# MINUTES

## EMERGENCY MEDICAL SERVICES

## FACILITIES ADVISORY BOARD MEETING

## MAY 14, 2001 – 4:00 P.M.

### MEMBERS PRESENT

Karla Perez, Chairman (Desert Springs Hospital)
K. D. Justyn (Summerlin Hospital)
Blain Claypool, Alternate (Valley Hospital)
Michael Walsh (FAB Rep. To MAB)
Sandra Cromwell (St. Rose Hospital)
Helen Vos (Mtn. View Hospital)
Donald Kwalick, M.D. (CCHD)

### MEMBERS ABSENT

Kim Crandall (Boulder City)
Jeff Greenlee, D. O. (MAB Rep)
Suzanne Burton Cram (Sunrise Hospital)
William P. Moore (Lake Mead)
Jacqueline Taylor (UMC)

### CCHD EMS STAFF PRESENT

Jane Shunney, R.N.
Mary Ellen Britt, R.N.
Jean Folk, Recording Secretary
LaRue Scull
Kelly Quinn

### PUBLIC ATTENDANCE

| NAME | ASSOCIATED WITH |
|---|---|
| Joe Calise | Summerlin Hospital |
| Pam Turner | Valley Hospital |
| Steve Peterson | American Medical Response |
| John Wilson | Southwest Ambulance |
| Davette Shea | University Medical Center |
| Richard Mazzochi | WestCare |
| Ken Riddle | Las Vegas Fire Rescue |
| Scott Rolfe | University Medical Center |
| David Slattery, M.D. | St. Rose Dominican |
| Virginia DeLeon | St. Rose Dominican |
| Sandy Young | Las Vegas Fire & Rescue |

CALL TO ORDER-NOTICE OF POSTING OF AGENDA

The EMS Facilities Advisory Board convened at 4:07 p.m. on Monday, May 14, 2001, in the Clemens Conference Room at the Otto H. Ravenholt, M.D. Public Health Center. Karla Perez called the meeting to order. The Affidavit of Posting and Public Notice of the Meeting Agenda was executed in accordance with the Nevada Open Meeting Law.

I. CONSENT AGENDA

A motion for Board approval of the meeting minutes was made, seconded and unanimously carried.

II. REPORT/DISCUSSION/POSSIBLE ACTION

A. Discussion of Open/Closed Model:

Ms. Perez asked for discussion on how the Open/Closed was working.

Blain Claypool felt it was working well for Valley Hospital. In the first fourteen days of the month, Valley Hospital was on closure 8.5% of the time, which is probably indicative of most around the valley.

Michael Walsh discussed a report sent out with the divert statistics for the period between the 25th through the 30th of April. It showed Valley Hospital at 67% open, UMC at 73%, Sunrise at 64%, Desert Springs at 80%, and the smaller hospitals in the 90% range.

Helen Vos stated that Mountain View has experienced a decrease in confusion about whether they are on Critical Care, ER, or Super Divert. The volume of ambulances coming to the facility appears to have significantly decreased.

K. D. Justyn said that Summerlin had also seen a decrease in the number of ambulance runs and been told that the ambulances were sitting in the ERs for an excess of two hours at the other facilities, UMC and Valley. She thought the issue was to prevent anyone from having to wait anywhere. Ms. Justyn said she does have some concerns but would like to wait until the program has been in force for thirty days.

John Wilson said there has been a lot less confusion as to open or closed, which has been helpful to the two ambulance dispatch centers. Before they had to call back and forth between AMR and Southwest. Patients are happier being able to decide their destination. There have been times when they waited two hours or

more even with the system in place. The facility will say they're open, and because only one facility can be closed at any given time, open isn't always the clearest measure of the hospital's status. Ms. Perez asked if that was because the hospital is in cue or they just haven't gone on closure. Mr. Wilson said the first few weeks some were forced open, waiting to close. When the facilities type in when they are busy, it helps us direct patients. He requested the facilities to type in "wide open" when they're not busy.

Michael Walsh asked if a hospital is busy and there is a two-hour wait, are the patients refusing to leave because that hospital is their preference?

Mr. Wilson said they tell patients when they arrive on scene what hospitals are closed. They will then tell them what facilities are available and ask them where they want to go.

K. D. Justyn said once a patient is at a facility that is open and you know when you get there that it's a two hour wait, do you ever put the patient back in the rig and redirect them, or is it once you're there you stay?

Mr. Wilson said sometimes a patient signs out AMA (against medical advise) and requests service for a transfer to another hospital. As you know this is an EMTALA violation.

Sandy Young said they had a crew that arrived at a hospital where the wait was lengthy and the patient did not want to stay so they transported him to a different hospital which is not appropriate. She felt the crews were understanding open and closed much better.

Ms. Perez asked if the statistics include all transports, both AMR and Southwest, or is it just AMR statistics. Steve Peterson said the intent was that it would include all of the statistics but it was just for a short period of time in April and it was AMR statistics only.

Ken Riddle advised that several systems had been looked at, a microwave system that was quite expensive and an internet based system called the EMSystem out of Minneapolis. A demonstration of the EMSystem was held around the 10th of April and attended by most of the Nurse Managers. It's a system that is similar to what is being used now to get an idea of how it works. The additional component will be the hospital notification component where, in about two minutes, you can get a brief report of whose coming in, their condition, the ETA, and patient's age, etc. The plan is to be able to do that from the field too. He said federal financial

funds are available to pay for the system and he thought they had agreed to pay for a couple of years. The funding of the system is due to the fact that the Metropolitan Medical Response System requires a communication system connecting public health, the emergency agencies, and the hospitals, primarily for surveillance for chemical and biological exposures and weapons of mass destruction. Since people are using it every day if we do have a multi casualty incident, everyone would be familiar with the system. The vision is that big screens would be in the ER and a monitor at a clerical person's desk When a patient is arriving, a signal would be heard and would continue until acknowledged. The system would also display the options available with that system such as bed availability, who's open and who's closed and other information shown on the screen.

Deputy Chief Riddle said we are at the stage where we're ready to purchase the system if it's approved however the decision is up to the hospitals. He said if the decision is to purchase through the government, bidding is required and could delay the process. The hospitals could purchase their own computers and be reimbursed with the federal dollars. Ms. Perez said the Nurse Managers had seen and approved the system.

Ms. Perez said she would try to set up a meeting for the purpose of demonstrating the new system. K. D. Justyn recommended an interim meeting to concentrate on the system only. Deputy Chief Riddle said Mike Myers is willing to come to the individual facilities to do the demonstration. The Board decided on holding an interim meeting.

Blain Claypool reminded the Board of a discussion that took place during a meeting regarding what Open/Closed meant. Everyone agreed that if you're closed, you are closed and that would include air traffic. Mr. Claypool advised that a memo was sent by UMC, which indicated their opposition. Since UMC was not represented at this meeting, Blain requested this issue be placed on the MAB agenda next month.

B. <u>CPI Training/Cost Shared by Hospitals</u>

Davette Shea advised that over two years ago she had decided to spearhead, through the ER Nursing Supervisors group, a task force to look at the problem of the overcrowded emergency rooms from the standpoint of who didn't need to be there and what population of patients were not being served well in the emergency departments and were also very problematic. Obviously the top two were the chronic public inebriate and the mental health patients. Since that time,

a wonderful effort on everyone's part has really made some headway in clearing these patients and looking at some better treatment modalities and better destination points for them. Data has been collected which you received in your packet. These are rough numbers and I collaborated with the ER supervisors and we identified about 14 to 20 ICD9 codes and had our MIS system quarry the data. The statistics on the front page indicate that in 1999 there was a total of 4,119 patients. The costs to the emergency departments and hospitals were over $3,000,000. The year 2000, going by calendar year, the number increased to 5,562, which would be commensurate with what's happening in our community due to population growth. Therefore, as the population grows, this population will continue to grow. There was an increase of 1,443 patients with an increase of yet another $1,400,000 dollars. On the second and third page are the 1999 and 2000 comparisons. The identification of the hospitals has been blinded. A couple of the facilities had some sensitivity in having exposure. The numbers are strictly CPI. Mental Health was broken out separately. The 4th page, in 1999, indicates the total number of emergency room beds that were available. Sienna was not included. The break down is from May of 1999 to September of 2000; the percent of bed availability and the actual bed count available. Sometimes the figures indicated a desperate situation with 44 – 48% availability during certain months. The next page, looks at some cost issues and the comparison for an average stay in the hospital, to an emergency department visit, to what a stay at WestCare would cost and this was presented to the Southern Nevada Regional Planning Board, which is the group that was approached collectively to plea for more dollars for WestCare to open approximately 25 more sobering beds. An emergency department visit, on average, is about $1,500. If this patient is admitted to the hospital, it's going to cost us a minimum of $824 for a 24-hour stay and if they go to WestCare, it costs about $130. The greatest percentage of those patients are true CPIs and the paramedics could very comfortably do that screening at the scene. The protocol that Jane Shunney is going to discuss together with the training program, these calls will be assessed in the field at the time of contact and the patient will be diverted from the emergency room directly to WestCare. Not only does that help the emergency and hospital situation but it helps the patient. On the inpatient side, treatment programs are not offered particularly to the uninsured. The greatest percentage of these patients are uninsured or un-funded. The last page was at the courtesy of AMR. They helped with some of the statistics. A transportation fee is charged for moving these patients around. This transport cost also has to be figured in the total dollars that the hospitals may have to spend. A meeting with the Southern Nevada Regional Planning Board looked at how additional funding could be obtained. Ms. Shea requested the Board's support on a cost efficient training program to get the paramedics trained to make a pre-hospital decision whether the patient needs to be transported to the hospital or Westcare. She also requested supporting WestCare in their attempts to get funding to open up 25 more sobering beds.

Jane Shunney said the next step taken was to develop an algorithm which was prepared by members of the original group that met to address the CPI issue. It was then brought before the Medical Advisory Board. The Medical Advisory Board approved it with one caveat, the pre-hospital providers needed to have a specific training before they were to do the assessment in the field. Dr. Jackie Harrigan is credentialed in the treatment of drug and alcohol abuse and was the choice to do the training. She gave us an outline of what she might do and the cost to provide a training program based on a needs assessment of our community. Her cost was $13,500.00 to proceed. The Health District paid her do an initial assessment of what the paramedics in the system already know, based on review of paramedic textbooks and input from District staff. She then presented this proposal which you have on the purple insert in your packet. She is going to provide a three to four hour training the trainers program based on the review of the current paramedic textbooks, specifically in reference to addiction and alcoholism, including the algorithm and the protocol that goes along with the field check list. She will look at compliance with the variance because we had to go to the Board of Health to get a variance for the paramedics to do a field assessment and then directly transport the patient to WestCare rather than going to the emergency rooms. There are legal issues involved in doing this kind of a field assessment and she will look at the state statutes and EMS regulations that pertain to what we want to be able to do. And then the quality assurance component of the field assessment and appropriate disposition of the patient will be evaluated. Dr. Harrigan advised there is a need to have a quality assurance tool to assess whether or not what we are doing is actually beneficial to the patient and to the system and to also identify whether it's cost effective. She is going to add some things to that quality assessment tool and then we will do the QA here at the Health District.

Dr. Harrigan will do an organizational needs assessment by visiting each of the ambulance providers, as well as the fire departments interviewing field paramedics. So what she is doing is actually building the training based on an assessment of our own community rather than taking an off the shelf kind of a product. So it's definitely geared and designed for our own community. She also will have a written manual for the trainers so that what the trainers teaching will be consistent throughout the system and based on principals of the American Society of Addiction Medicine and the National Institute on Alcohol Abuse and Alcoholism which is indicated on the handout. And then the EMS office will give CEU's for the paramedics training.

Richard Mazzochi said the other component of the training will be what does one expect when one gets to WestCare and we'll have WestCare staff involved in the training to talk about the procedures, the policies and procedures and what we do once a patient gets to WestCare. That hasn't been written up yet but that will be included. Currently, as most of you know, WestCare has 25 beds functioning at 100% capacity all the time. If it's not 100% capacity right now it will be in the next three or four minutes rest assured. We turn away roughly an average of 20 to 40 people a week because we're full. We have the space, we have the building and the property and we're looking to expand to 50 beds and that's common knowledge. We can do that on the property we have. We applied for the City of Las Vegas Community Development Block Grant Funds. They gave us half of what we applied for to be used for construction and alterations to the building. We have to submit plans to them about how we're going to change the building and improve that or work with us to get them through. It's not enough money to finish the construction job. We're looking into other avenues, other resources. The president of WestCare is constantly talking to local city officials, county officials and state officials and Washington officials. There is a possibility that we could apply for federal funds also. So that's ongoing. That's happening as we speak. I can tell you that by midnight tonight we'll have turned away eight or nine people and they'll be in the ER.

Ms. Shea added, in meeting with both our Mayor and Councilman Larry Brown who's been extremely supportive and helpful to this group as well as meeting with the County Commissioners and the other City and County entities, the one question they come back with is "well what is the hospital going to do" and my report has been we are doing and that is the problem. We are doing more than we should be doing because this is not our Mission Statement if you will, but we have an obligation to medically clear these individuals, make sure they don't have a medical or trauma emergency but then what. And the only "what" that we have is obviously WestCare who's been in this community trying to do this work for over 20 years. So again, they frequently say "well are the hospitals willing to participate" and what we respond is, they are participating. We're housing these individuals inappropriately and we're not able to administer a whole lot of treatment, we discharge them and then they recycle themselves back to the EDs. Now occasionally they will hit WestCare kind of like a pinball machine but again, instead of getting into the treatment program, as Richard said, they've got to move everybody along. I would also just like to add that Dr. George Kaiser who's with the school of medicine is working with us on increasing the ability to do detox and do a medical detox model that is what we would like to see happen.

We basically, I think you all know use the King County model and the model out of Phoenix, the Lark Program, to look at if we are going in the right direction. These are programs with 20 and 25-year histories with minimal bad outcome and excellent results in returning people to work, home and family. And I think that's our overall goal, to look toward a rehabilitation program that can return these people to be productive and keep them from cycling in and out of the system. So, again I think the dollar amount in coming to the hospitals to ask for assistance in providing this training program, rather then us trying to create it through the Education Committee and multiple meetings and trying to bring in consultants, Dr. Jackie as we call her here, has the portfolio to put this together and make it consistent and give the physicians a feeling of comfort in allowing the paramedics to be trained at this level to make these decisions so that we don't have bad outcomes and we don't have patients inappropriately being taken to WestCare instead of being medically screened which is very important. WestCare is very proud of their record, Richard is just being a little humble here, but you know over 4,000 individuals are taken in police cars every year in Las Vegas to WestCare. They've not had a bad outcome. So I truly believe in our paramedics and our EMS personnel being able to do the same thing the police officers do which is identify someone who is not having a medical emergency. But again it's just another step to guarantee that we've got continuity of care and quality of care and again reassure the physicians their liability hopefully is going to be minimal with this.

Ms. Perez asked Jane Shunney to go through the costs again. She asked if she had a recommendation on how she envisioned the cost to be shared amongst the hospitals or the other entities that are going to share in the cost of this training. Ms. Shunney said we have discussed the cost, which is $13,000.00 for the training program with follow-up and any kind of input that would occur after that time. In fact, Dr. Harrigan is willing to also do some training and educating for the hospital ED staff if so desired. We looked at the number of hospitals that have been encumbered by this group of people and thought perhaps that they could each share in the cost of the training which will come to probably about $1,200 or $1,300 per hospital. Richard indicates the hospitals could give this as a donation to WestCare and WestCare would pay the consultant with these donated sums.

The following question was asked: " when a CPI patient occupies an emergency room bed instead of a patient who is an insurance paying patient, how does that affect your bottom line? Is this a plus to have them not there?" Answer was it's definitely a plus to not have them there. I don't think any of us can disagree.

K. D. Justyn asked Mr. Mazzochi how much money was given for the expansion. His reply was $201,000. Davette Shea said a minimal of $200,000 is needed to open the other 25 beds. She said Clark County contributes $600.000 a year to WestCare. But that's not just for detoxification. This is for all of the services provided. Ms. Justyn stated you do an excellent job and trust me we wish you could be 75 beds. I guess if we're going to train these people where are they going to go if you don't have the facilities in order to take the additional people. Do you have a place where you're going to get this additional $200,000 or a time line when you're going to be able to expand so that this education will actually go well so that you can accept all of these additional patients? Mr. Mazzochi said we don't actually have a time line but time is of the essence and we don't have a resource for that. We thought that we would go back to the County with a plan about how to spend this first pile of money and ask them to reimburse us for the next pile of money. That at this moment is the plan. That doesn't mean we can't get money from other places. Davette Shea said WestCare received additional beta funds this year. They also have a foundation with grant money and they have just expanded their services in another state possibly so again there are a lot of things going on because they are a bigger entity then just Las Vegas. They now provide services in California, Arizona, Nevada, Florida and they're looking at one additional state so again, looking at the corporate model if you will, it's all non-profit.

Ms. Justyn said, I don't think there are any of us here that don't want to see this happen, don't get the wrong impression, please because we're all silent. Before I can in all good conscience give money for your program, I need to see, because those who are trained today, I don't know what you're turn over rate is but I 'm not sure that training paramedics today for something that's not going to be available for two more years is the wisest use of our resources. So that is what I'm trying to get at, when are we going to see these expanded beds.

Sandy Young said the city is looking at more funding through grants and part of the issue was that they wanted to put more money into right now the governmental agencies are concerned that that funding distribution and percentage of shifting tax dollars to different municipalities that they're not sure what their going to get as far as a tax revenue base. So I think that was part of the thinking well we can only afford half right now because we don't know if we're going to keep our total reimbursement. I think their goal is to give them the whole enchilada eventually but they just aren't sure yet.

I would agree to absolute support in wanting to be able to divert our ERs by not having some of these patients there. But it almost feels a little bit like we're putting the cart before the horse.

Jane Shunney – I'm sure it sounds that way but since we passed this variance last October, we have not been able to begin the transports to WestCare by using the field assessment we've designed.

Mr. Mazzochi was asked how he is getting his patients now to whom he responded that they come from all avenues, they walk in, and the police bring them in. He was then asked, if we did the training for this program so that the paramedics were able to transport to you and they were never able to transport to you because 99 to 100% of the time you were full, what have we accomplished.

These are not acutely ill people. They do accommodate them and sometimes their capacity is 25 but they have 30 because they are constantly triaging and moving people on. Ms. Shea said our point is if we don't go forward then we're going to look at another year of these patients in the emergency departments.

Ms. Perez said the point that we're trying to address here is to establish a training guideline so that the paramedics can transport these patients directly to your facility and bypass our emergency rooms, is that what we're saying.

Ms. Shea said that's what we're saying.

The comment made was but you're always full.

Sandy Young said they're full getting patients from the ER. The point is rather than the patient going from the field to the ER to WestCare why can't we go from the field to WestCare.

Helen Vos (?) said I guess I want to ask the smaller facilities, St. Rose, etc., I don't have any problems dividing it by nine but is there an issue with when you look at volumes and dividing it by volumes as opposed to dividing it by nine.

How is it going to be divide?

Ms. Perez said we could look at it just total ER volume and do it that way.

Davette Shea's suggestion was to break it up by percentage on the two years, we will analyze it for you.

Ms. Perez said, or look at total ER volume in general or beds, or some methodology that kind of distributes it based on the patient volume.

The ER volumes were collected this past fall when we were working with the Abaris Group.

A motion was made that the FAB support the $13,000 and have the allocation made based on the percentages of ER volume, seconded and approved. The hospitals will support the CPI training program in proportion to the overall ER volume. This will be an invoice as a donation to WestCare.

Jane Shunney will provide the information to WestCare and they will invoice the hospitals for the donation.

III. Informational Items/Discussion Only:

Michael Walsh said the MAB did discuss the waiting time issue and the concerns. The average waiting times in general were down and that there was a request for a report back to the MAB on the waiting times by hospital so they could get a feel for where the delays were and that the Divert Committee is going to meet sometime before the next MAB to discuss this issue. They wanted something in addition to the drop times. AMR and Southwest will provide MAB with that information.

They are working on new emergency dispatch priorities on a priority system and they have some new protocols, 11th Edition of these protocols and the dispatch people use them when the 911 calls come in. It's supposed to be a simplified terminology to make it a little easier for the caller to understand what the questions are and it helps them categorize the type of rig they will send to the scene based on this information.

A request was made that when the drop time statistics are gathered to include month/year with previous month/year. For instance, statistics for May 2001 in comparison with May 2000.

Matt Netski said there are some statistics being gathered as a result of the Quality Assurance Monitors under the new open/closed methodology. The EMS time intervals, the travel time, the time in minutes/seconds from rigs roll in towards an incident to arrival at the dispatch address, scene time, the time from arrival at dispatch address to wheels rolling in route to destination hospital, transport time, the time from wheels rolling from scene to arrival at destination hospital, the turn

around time, the time from arrival at the hospital emergency department to time available for response back in service. Then there are some system note statistics, the number of unit's response per time of day, per day of week, the number of transports to each hospital per time of day and day of week, the number of hours of closure per time of day and day of week and there is going to be some patient satisfaction statistics. The reason for destination, whether or not the patient received their first choice, second choice and there was a question about whether a potential survey would be done. This came from the MAB Divert Committee.

Sandy Young said this is something we're looking to provide. This has not been done yet.

IV. PUBLIC APPEARANCE/CITIZEN PARTICIPATION

No response.

V. ADJOURNMENT

Adjournment 5:08 p.m.