything to my knowledge that's like that for the fire departments, but if there was, I think that would be useful too. Because what this is really looking at and why you are seeing a red dot is this is actual response vs. the response zones. So maybe there was a situation going on where we had a fire that the fire agencies were responding to and so they weren't able to pull a unit on that day to respond to this particular house, and so that is driving a data point that you're seeing here, but it's not necessarily what that location should expect throughout the year under those response standards. So I think it would be good to couple this actual performance with how the plan is put together for the planned responses to those areas.

Ms. Kerwin: We can run through a couple iterations and bring it back to the Board and see what types of versions of smoothing of those center points as you mentioned, and then also providing some of these caveats, like your REMSA response zones, population density, fire districts, other factors to take into account when digesting this type of information.

Mr. Thomas: For me personally, the individual data, what's nice to have is probably more valuable to the service providers, the direct service providers, what's helpful for me, as a decision maker sitting in this seat is kind of a, over the year, what's going on. Because that is something you can compare year to year to see what the trends are, as opposed to individual incidents that may or may not be an anomaly.

Mr. Dick: Couple of different things – on the data analysis template, the stuff that's involved in the reporting there, there had been some discussion about, and when I met with some of the fire chiefs about separating out looking at fire response for the priority calls and separating out the low priority calls when looking at fire response and I don't know if that was discussed, but I don't really see that here, and I think that's a concern that I had heard, is that when we are looking at fire response times, or we are looking at a median response time, it's more important to look at the high-priority calls and how the response is occurring for those vs. pooling everything together and having a lower-priority call maybe pull out that median response time.

Ms. Kerwin: Historically we have tried to show response times by REMSA priority and when fire priority is mentioned, to my knowledge, when WCSO and RENO ECOM do prioritize it, it just is a priority call or non-priority call. All the calls that we're currently receiving are deemed to be a priority call. Now when you get into the EMD process in terms of is it a P1, 2, 3 or 9, those are the calls that we receive on the REMSA half, we have limited the current analysis that I have done has taken that into account and has been looking at P1's and 2's, but the only other fire department that does a prioritization that has a numerical association is Sparks, and it's either a P1 or P3. So there are differences among just the fire departments themselves and how their dispatch centers would call a call priority or non-priority, or at what level.

Mr. Dick: Just to follow up on that, if we are matching the fire calls with the REMSA calls, then we could use the REMSA priority as a surrogate for the fire priority, and that's how you've done it in the past?

Ms. Kerwin: Right, that's been our proxy for the past, yes.

Mr. Dick: Is that a possibility then moving forward for the data report template?

Ms. Kerwin: Yes.

Mr. Dick: Just a couple of comments on data. I had the opportunity to meet with each of the fire chiefs and talked about data. It's been an issue that's been ongoing, and heard concerns about the amount of time that had been taken in the past in trying to provide the data and work through it and all that. So currently we are receiving just the RMS data. I had some discussion about possibilities for moving forward if we could streamline the way we would be working with the CAD and RMS data, and Chief Moore agreed to review a proposal and consider that as far as what we might be able to do. I had just a brief conversation with Chief Moore that he thought that there was some possibility, I believe, and correct me if I'm wrong, with looking at an approach like that but I think we just need to continue to work to figure out how to get the data in a timely manner in a consistent format I know we're getting it in two different formats now from fire agencies and it's requiring some extra work on our part. And if we're not going to be able to move forward with the CAD and RMS data as was discussed previously, and agreed to through the EMSAB, then I think that is an item that needs to come back before the EMSAB since that would be a different direction from the Board.

Mr. Thomas: Can I ask one quick question from Kevin just to clarify. Were you talking about separating or blending the medical and the fire? There are two functions, right? There's a medical response and there's a fire response.

Mr. Dick: There's, in the fire agencies, there's the CAD data from the CAD system as the calls are coming in, and then there is the RMS data which is how the CAD data is transferred over to the fire agencies and there are additional data collected for that response. There is more information in the RMS data, but what we've found is that it doesn't always match the data in

there from the CAD because of different circumstances that occur and how that interface functions. Previously we had decided that the best approach was to try to match the CAD data with the RMS if possible and there was reluctance from fire to provide the CAD and RMS data following that. The proposal that I made to Chief Moore, I was attempting to try to resolve some concerns about time that fire agencies were spending on data, streamlined that approach and proposed a path forward that might work. That's what's going on with that.

Ms. Conti: May I add, just for the record, Manager Thomas, the discussion of sending fire data to us was had. The outcome of that discussion was to simply send, with the CAD RMS that Mr. Dick was talking about, EMS and EMS-related calls, which calls that are fire in nature would not be sent to us. It is obviously beneficial if any call that has a patient associated with it is sent, because then it increases the look of what EMS looks like in this region, but there's no easy way to just click a button and say anything that had a patient, send. So it's EMS and EMS-related, not the other ones that are associated with the fire department.

Mr. Thomas: The reason I asked is because I do see them as two different events that have two different responses. And so to the extent we can be as pure as we can, maybe that's the challenge, in defining what was….. Like if you have a fire and somebody gets hurt, is that then a medical response, or is that a fire response? To me it would be a fire response because the reason they were called there was for a fire, so that should be captured on a fire response map vs. a medical response map. I guess where we would try to get to, we would have two maps, one which is a medical map, and one which would be a fire map.

Ms. Kerwin: I don't receive the fire-only calls, so I wouldn't be able to produce that, given that those data elements are not reported to our program. So we are receiving the EMS-related components of medical calls, and unique circumstances do happen, we do receive calls through REMSA that they dispatch an ambulance to be on standby for the fire department, although there may not be any patients associated with that call. There's always the unique situation.

Mr. Dick: Mr. Chairman, one more comment on the data analysis template. I would suggest also that when the jurisdiction standards are established and provided to the, response standards are provided, to the EMS program, that the performance under the standard be added to the data analysis in those reports.

Ms. Kerwin: Absolutely.

Chair Slaughter: This is an action item, so does direction need to be taken on the item itself?

Mr. Dick: so can we...so that's the direction we provided and then can we just accept the report? I would move to do that.

–Mr. Thomas: I'll second what he said. If you guys can figure out what it was. Ms. Conti: it might be best to repeat it.

Chair Slaughter: so moved and seconded, all in favor say Aye.

Ms. Kerwin: Clarifying question, just to be sure that I clearly understand, I want to make sure, when the jurisdictions, because within our EMS Strategic Plan we do have a deadline by March, end of March, that the jurisdictions come back to us with their jurisdictional standards associated for their performance metrics. Once those have been decided upon and communicated with our program, you want to see performance measures relative to those standards put into this data report.

Mr. Dick: correct. But then also, as I had mentioned previously, I'd like to see the fire

response times broken out by the Priority calls as well, unless I hear objection from the fire agencies. But I believe that was an interest that the fire agencies had.

Chief Cochran: clarifying question, are you talking about the response by fire to an EMS call or to a fire call?

Mr. Dick: to an EMS call. I think the feedback I heard was, instead of having all of the priority responses pooled together in looking at a response time, that it was more appropriate to look at Priority 1 & 2 calls and determine what the median response time was for those calls. Chief Cochran: Yes, based on Manager Thomas' question, I wanted to be sure he wasn't blending fire responses vs. EMS responses.

Mr. Dick: I'm sorry, I was talking about fire, but in this room I'm really focused on EMS.

Chief Cochran: Since I'm interested in clarifying, you mentioned standards. We've had this discussion at a prior meeting that the jurisdictions will turn in, if they have a standard, and when they make that determination and we will measure against that. I'm speaking for Reno. Mr. Dick: right, and if you don't have a standard we can't measure you against it. Chief Cochran: right, I want to be clear that we are not obligating ourselves to develop a standard. Mr. Dick: right.

Ms. Conti: It's a clarifying question but then also a comment. If there are jurisdictions that aren't going to have a measurable standard that we can use, if that also can then formally be told to us by the March deadline, then that kind of completes our circle and we can check that box. So I just wanted to put that for the record and then Heather and I just wanted to gain the clarifying point. The reports and the frequency, would you like to switch to a semi-annual instead of a quarterly? There was a passing comment on what the value of the data back is to decision makers and policy makers and I don't want to lose sight of that one comment and make an assumption that shouldn't have been made.

Mr. Thomas: is there enough information quarter to quarter to make it valuable as far as work effort?

Ms. Kerwin: As far as being statistically valuable, yes, although over the course of looking at this data pretty closely for two years, times don't necessarily fluctuate, median times don't fluctuate a whole lot for any interval. Now if we were to measure someone against a standard, their own performance standard, for example, and there was some opportunity for improvement, that would be a point in time where we could sit down and discuss the processes that are involved in that particular time interval that maybe isn't meeting or exceeding expectations, and then hopefully apply some changes to make that process more efficient and potentially reduce times, and I think it would be of value to then re-measure. So just with that information.

Mr. Thomas: I mean for me, in terms of what our role is here, we're not going to respond very quickly. This is more of a policy Board, so the quarter to quarter information is more valuable to the actual service providers because they can find out if there is a glitch or a problem or something going on. Not that it wouldn't be nice to have, but I know for me it doesn't really, sitting here on this Board, there's nothing I'm going to do in three months that..

Ms. Kerwin: Is going to turn around in that time.

Mr. Thomas: Exactly. But annually I think it does, because it's a bigger picture like where's the region going, what are the direction of things. So that's just my two cent's worth. If you guys

want to do them quarterly, more information is always better, but it's really a question of the time value of your effort, do you really want to collect that. I would go back to the providers to see if it is valuable to them quarterly.

Ms. Kerwin: I do, I would run those just as a making sure there's nothing happening internally, and I can provide those back to the agencies as they are requested, as frequently or infrequently as they would like, and from what I'm understanding, correct me, it would help for the Board to receive a more formal report on an annual basis.

Mr. Thomas: That's my opinion, I don't know how anybody else feels.

Chair Slaughter: Sounds logical.

Mr. Thomas: So annually to us, does that need to be in the direction, or be in the motion?

Chair Slaughter: I have a motion on the floor that has been seconded. Do you have all your direction?

Ms. Kerwin: I think so.

The motion was approved four in favor and none against.

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8. Presentation and possible acceptance of an update on the five-year Strategic Plan, a requirement of the Interlocal Agreement for Emergency Medical Services Oversight.
Christina Conti

Ms. Conti: What you have in front of you in the staff report is what the tracking for the strategic plan will look like in your packets every quarter. As part of Objective Six, the Oversight Program facilitates the Strategic Plan and reports on the progress of it and so there are 12 identified strategies or objectives for this first year, which was a little bit alarming to me. But when you look at it, a lot of them intertwine, so hopefully the commitments of the partners to achieve these goals won't be very extensive. So the format I have, and I'm open to feedback for the future, is that the objective or the strategy itself is in bold, and it has the reference. If there is an update on that one item, then I have that written after it. Obviously we have an update on CAD-to-CAD and we have an update on the protocols, but those were in different reports so I did not duplicate it here. So I am happy to answer any questions on where we are with achieving our goals of the Strategic Plan.

Mr. Thomas moved to accept the update on the five-year Strategic Plan. Mr. Dick seconded the motion which was approved four in favor and none against.

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9. Presentation, discussion and possible acceptance of an update on the regional protocol project, an objective of the Washoe County EMS 5-Year Strategic Plan.
Brittany Dayton

Ms. Dayton: EMS Coordinator for the record. I will reiterate some of the information that Dr. Michelson provided during his PMAC update and provide some additional information. As a refresher, Goal 5 of our strategic plan is to design an enhanced EMS response system through effective regional protocols and quality assurance. The purpose of this agenda item is to give you an update specifically on Objective 5.1, which has a goal completion date of June 30, 2017.

Ms. Dayton: As Dr. Michelson already mentioned, PMAC met on December 14 and received

a 129-page document from our consultant, EMS Consultant Group. They flew out from Philadelphia and provided a presentation on their analysis. The first steps for the contractors were review the current EMS agency protocols and then do an analysis based on whether they were identical, where there were some variances, and then provide recommendations on which protocols to move forward with, based on evidence-based practices.

Ms. Dayton: The contractors reviewed all the protocols, provided summaries on each one based on the agencies that provided their current documentation, and then as previously mentioned,, after the presentation, the PMAC moved to develop a task force. They requested that each agency that's participating identify two individuals to meet on a regular basis to go through all the protocols and start establishing regional protocols. I received all of those names from the agencies this week so I will be reaching out to start scheduling bi-weekly meetings with these individuals. The first meeting will start with identifying an appropriate format. We have a few agencies that are very interested in the Clark County regional protocol format, but we have some other options that the contractors gave us, so we will hash out a format and then start working on the actual meat of the protocols and what will be going into them.

Ms. Dayton: Progress will be reported both to the PMAC and the PMAC's next meeting will be in March, and then we will be giving another update to this Board in April. And with that I will be happy to answer any questions.

Ms. Conti: It just occurred to me that it might be nice for the record to note that the implementation would not be until January, to give the partners the six-month train-up time, to purchase any equipment, or anything that would go if there are changes to their existing practices. That was written into the strategic plan, to have a six-month period between approval and implementation.

Mr. Thomas: So did you say one year from now, like next January, or six months from now? Ms. Conti: in theory, January 1 the whole region would be operating.

Mr. Thomas: 2018.

Ms. Conti: Yes.

Ms. Dayton: If we hit our goal deadline of June 30, then they would have six months to implement the new regional protocols.

Chair Slaughter: Any questions, thoughts, comments? Motion to accept?

Mr. Dick moved to accept the update on the regional protocol project. Mr. Thomas seconded the motion which was approved four in favor and none against.

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10. *Board Comment

Limited to announcements or issues for future agendas. No action may be taken.

Chair Slaughter: Any comments or requests for agenda items?

Mr. Thomas: I don't know if this is a request for an agenda item, but maybe it's just again maybe I'm new to this Board and what we are doing. I have interest from the standpoint of both an organization and health care costs but also for the citizens of the region to understand what is the role that we can play? Traditionally local governments aren't very involved in health care, other than being a client that has to pay for it. To what degree can we, in this group, or regionally,

do things that would help address the ever-increasing and more complex medical environment in the community? I guess it's directed more to you, Dr. Michelson, if there is any role that this group can play to deal with the cost side of it? The one side is making sure we show up on time to give people the best but the other side is what can we really afford to do? I know personally for me there are a lot of physicians I've talked to that are all over the map in terms of whether there is anything you can do, but every one of them tells me that they feel that the whole medical environment, there is a lot of stuff that needs to be done to maybe change the direction it's going. So that's kind of just more general questions in terms of what the whole relationship would be, maybe go beyond some point just to even ask but what's the role of the locals to help address that service.

–Chair Slaughter: If that's an agenda item that we can deal with in the future.

Mr. Thomas: I'm not saying it is, if there is nothing for us to do, then let's move along.

Mr. Dick: I've got a couple ideas on agenda items. One would be to have a report from REMSA on results of their ongoing activities with Nurse Healthline and the Community Paramedicine program. I'd also like to request an update around plans that had been discussed previously, Chief Brown had I think initially brought this up, regarding outreach on appropriate use of 911, the idea being that we've done too good of a job marketing 911 so now everybody calls it whether they need it or not. And so I'd like to have an update on plans that I think are in the works and how we might move forward in that regard.

Chair Slaughter: Anything else, any other comments or requests?

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11. *Public Comment

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

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

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12. Adjournment

At 10:20 a.m., **Mr. Thomas moved to adjourn. Mr. Dick seconded the motion.**

Respectfully submitted,

Dawn Spinola

Dawn Spinola, Administrative Secretary
Recording Secretary

Approved by Board in session on April 6, 2017.