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

WASHOE COUNTY
HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

Sabra Newby
City Manager
City of Reno

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

Terri Ward
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MEETING MINUTES

Emergency Medical Services Advisory Board

Date and Time of Meeting: Thursday, April 5, 2018, 9:00 a.m.
Place of Meeting: Washoe County Health District
1001 E. Ninth Street, Building B, South Auditorium
Reno, Nevada 89512

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1. *Roll Call and Determination of Quorum

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

The following members and staff were present:

Members present:
John Slaughter, Manager, Washoe County, Chair
Kevin Dick, District Health Officer, Vice Chair
Sabra Newby, Manager, City of Reno
Terri Ward, Hospital CQI Representative, Northern Nevada Medical Center
Steve Driscoll, Manager, City of Sparks
Dr. Andrew Michelson, Emergency Room Physician, St. Mary's

Members absent: None

Ms. Spinola verified a quorum was present.

Staff present:
Leslie Admirand, Deputy District Attorney
Randall Todd, Division Director, EPHP
Christina Conti, Preparedness and Emergency Medical Program Manager
Brittany Dayton, Emergency Medical Services 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** (For Possible Action)
Matters which the Emergency Medical Services Advisory Board may consider in one motion. Any exceptions to the Consent Agenda must be stated prior to approval.

A. **Approval of Draft Minutes**
January 4, 2018

Vice Chair Dick moved to approve the Consent agenda. Ms. Ward seconded the motion which was approved with five in favor and Mr. Driscoll abstaining.

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

Dr. Michelson stated he had not attended the previous meeting but one of the other members had led it. He was informed that there had been many agenda items. He noted that PMAC has a new secretary. Although there has not been much interest in changing leadership, which is scheduled to occur every 24 months and is coming up again.

Dr. Michelson noted to the Board that there is a scholarship fund for paramedic students and PMAC is working to increase the funding for that, to include attempting to find other sources.

Dr. Michelson explained there was some interest by some of the members to use PMAC as an option for QI with pre-hospital cases. This has been done a little bit before, but not in any kind of formal or recurrent manner.

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

Ms. Conti opened by stating she just wanted to bring a couple things to the Board's attention. Over 37 individuals, including regional fire partners, EMS and law enforcement agencies, participated in MCI tabletops over the course of three days. The MCI is being updated to include their feedback.

Ms. Conti explained the CAD-to-CAD update testing was set to begin the first week of May, with a rollout in early June if all the tests go as anticipated. She noted that City of Reno staff were available to explain further or answer questions.

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6. ***Presentation regarding the EMS Today conference attended by the EMS Program Manager and EMS Coordinator.**
Christina Conti and Brittany Dayton

Ms. Conti noted this was the third year that she and Ms. Dayton had attended the EMS Today conference, and they find it to be a very valuable conference. There are 4,500 attendees and six different conference tracks available. This year's conference featured longer presentations and more time in between for networking and expo attendance, so Ms. Conti and Ms. Dayton attended three or four sessions per day. In keeping with what has been done in previous years, they brought back information from sessions that may have the opportunity to be implemented here in this region.

Ms. Conti began the discussion of the presentations with one called In Harm's Way, which uses simulation to protect EMS personnel. She stated she appreciated this conference session, because healthcare workers are ranked as having the highest risk for workplace violence. One of the things the community did was partnered with their law enforcement counterparts. The law enforcement officers created four different simulation scenarios. Each scenario had the same components, such as there would always be an aggressor. Additionally, they also held the simulations in unfamiliar locations, so that when the crews arrived, it was not something that they were familiar with.

Ms. Conti explained the next session was regarding an activity somewhat similar to something currently being done in the region, but taking it to a different level. In Oklahoma, they have social workers that are being used. It is called the CARES program, and is a bit like Washoe County's MOST program. They seek to prevent and reduce super usage of emergency services. But they are looking at physical health, mental health and social support systems. As a result of discussions among all the different agencies, they realized they were having the same issues and dealing with the same customers, and EMS was being used far too often as a primary care resource. They decided to utilize social workers in integrated teams. They used their EMS agencies as practicum sites for social work students to give them exposure on the front end, to know when they are going to work in the social work field that is something that will have already had exposure to. They also embedded licensed social workers or master's students into their teams.

Ms. Dayton stated the first session she would be introducing was regarding lessons learned from Hurricane Harvey, given by the medical director for the health department. The biggest takeaway was that the disaster does not follow the plan. She noted she enjoyed the quote used from Eisenhower that said "Planning is everything, the plan is nothing." Hurricane Harvey really highlighted that for them, as the disaster did not read their plan and they did not respond how they intended. However, they were very flexible in their ability to respond and get the appropriate care for the thousands of people that needed it.

Ms. Dayton went on to highlight two things. The first was that the presenter was very expressive when he said do not use a convention center as your shelter, as many plans across the country do. They found that the number of people became overwhelming, and they were unable to provide proper care for the thousands of people that ended up showing up at the shelter. The second highlight was that they did not use a credentialing process. The only person that they credentialed was a certified Pharmacist, so that person could go through all the medications that were being donated during the disaster.

Mr. Driscoll asked if they had other suggestions for shelters, since they were discouraging use of a convention center. Ms. Dayton explained they had opened a strip mall that was vacated at the time. Because it was compartmentalized, the rooms were smaller and easier to control. The presenter had been very concerned about the possibility of viruses spreading in the convention center , where if an outbreak were to happen it would have been uncontrollable.

Ms. Dayton noted that the second session she wished to highlight was titled "Best Approaches to Special Needs Patients." The EMS Oversight program received a grant from the Nevada Governor's Council on Developmental Disabilities to develop some trainings for first responders related to responding to individuals that have intellectual and or developmental disabilities. Ms. Dayton is currently working on that project, and attended the session to make sure the training materials being developed were on target. She stated that all

of the information was similar. Additionally, she did have a few good takeaways, and one of them was what was called the TIPS application. It was developed at the University of New Mexico Center for Developmental Disabilities, and is in paper form. The individual who gave this presentation was a firefighter from Chattanooga, Tennessee, and he put one of these in hard copy on every fire apparatus in Chattanooga, but it is also available as a phone application. She further explained that the application provides tips, not only for individuals with developmental disabilities, but also for seniors and other populations who may have varying needs as far as EMS is concerned.

Ms. Dayton stated the final session that she wanted to highlight was called "EMS Around the World," and it combined three presentations about the EMS systems in Austria, Israel and Denmark. The first presenter was from Copenhagen, Denmark and he talked about how they reorganized the EMS system in 2014. Ms. Dayton displayed an image of what the system looked like in Denmark prior to 2014. People had a variety of options as far as where they were going to get their medical care, and they restructured EMS so that when an individual needs to go to a hospital they are required to call and tell a dispatcher or nurse what is going on. As the patient is describing their situation, the dispatcher or nurse will find a hospital, triage the patient, and then send that information to the hospital so when they arrive it is already there. They have found that this change has reduced the overcrowding in the hospitals and has decreased healthcare costs significantly.

Ms. Dayton went on to explain the next presentation was given by the president of the national volunteer-based organization in Israel. Their system is very unique. They recruit community members to be lay responders, and provide them with a motorcycle, a medical kit and an application. If a responder is near an EMS call location, the application alerts them to the situation and directs them to the scene, they respond, and they become the first first responders. There are over 5,000 volunteers and they go on approximately 1,700 calls a day. Ms. Dayton questioned why employers accepted this process, and the presenter explained Israel's culture strongly supports helping people. Therefore, there is no concern about people leaving and coming back or getting time off to be one of these volunteers.

Ms. Dayton finished by noting the presentation about EMS in Austria was cut short because the two first presenters ended up going a little bit over their allotted time. She did learn that Austria's system is similar to Denmark's, in that they utilize a number to reach dispatch systems and the presenter focused on their interface between EMS and social services, and how that has improved their EMS system.

Ms. Conti opined that there would be value, since this was the third time that they had come before the board, to circle back on some of the presentations that have been provided before, and explain what has been implemented in the region as a result. From the 2016 conference, the Stop the Bleed campaign is in this region. It is starting to get some traction, certainly here at the Washoe County complex. Additionally we have signatures from Vice Chairman Dick to obtain the license to use the nomenclature of Stop the Bleed, so that the region can use that same language and be tied into the same program nationwide. The "Terror in Paris" presentation predicated the Alpha plan that is in currently being developed and is anticipated to go to the District Board of Health in June. That has been a strong partnership, not only with the EMS partners but with law enforcement as well, because it starts incorporating them into the planning process.

Ms. Conti explained that the simulation scenarios for the joint trainings between REMSA and fire partners, using the same format for each one, was also something that was brought back from the 2016 conference. During the 2017 conference, she and Ms. Dayton learned

more about burns, and that type of information has been incorporated into the Mass Casualty Incident plan. The MCI plan is currently undergoing a revision, making it more robust. The regional protocols, also a topic presented at the 2017 conference, went live with all agencies on April 1. Ms. Conti went on to note that the MCI lessons learned was a session that highlighted a myriad of incidents. The main issue brought back from that session was the need for alternative EMS transports during responses and what does that look like for the region's health care system. Law enforcement can be an asset, as can Uber, and also self-transport.

Mr. Dick asked if there was any data available on improvement in survival rates for cardiac events, etc. from the Israel project. Ms. Dayton she stated she did not know, but that they had access to all the presentations, so she would find that for him. Mr. Dick then asked if the reason for the reduced overcrowding and decreased healthcare costs in Copenhagen was because this is a screening tool to divert people from going to the hospital if they don't need to. Ms. Dayton stated that was correct, further explaining the caller will either get a dispatcher if they need 911 services, and then if not, they will be sent over to a nurse to be triaged, and the nurse will get them the appropriate services. The system has helped decrease not only the number of unnecessary EMS responses, but also the overcrowding in the hospitals.

Mr. Dick asked if he could just get the TIPS app from the app store. Ms. Dayton said he could, although she did not know if there was a cost for it. She has looked into potentially ordering the hard copy version for the fire apparatus in the region, and there is a cost associated with that.

Mr. Driscoll moved to accept the report.

Deputy District Attorney Admirand noted no action was necessary with the item. Chair Slaughter expressed that his copy of the agenda indicated it did, but accepted input from the dais that it did not and stated they would move on to the next item.

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7. **Presentation, discussion, and possible acceptance of the mid-year EMS data report.** (For possible action)
Heather Kerwin

Ms. Kerwin noted she only had a few things to point out and then would be happy to answer any questions. The report did include REMSA Priority 0 calls, which happens when a unit is cancelled enroute prior to the entire EMD process being completed or the unit arrives on scene and the responders have eyes on the patient before that EMD process is completed. For the lay reader, the report clarifies the designation and the differences between Priority 0, 1, 2, 3 and 9. She pointed out the Nurse Health Line Omega call report per the methodology for review that was previously approved is included in the packet. She noted n the future that information will be included with the mid-year data reports so the Board can see those calls as they flow through the system.

Mr. Driscoll noted the package included nice performance reports for two of three agencies. He opined it would be nice if all three agencies provided performance data. That is the intent of what this group is for, so he implored the one that did not provide the data to please provide it in the future.

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

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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.
(For possible action)
Christina Conti

Ms. Conti addressed Manager Driscoll, pointing out the new formatting initially presented at the previous meeting, which Mr. Driscoll had been unable to attend. It was staff's attempt to achieve his request to continue to see what was happening with the strategic planning items. If there were any changes that he would like, the formatting was a work in progress and staff would happily make those changes.

Ms. Conti reiterated that the regional protocols had been developed and were effective as of April 1. There is a task force meeting scheduled for the 19th that has been set for the last six months. The intention of that meeting will be to talk about how the training went, if there are already some identified concerns with the protocols that need to be reviewed, or if there are any items that the partners would like watched and get some statistics on for the next update.

Ms. Conti explained the implementation of appropriate protocols to determine service levels through the EMD process to low-acuity Priority 3 calls continues to be addressed by a robust subcommittee that is working together to achieve the objectives of the strategic planning item. She did have an update since the report was completed. All three fire agencies have now come to consensus (on Card 33 facilities) that they will only respond to Priority 1 calls and that REMSA would respond alone to Priority 2 and 3 calls. However, prior to that being implemented, the EMS Oversight program will develop the processes for notification as well as for a review, in case any of those Priority 2 calls do in fact turn out to be a Priority 1 call where both tiers should have gone. That is also something that Dr. Michelson was discussing, where PMAC can come into play.

Ms. Conti stated that all other updates had their own stand-alone items, so she was available to answer questions, if there were any.

Mr. Driscoll moved to approve the update of the five-year strategic plan. Dr. Michelson seconded the motion which was approved unanimously.

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9. *Update on the public service announcement (PSA) project relating to the appropriate use of 911.
Brittany Dayton

Ms. Dayton reminded the Board that during the meeting held last August, Board members received an update on the PSA project and saw the videos that the regional partners submitted. The DBOH had held a strategic planning retreat in early November, during which the management team updated the DBOH on progress of strategic planning items. During that meeting, DBOH members expressed there was a need for more public education on appropriate uses of the 911 system. On November 13 the DHO requested that an initiative be added to the Health District strategic plan. Initiative 2.2.5.1 includes the development of a marketing plan to educate the public on appropriate uses of 911.

Ms. Dayton explained that the EMS program contracted with a company called The Factory, a local graphic design firm. The Factory developed a set of marketing materials for staff to utilize to educate the community on appropriate uses of 911. The materials were created to be displayed through a range of mediums, and staff has chosen to post them on RTC buses and social media, and in the future, they may also be displayed at movie theatres. The materials have also been

translated into Spanish.

Ms. Dayton displayed the "Bad Hair Day" advertisement. She explained that each of the different ads have the same tagline, which is "Certainly a Problem...but Not an Emergency." A dedicated URL has been created, called thinkbeforeyoudial.com, which directs people to a Washoe County page that lists all of the non-emergency numbers for the region. Ms. Dayton explained there were many more ads and launch is scheduled for April or May. They will be displayed throughout the summer. The EMS Oversight program wanted the Board to be aware of the campaign, should they see them around town.

Mr. Dick noted this was added to the Health District strategic plan at his request because of a request that came from Chief Mike Brown during the strategic planning retreat, that WCHD help educate the public about not calling 911,. Mr. Dick opined this was a good start, but stated he felt that the region needed to have a longer-term and larger, ongoing campaign to be effective in changing this behavior in the community.

Mr. Dick opined he felt that this was an opportunity for the region to work together, because it was going to require an investment, which could be spread across the jurisdictions. He suggested engaging REMSA and the hospitals also, because a reduction of the number of people calling 911 would bring a financial benefit to all of those entities. He pointed out that although the Health District was expending funds on the campaign, it would not result in any savings to the District if people did not call 911 as often. He reiterated that it was necessary to come together as a region around an outreach campaign plan, to determine the cost of an effective campaign and decide how to fund that across the different entities that might benefit from it.

Ms. Dayton explained the marketing plan and a project summary were sent out to regional partners, in part to request in-kind or financial support. REMSA has provided an in-kind donation to help with the media buy.

Ms. Ward stated she was sure the hospitals would be interested. They get some financial hits when it comes to readmission so it would be of benefit to have these resources, they could use those when discharging. She noted that happened quite often and opined there was a partnership there to be had.

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10. Presentation, possible acceptance and direction to staff regarding updates to the online heat map of regional response times. (For possible action)
Heather Kerwin

Ms. Kerwin introduced the heat map, noting that she had been adding data to on a quarterly basis to keep it up to date. The EMS Oversight program now has 2 ½ years' worth of data and a couple hundred thousand calls. Ms. Kerwin explained Mr. Jay Johnson from the Washoe County Geographic Information Systems (GIS) department was the mastermind behind the map development. She gives him the data and then he creates or modifies the visual representation.

Ms. Kerwin stated the only change is that the fire jurisdictional boundaries had been added to the map. The next tab also included trends and seasonality. While this was not in a map format, it illustrated the increase in call volume per month, by year, from July of 2015 through December of 2017. Staff wanted to research whether there were seasonality trends, and so each of the years were aggregate. The second graph showed the median response time in minutes by month. It does not show a major difference, but there is a little bit of an uptick in January and February, and then it drops back down. That does mirror some of those increases in call volume that the region gets during the winter months.

Ms. Kerwin displayed the standard population density map. It was included so that people can get familiar with the concept that living in a more rural or frontier area, they might not have the rapid response that they think they might get.

Ms. Kerwin displayed the map of the REMSA zones, showing the zones and the priority responses and the times associated with those, noting there were no changes on the map. Mr. Johnson was able to make the day versus night comparison clear. While this might be helpful in showing some of the differences in day versus night, those differences were getting washed out due to the fact there were a large number of calls.

Ms. Kerwin pointed out one of the changes in the overall was the I-80 East corridor, which included the USA Parkway seen in the Year 1 versus Year 2 map, which is being recommended to be used to replace the day versus night information. She demonstrated the contrast between Year 1 and Year 2, and pointed out the uptick in accidents in that area. That was really the noticeable difference from a high-level perspective. She opined that since the program now had two and a half years' worth of data, staff believed it might be of value to start looking at those time comparisons from one year to the next to try and see if there were changes.

Chair Slaughter asked if there was a link to the maps on the EMS Oversight page. Ms. Kerwin explained there was not a link posted for this version yet. When Board recommendations are completed, it will be uploaded to the site.

Mr. Driscoll noted this was good historical information and good for doing comparability. He asked if it was intended that this become some type of management tool that provides the first responders ways of changing how they stage or train or equipment that is available for certain types of calls. Ms. Kerwin replied that it was definitely intended to be a resource, mostly for lay populations to learn about their community. However, for EMS agencies, because the data was limited to just Priority 1 and Priority 2 calls, and each jurisdiction may change or alter the way that they respond to call priorities , this map might not meet the intentions of each jurisdiction. So it is a regional approach, looking at the response time from the patient's perspective. She opined it could be used, but the intention is broader than that.

Ms. Kerwin requested clarification from the Board on any recommendations, which maps should remain, or did they want any changes or replacements.

Vice Chair Dick moved to approve the demonstration and to update the online heat map and regional response times on the website. Mr. Driscoll seconded the motion which was approved unanimously.

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11. Board Requests:

A. ***Presentation on Advanced Life Support (ALS) services utilized by regional EMS response agencies.**
Regional partners through Christina Conti

Ms. Conti introduced the item, noting there are two partner agencies were not able to put something together for the packet, but did want to speak and another agency had a PowerPoint presentation.

Dennis Nolan, EMS Division Chief, Reno Fire, began by addressing Mr. Driscoll's earlier comment. If it was regarding the data that Reno normally provides the EMS Oversight program data on response time, our statistician, who normally runs all the department reports for Reno Fire, has been on an extended leave of absence because of a death in the family, and unfortunately the department just was not able to get the data to the Health District. He would

make sure future reports would have the response time data.

Chief Nolan went on to say that, with regards to Mr. Driscoll's other request, regarding ALS responses, Reno set out to accomplish what they were asked to do, which was to provide the Board with information about, basically how many calls, what percentage of calls are Reno Fire using ALS-level care on. It sounds like an easy question, and on face value they thought it was going to be an easy task, but it proved to be much more challenging than originally anticipated. Just understand that in our community, and nationwide, really, there are three levels of emergency medical service providers. First is the EMT, which accomplishes about 150 hours of training in what is equivalent to a semester. It is really advanced, first-aid level training. The next level is the AEMT, which can complete about the same amount of training, which augments their basic EM training with advanced airway techniques, the ability to start IVs and administer about six different non-narcotic, non-cardiac medications in particular emergencies. The Paramedic level training is anywhere from one year full-time training to a two-year Associate degree training program, which includes internships riding along with transport agencies, in clinical experiences in the hospitals, doing rotations on a much shorter base, similar to what a doctor would do, rotating through emergency room surgery, OBGYN, etc..

Chief Nolan explained that reviewed advanced-level care of patients in terms of the nature of the complaint and the response level. Then, realizing that there are a large percentage of those calls that might come in as shortness of breath and upon arrival find that it is a hyperventilation, which was an advanced-level care. Shortness of breath could be an advanced-level care. They thought maybe they would narrow this down by the interventions that were provided. Did the patient receive an IV? Did the patient receive medications? In fact, some of those calls, a large majority of the ALS calls, the patients did receive an IV or did receive medications. But they were provided by AEMTs, not necessarily paramedics.

Chief Nolan went on to say that, additionally, because they work in tandem with REMSA on the scene of calls, who provides what intervention is not always clear by the data that is gathered. So they have electronic patient care reports, but a lot of the information is gathered through a click, or a data point. But the real information that they have to drill down on is looking at the hand-written narrative of that call. For instance, one call would be an 80-year-old woman who is just not feeling right , because of the nature of the call and her history, it comes out as a Priority 2, paramedics are dispatched, they get there, and the paramedics begin to assess the patient. Blood pressure is fine, pulse is fine, all vital signs are within normal limits, she is conscious, alert and oriented, and just says she just does not feel right. If that was an EMT or an AEMT on that call, they would probably say well, she looks good, she is doing fine standing up, talking, walking, everything looks fine, she is just not feeling right, and may have advised the patient to go to her own doctor, go to the hospital, but the paramedics will assist that patient and do a 12-lead EKG, or, in some cases, some paramedics who have received advanced training to do a 15-lead EKG they can see some rare type of heart attacks. In the case of this 80-year-old woman, she would have received a 15-lead EKG and was determined that she was having a right-sided myocardial infarction.

Chief Nolan explained the real difference in advance-level care, is the training of the paramedic, and their ability to assess patients at a much higher level. The only way really to kind of drill down and say what are advance-level calls, based upon the response, the interventions that were provided, and the training of the paramedic, is to go in and look at each of the narratives of the calls. Reno Fire on average runs about 3,500 calls a month , of those, 70-75% of those calls are EMS calls. Of those calls, looking at just the parameters, of

the nature of the call, and not being able to really sit down and read 2,400 -2,500 narratives, Reno Fire estimates that 20-21% of the calls excluding the calls that they said a paramedic was utilized to assess a patient on , that 20-21% might be ALS or paramedic-level calls.

Chief Nolan finished up by explaining that, as they were combing through this, they contacted their fire partners, asked what their methodology was. It was pretty similar to what they were attempting to do. The partners were having the same challenges and, on a percentage basis, it sounded like their numbers were coming up to be pretty similar. With that he offered to answer any questions or let the other agencies offer their same observations of this particular project.

Joe Kammann, Division Chief for TMFPD noted a lot of what he was going to say was probably going to echo what the Board had just heard from Chief Nolan. When TMFPD tried to attack this project, what they kind of looked at, that may be a little bit different than what Reno Fire did, to understand a little bit of the differences between the departments. TMFPD has all 11 stations operating at the ALS level and they have been for several years. Taking all of that data, they split that off into EMS calls, fire calls, ones that had patients, ones that REMSA was there before, REMSA was there afterwards.

Chief Kammann explained that once they looked at all that data, he had to also split it out. They have two different charting systems that they used over the last year. The first six months of the year they used Fire RMS, the last half they used ePCR. There were some labor-intensive issues that they found on that. They also used some of the same models for, let's see what paramedic-level protocols and skills may be used, versus incident type and complaint, and everything seemed to be very consistent. Across the board, when they looked at the total for both systems, they were also coming in right at about 22.1%. ALS-level techniques were being used on scene. They took that number, and pulled a sampling. As Chief Nolan mentioned, to go through and read a narrative to see exactly what happened on a call will tell you a lot more than specifically whether or not a cardiac monitor was used. Chief Kammann pulled a random sampling of these calls and went through each one of them to look at where they may have some limitations in the studies that the Board asked for. He found some that he thought were definitely of note that they should probably pull.

Chief Kammann stated that one of the first ones is, it does not really identify that a paramedic-level assessment is done on all of these patients, 100% of them. Some of the benefits in that is the ability to accurately determine which one of these calls are advance level, which ones are actually non-life-threatening emergencies. It is not able to be quantified by simply looking at those skills, but the assessment level, he opined, was really important that when an ALS-level responder is on scene, patients do get that assessment.

Chief Kammann noted that the other limitation that they found on this was they also respond with REMSA, so depending on who was there first and just the scene efficiencies, on an ALS level patient, some things may not be done by their crew members. If a TMFPD crew member is assessing the patient, a cardiac patient, going through a whole assessment to get everything, all the initial steps fixed, and then REMSA shows up same time or shortly after, it was very possible they would say hey, let's just use your cardiac monitor on this patient, there is no sense in switching over. So those things were not captured from their documentation side. A true level of saying that 22.1% of patients would be ALS, he did not think that was an accurate number for the Board, just due to that response model.

Chief Kammann stated that one of the other things that he noticed was when they simply base it on what skills were used, they pulled several anecdotes from the sample that would

show not just ALS-level care is necessary for certain patients regarding traumas. Trauma was a big thing that they pulled. He gave an anecdote of a multiple-stabbing patient that had chest injuries, arm injuries, arterial bleeding, that was not breathing effectively, that had a bag valve mask being used, an occlusive dressing placed, and tourniquets to stop the bleeding, those would not qualify, technically, as an advanced-level chart, because those skills that are not something that are solely exclusive to ALS-level providers. But the ability of a paramedic to manage that scene efficiently and handle some of those, even basic techniques, at a much more efficient level, is not quantified either. Chief Kammann went on to say that what they did find, in summary, is, that they can really look at the ALS fire apparatus model as more of a standard of care and best practice, and not something that would be simply just a luxury, if necessary, to citizens. They do see that as kind of a standard of care around the nation now. Ed McDonald, Sparks Fire Department, Training Captain and EMS Coordinator, stated he would echo what the two chiefs said, in the challenges and pulling the data. Sparks had two databases as well over the course of the time period and, just pulling the literal skill set, which is what they did, does not paint the picture. He had the luxury of a smaller sample size; they have been ALS for 11 months. On two engine companies he was able to read through every paramedic narrative to dig down into that. And it becomes apparent, even when an ALS paramedic scope of practice intervention is not used, it can be seen these assessments of the patient and the efficiency that they move through their protocols becomes apparent, and that is a value that cannot necessarily be seen in the numbers.

Captain McDonald stated that they, he though the data request was for a fiscal year (FY), they did not have a FY. They started their ALS, or paramedic program, on April 3 of 2017, so he provided about an 11-month period from April 3 to the end of February of 2018. In that 11-month period, overall the Sparks Fire Department ran 12,219 incidents, all types. Of those, they sent 10,871 to Washoe County EMS, that might have had an EMS component, so those were the calls that they used to look at. Of note, 3,710 of those calls were EMS calls and they were cancelled either in route or on the scene, which coincides with the efforts that are being made for the strategic plan to identify appropriate resources and the appropriate tier-level response to some of these facilities and to some of these calls. That is a number they should all be aiming at. He thought that number would be fairly consistent throughout the region, not just with Sparks Fire Department.

Captain McDonald explained that overall, the Sparks Fire Department did arrive on 7,161 calls that had a patient care opportunity. They focus on the paramedic engines, because that is what the data requested. Those engines had 2,499 responses, consistently with a percentage, 908 of those calls were cancelled in route or cancelled on scene. They looked at 1,591 calls where those paramedic engine companies arrived on scene with patient care opportunity. Of those calls, of those incidents, 340 incidents, a paramedic provided at least one paramedic skill level call. That is not the number of total interventions, that is the number of incidents that they used at least one intervention on. The percentage matches with the two fire partners, roughly in the 20-21% area when that was used.

Captain McDonald went on to say that again, some of the takeaways, it is a challenging set of data to pull. He though it provided a very high-level view, it does not paint the whole picture of the value of having a paramedic on scene, whether it be in the fire partners arena, or in the REMSA partners arena. He believed there was more value than what the numbers actually state. The takeaways have been very good, for 11 months, their relationship with their partners and the feedback in both directions has been very positive. Looking through all the narratives, they were very satisfied that the opportunities were there that they thought were there, in the patient's assessments and airways, and the use of tools, like Entitled CO2 and

CPAP, cardiac monitoring medications. They see the benefit throughout the system in Sparks. Those paramedics are not just assigned to those engines, they do work on downtown, Station 1, Station 2, and Station 3, so they are still working with their partners at REMSA, which, we now share protocols, so they still have those opportunities in assisting REMSA. He reiterated, moving through the ILS protocols that they have and their equipment, more efficiently, becomes apparent when you look at the narratives.

Captain McDonald finished up by saying that, lastly, they are aiming and hope to have Station 2 with paramedics on Engine 21 next month, so that will be their third engine company providing paramedic-level service. Mr. Driscoll thanked all three of the partners for what they did. He stated their comment about 20 percent maybe not telling the story; he thought it told the story exactly. That was what he was looking for. When management did the presentation to the Council to bring paramedic into Sparks, it was all about having some outcome changes. And with the high level of medical, understanding that when the opportunity for that protocol was needed, that we would have someone to be able to assess and to do that. The fact that the region has got about 20 percent of our calls are actually seeing a level or one or more of the protocols being used, the agencies are at least getting into possibly using protocol. He felt that tells a great story, and opined that this substantially backs up what Sparks was looking to do when they brought paramedic on board, because it was a question that was asked of why do we need it. This shows why we need it. He thanked all three agencies for the work. He stated he did not intend for it to be as difficult. When they were doing the presentation to the Council, it was really kind of, well, here are 20 new things that we will be doing that we could not do before, so he was just thinking it would be kind of like checking the boxes that said we did that protocol and that protocol, and can go forward. He apologized for the extra amount of work and thanked them very much for their thoroughness.

B. **Presentation, discussion and possible direction to staff regarding the Regional EMS Strategic Plan items related to automatic vehicle location (AVL).** (For possible action)
Christina Conti

Ms. Conti noted that at the last EMSAB meeting, there was significant discussion related to AVL during the program update agenda item, as well as after, in the strategic planning item. The EMS Oversight Program had begun work on the AVL strategic planning items using surveys in the region to assess where the region was at, and it was through discussion that this information paper was tasked to the EMS Oversight program. The project pitch originally began with partnering with GIS so that there could be some data and some information available to the governing boards and to this governing body for the discussion of AVL.

Ms. Conti explained that was expanded to include a review of the information explaining the work that would need to go into being able to design the system. Again, it had nothing to do with the policies of the jurisdictions, or the recommendations of which way to go, it was simply an informational item. The EMS Oversight Program went about achieving this objective in two parts. The first was that partnership with GIS, and then meeting with the three dispatch centers in this region to discuss it with them and determine the barriers and challenges related to the technological aspects.

Ms. Conti stated after this informational paper was complete, there is an update available, and she would turn it over to Ms. Kimji if the Board has questions on it, but it is staff's understanding that through the E-911 board, funding has been obtained for the City of Reno for the AVL enhancement to their CAD system. She said she was not privy to the timeline or further details

and that simply some money has been obtained for that technology.

Ms. Conti reiterated that the scope of the project was solely focused on the technological aspects of the existing infrastructure and challenges that might exist to the implementation of AVL in our region. There are a lot of other elements that might be associated with AVL dispatching , however staff did not get into any of that--they were simply looking at the technological aspects of it.

Ms. Conti noted the Board would find a summary of the project, the CAD system, what AVL means and then different models throughout the country that use AVL in the informational paper. The drive time analysis is using the GIS software that staff continue to use on projects, so it is a standardized practice and looks at the predictive modeling that takes into account distances, speed limits, turn restrictions and other road characteristics. It certainly does not take into account the lights and sirens aspect available to the first responders. This is also simply a drive time analysis, not a response time. So that delineation is important to be clear on. Ms. Conti reiterated that Mr. Johnson was there from GIS to discuss these maps, because he is the expert on them.

Ms. Conti transitioned to the second part of the maps. One of the things that staff did look at is the average call volume by station. They felt like it would be a benefit to see how the stations are responding right now, what the impacts to them might be with the AVL dispatching based on how busy they are right now. Ms. Conti pointed out that in the packet, staff included a bar chart for showing call volume per stations in descending order. Ms. Conti then demonstrated how often agencies currently respond out of jurisdiction, GIS mapped the number of times, based on the data that we had from July, 2015 through December, 2017, how many times the EMS calls went out of their respective jurisdictions. She noted that there is a limitation with this data that the Board really needed to be aware of, during this period of time, the types of data and the call types reported to the EMS Oversight program did change and the data used to inform this map may not represent the total number of EMS calls where a fire agency responded outside their jurisdictional boundaries.

Ms. Conti guided Board members to refer to the meeting packet a graph and table with accompanying narrative was available in the informational paper. The data indicate among Priority 1 and Priority 2 calls, Reno responded out of their jurisdiction 1.1% of the time Sparks responded 1.1% as well and TMFPD responded 3.4% of all their calls were out of their respective jurisdictions during this period of time.

Ms. Conti then moved into the technological considerations. Based on the three meetings with the dispatch centers, the major takeaways were bulleted for the Board. All three dispatch centers currently use Tiburon and have the AVL product functionality. It is the software enhancement, the technological enhancement that would allow the utilization of AVL that is the missing component. She reiterated the City of Reno's recent funding opportunity, so for City of Reno at least, that part will change.

Ms. Conti noted another item to be aware of is the City of Sparks fire stations and their paging system they currently employ. Along the same lines with the paging system, what staff found out is that there would need to be an upgrade to the paging systems in general, to allow for multiple dispatching to occur that is separate within the jurisdictions. She noted there were dispatch partners in the audience that could clarify, but there is a queue system in place, so that is something that would need to be looked at to change and update so that calls are not waiting in the queue for their turn to be toned out.

Ms. Conti pointed out that one of the things the Board would see listed is a policy and procedure. The EMS Oversight Program had said that they were not going to look at that, but that

was something that had come through from the partners that was important to note: the dispatch centers have different operating policies and procedures and the three fire departments have different policies and procedures for dispatching. So if this is something that the governing boards wanted to do, then that would be something that is recommended to be streamlined so that there are not three dispatch center personnel trying to figure out when to dispatch an agency based on the different policies.

Ms. Conti said the last item that was important to note is the implementation. Depending on if this went forward through the governing boards and in what manner it was approved to move forward, the implementation could take several months or it could be quick. Being aware of what that timeline looks like, it was recommended to do a tiered approach, because some things would not take as long as other things. Then being aware of the ripple effect that might come through when changes are made on one side of the house there may be impacts to the other. Also, so make sure there is a long enough testing period in there so that there are no inadvertent impacts to the other partners that use the system.

Ms. Conti summarized what staff found through this three-month process through meetings with partners and staff research is simply that the technology is currently in place, with some modifications to the software, paging system, and policies and procedures that would need to be conducted. Ms. Conti turned it over to any partner who wanted to add more information or to the Board for questions.

Mr. Dick asked what would be required to change the paging system from how it is done now with the queue, to what we would need for the AVL, and if it was something that can happen within the existing software that the jurisdictions have, or is that an additional software or hardware investment. Ms. Conti stated it was her understanding from those meetings that it would be a purchase of an entirely new system, so there would be a large cost associated with that.

Chair Slaughter clarified that all of the data, for example the last map, out of jurisdiction calls, those are EMS calls only. Ms. Conti stated that was correct, that EMS calls were the only data the EMS Oversight program had received. Chair Slaughter suggested that that be noted on all the maps Priority 1 and 2 is noted, but not everybody knows what Priority 1 and 2 relates only to EMS calls. Ms. Conti confirmed that staff would make those changes to all the maps that have EMS calls overlaid on the drive time maps and sought clarification that the change would not be needed for those maps that are demonstrating drive times alone. Chair Slaughter confirmed that the drive time maps did not need to be labeled as “EMS only calls”.

Chris Maples, Fire Chief for the City of Sparks requested clarification. He understood the 911 committee authorized some AVL component for Reno. He had heard different stories as to whether or not when Reno purchases it and it will work for TM and Sparks, or if that’s something else that City of Sparks would have to buy, he would like clarification on that. One of the things that Ms. Conti addressed was the paging systems. Sparks uses First In, the trade name for the system Sparks uses, Reno and TM use Z-Tron. The First In boxes cost about $7,000 a piece, and those would be needed in five stations to give an idea of some of the cost that would be incurred if we did this.

Chief Maples opined that everyone was in agreement that it is the most efficient way to dispatch fire units on this. TM and Sparks have an enhanced automatic aid agreement, which kind of does the same thing, but it is certainly much more convoluted than if we went to AVL.

Chief Maples went on to say that the last point he wanted to make was, any discussion on AVL, he felt Ms. Conti alluded to that as well, among the different dispatch centers, that complicates this. If the region had a single dispatch center, that would certainly make the

utilization of AVL much easier.

Rishma Kimji, City of Reno, wanted to respond to the question of AVL and the City of Reno's purchase of components for it. Currently we do use AVL, and she wanted to kind of make the technology a little clearer to the Board. AVL is just the GPS information that is relayed back to the Tiburon system and onto the CAD. It shows whether it is static or dynamic the movements of the vehicles or apparatus that have the GIS, sorry, the GPS locaters on them. To make this work in the manner that everyone has been speaking about, AVL needs to be partnered with a module called calculated routing. Calculated routing is what is used to then relate back to the system of how to respond with first unit, available unit, and closest station, so it is a combined effort. AVL is Part 1 of it, Part 2 is the calculated routing. Without the two components together, the city cannot make what everyone has been generalizing, and calling AVL, to work in the system.

Ms. Kimji stated the Tiburon system that is in place for the dispatch centers currently has the AVL functionality availability and it also has the calculated routing. The calculated routing is just not used. So the City of Reno has partnered with Tiburon, aka Tri-Tech, to come in and give City of Reno training on how to set up the calculated routing tables. This will be based on the City of Reno's needs of dispatching based on available units, first available, next to the station, but will have no correlation to how we work with other agencies at this time.

Ms. Kimji explained the reason they were doing this is that so they can get familiar with the calculated routing methodology that is inside Tiburon, so that they can then relay that information to other agencies. That will be available to other agencies. City of Reno will become part of the Train the Trainer kind of program and will be able to train the other departments on how to set up the calculated routing. At that time, as all agencies want to become a part of the system, then they can talk, she would let the respective agencies talk about how they want those policies and procedures to come into place.

Ms. Kimji noted that what they were doing with Tiburon is getting training on the functionality, then City of Reno will do some testing to make sure that they have the calculated routing correct. It can be cumbersome, it can be, it is based on priority call types, run cards, availability, all the good stuff that makes AVL, as everyone keeps calling AVL, work the way that the city wants it to. So they will do the training, do some testing, implement it to see how it works at Reno, and then open that up to other regions.

Ms. Kimji pointed out that they wanted to take this in a step-by-step fashion, so that they were not all getting into the same system, causing a disturbance that can be chaotic. What they wanted to do this systematically so that they can at least then ensure that it works in the way that they are hoping that it will work in the end. She hoped that answers the questions that the Board had. Any other questions for the Board she was available.

Mr. Dick asked, noting it was not on the enhancement calculated routing, but Chief Maples had mentioned his estimated cost for changing out the paging system that Sparks is using and he mentioned that Reno and TMFPD use Z-Tron. Ms. Kimji stated that was correct. Mr. Dick asked if the Z-Tron also need to be changed out to accommodate the AVL. Ms. Kimji replied that it would not need to be changed out, they do not necessarily have to change systems, they will have to enhance the availability of the Z-Tron hardware that allows them to do the multi-alerting system. There are some software changes, but there are definitely some hardware inclusions that they have to budget for and get available to the fire stations. But is something that they are already looking at, they just do not have costing on that. They want to know how the calculated routing will work first, and then start looking at how they are going to get the paging system up to play.

Mr. Dick asked if they have any ballpark idea about what the cost might be. Ms. Kimji asked

if he was referring to the Z-Tron system and Mr. Dick said yes. Ms. Kimji replied no, she really did not, because it is all, a lot of it is hardware-related, so the alerting system is available, but it is how the distinguished tones go out at the different stations, and the speakers need to be purchased, as well as kind of like a base station that sits there that relays the alerts out, so it would be, you know they would have to get a couple of those base stations. And then where those speakers need to be placed within the station, so. There is some more planning that needs to be done, in terms of policy, procedure, as well as the software and hardware costs that relate to that.

Chair Slaughter asked Ms. Conti if she had gotten the direction she needed on this item. Ms. Conti replied she thought it was simply either acceptance, or if the Board needed more information, but there was no direction that she was anticipating.

Mr. Dick stated that since Reno had already begun to explore the Z-Tron paging system, he would move to approve and accept this report, but also to request City of Reno continue in that activity to be able to report back at the next board meeting on what they think their estimate would be on the paging system. He believed the report indicated that, from a technical aspect, it was doable to move forward with this, and he felt that was one of the remaining pieces on what the cost looks like.

Ms. Newby requested discussion. Mr. Dick noted that was a motion, and Mr. Driscoll seconded for discussion. Ms. Newby stated, jumping in here on this, she thought that the difficulty in discussing it in this forum here, while she appreciated EMSAB and their work here, and all the work that staff has done, is that each of them, as jurisdictions, have a responsibility over their dispatch, over their operations, just as they have heard that it would cost Sparks a certain amount to upgrade their systems in their fire houses, it will likely cost Reno. So while they are having this discussion, and talking about moving forward, she just wanted to point out that this board does not necessarily compel any jurisdiction to undertake any costs in particular to this project. They are all cooperating and receiving the information together, and her understanding was that Reno's fire chief has met at least with the TMFPD fire chief and with others about going forward with AVL.

Ms. Newby went on to state that said, all of these costs, the request to get AVL, or the enhancement for the 911 board and the desire of Reno to be the proverbial canary in the coal mine to test it out and work out the bugs, is sort of an individual decision that they undertook in order to try and further this. So she wanted to point that out in terms of direction to individual staffs to come back and provide information to this board, it was her city council that needs to authorize that expenditure and/or her and she wanted to make that point.

Mr. Driscoll replied, stating he thought, following up on Madame Manager's comments, obviously getting into some of the specific details, jurisdictionally based and they need to be very careful what they do with them. But part of what was being done here is looking at and deciding what will be a testing base, and in that testing, there are things that will come up, and there are points of discussions. So he thought what Mr. Dick was discussing was, as they were figuring out how it works, there was going to be some cost components that Reno will have to endure if they are going to go forward with their system. He felt that what Mr. Dick was looking at is just advising the Board that says as Reno is going through, in their determining level of expense, to have the system be viable. the Board would like to know, and Mr. Driscoll would like to know for his own jurisdiction, what Reno's experience is, so that as the other agencies are making plans to move forward similarly, then he has as much knowledge as Reno has because you are sharing, kind of regional sharing, on your specific projects.

Mr. Driscoll went on to say Ms. Newby's point on not telling her what to do with what is there, everyone agrees with that. But sharing the information, the desire is for the region to have a

dispatch system that is as efficient and effective as possible. And to do that, having the GPS component and the software to drive the data the GPS component gives everyone, so that the closest available goes, and having protocols that make it to where dispatchers are not worried about who they are keying the mike to talk to, because that is ridiculous, he felt that that was the ultimate goal. So he was looking forward to hearing the progress on Reno's project, and it was great that E-911 is using all of the region's money to help Reno buy something like that. And so he was looking forward to helping and reporting to us what Reno is doing with everyone's money.

Chair Slaughter noted there was a motion on the floor that had been seconded. Ms. Conti sought clarification that the motion that the direction is not to EMS Oversight staff, that the request was to City of Reno staff. Because EMS Oversight is not a part of those discussions, they have not been, and so it would be easier if that recommendation for the information to come back was to those that are doing that instead of inserting into their process.

Mr. Dick stated he needed to amend his motion in a couple ways. The direction then would be then to Reno to bring back the cost for them for the Z-Tron paging, but also for TM Fire, since, his understanding was they also needed to change their Z-Tron system to provide what their estimate on that cost would be.

Mr. Driscoll requested clarification for the possibility of a second. Per the discussion, the Board was not directing them to do anything, what they were just asking them to do with your motion is to share the information that they are gathering as their project is going forward. And so his understanding of the motion, or at least what he would be willing to second, would be, as the project is going forward, sharing information with the other agencies and if, in this case, Mr. Dick is suggesting that TMFPD is also going down this path, is going to have to figure out what is there. So if his motion is for sharing of information related to this project, he would be more than happy to second that. Mr. Dick stated he would clarify his motion as sharing that information. Mr. Driscoll said then he would second the motion.

The motion passed unanimously.

C. **Amendment #1 to the Interlocal Agreement For Emergency Medical Services Oversight between the Washoe County Health District, Washoe County, the Truckee Meadows Fire Protection District, the City of Reno and the City of Sparks to allow representatives of the Advisory Board authority to designate an alternate to replace the representative in the representative's absence from meetings of the Advisory Board with alternates being a City or County Assistant Manager or Health District Division Director, and direct staff to present the Amendment to the signing jurisdictions for possible approval**. (For possible action)
Leslie Admirand

Chair Slaughter noted this was a request the Board has been discussing for a while, and asked if there were any questions on this item. He then asked if there were any clarifications from Counsel. Ms. Admirand explained she wanted to point out if this Board does approve the amendment it will be brought forward to be signed by the jurisdictions. If they all approve it, it will be brought back to the Board for an amendment to the Bylaws. And then the process should be in place.

Mr. Driscoll said he objected to this amendment, from the standpoint that he was concerned that, in his jurisdiction, the person that the amendment states is his only designee, may not be properly up to speed and understanding the details and intricacies of this particular board. Mr. Driscoll would have someone else that he would designate that would be more appropriate, than what is being mandated by. Therefore, he was not in support of the

amendment as it is in there. He did believe that they needed to define that they have a proper delegation, of someone acting who is going to be both responsible and has authority to take action as a member of this body in the absence of the primary person. He would be in favor of language that says that it is as designated by the member, and not telling him who he has to designate. If this was part of voting at this point he would not be supporting this amendment.

Chair Slaughter went on to state he would ask Counsel if that presents any kind of a legal issue, of leaving it to the member to define their alternate. Ms. Admirand explained that when drafting the language, the thought was to keep the appointment on par with the position or a person that would be appointed in either the manager's or the District Health Officer's absence within the different jurisdictions. With some of the issues that are being discussed with this board, depending on who the designee would be, there may be issues of conflict of interest. She could not speculate at this point as to what they would be. There's nothing legally that prohibits the member from designating who they want, but in drafting the language it was thought that we keep it on par with who would be an acting within the different jurisdictions.

Mr. Driscoll accepted that discussion and that there are different boards that the managers sit on or others sit on that, that has been as defined that it is the person that would be acting and taking action is as close to on par as the person that they are replacing. He understood what they were trying to do, but just because of the technicalness here, it would be his objection. However the vote goes, he would certainly support, so it is not that he will go off in a tirade if the Board goes forward, he just wanted it on the record of his objections to possibly being mandated to have someone who would not be at a proper level on a regular basis if he was not here.

Mr. Dick explained he just wanted to reflect back on the arduous process that was involved in establishing the Interlocal Agreement and the discussion about the representation on the advisory board. It was specifically identified as the City and County managers, an emergency room physician and a hospital QI representative. Part of that discussion also was whether other members were appropriate, other people besides those individuals from the jurisdictions. The determination at that time was no. He felt that expanding to the people within the jurisdictions that would be acting typically in the absence of the designated members in the ILA now, is appropriate for the Board to do at this time. But he could not support, if they were to expand it further to any person that was designated by one of the managers or by him.

Chair Slaughter asked legal counsel about the intent. Process-wise, the intention is that, using him as an example, that he would designate an alternate and that alternate would be his alternate from here forward, or would it be on a case-by-case basis. Ms. Admirand explained it would be on a case-by-case basis and just for the meeting. Chair Slaughter reiterated that it was just for the meeting.

Ms. Newby moved to approve Amendment 1 to the ILA for EMS oversight. Mr. Dick seconded the motion. It was approved five in favor with Mr. Driscoll opposed.

12.*Board Comment

Mr. Dick noted it was likely that everybody has seen in the news that there was a measles case in the community. Staff were very busy at the Health District, just getting the announcement out, getting the process in place to be able to get information to people that may have been exposed. If

staff anticipates any impacts on the EMS system from this situation in the future, the Health District will work through our EMS program in coordinating with responders to further engage them as the situation calls and it is appropriate.

Chair Slaughter announced that April 8-14 was National Public Safety Telecommunications week. He expressed his thanks to all of the professionals who work at the communications centers. He explained his background was on the E-911 Board in past, and this Board, he often express to the people he talks to about this that in all of the public sector jobs, that is probably one of the most difficult. He reiterated his thanks to our telecommunications staff

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13. *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**.

Adjournment

Chair Slaughter adjourned the meeting at 10:37 a.m.

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. An item listed with asterisk (*) next to it is an item for which no action will be taken.

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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. Dawn Spinola, 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. Spinola is located at the Washoe County Health District and may be reached by telephone at (775) 326-6049 or by email at dspinola@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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