FACILITIES ADVISORY BOARD

MINUTES MINUTES

September 28, 2001 - 8:00 AM

MEMBERS PRESENT

Karla Perez, Chairman (Desert Springs)
Jeff Davidson, M.D. (Valley)
Steve Peterson (AMR)
Jeff Greenlee, MD
David Rosen, MD (Mental Health)
Jackie Taylor (UMC)
Donald Kwalick, MD (CCHD)
Blain Claypool (Valley)
Michael Walsh (Summerlin)
Helen Vos (Mountain View)
Sandra Cromwell, RN (St. Rose)

MEMBERS ABSENT

Suzanne Burton Cram (Sunrise Hosp.)
William P. Moore (Lake Mead Hosp.)
Kim Crandall (Boulder City)

CCHD EMS STAFF PRESENT

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

PUBLIC ATTENDANCE

Matt Netski (AMR)
Brian Rogers (Southwest Ambulance)
Pam Turner, RN (Valley)
Alice Conroy, RN (Sunrise)
Davette Shea (UMC)
Kathy Kopka (Sunrise)
Lynda Courtney (Clark County)
Ken Riddle, Deputy Chief (LV Fire)
Joseph Calise, RN (Summerlin)
Joseph Kaufman, M.D. (HPN)
Amber Jicobo (Jr. League of LV)
Sheila Osterhuber (Lake Mead)
Virginia DeLeon (St. Rose)
Joelle Babula (Review Journal)

Blain Claypool – We worked on the project together. We were the sub-committee on improving hospital flow. A number of the hospitals were represented on this. We've done a lot of work over time and we came back to the FAB, I believe at the last meeting and gave an update of where we were at and had identified a few problems. The FAB asked us to go back and look at a couple of specific items. That was to examine the impact of late discharges, to try and find and identify why they're occurring. We all had pre-conceived notions on why they were occurring but subject to data, I just would not apply it here. And then to look at proposed alternatives that would improve our current situation and then to establish a monitor mechanism so we could report results. The first thing we looked at, we talked to the other hospitals and we tried to get some ball park numbers on average admission time and average discharge times. This is not hospital specific but on average you would see variances as great as 12:30 admission time, 8:50 discharge time and there's your discrepancy you've got, depending on which hospital you're talking about, 50-60-70 patients trying to come in on average at noon and 50-60-70 patients not leaving until 8-9:00. We've got a real late discharge problem that just quantified where we were at. And, again, all the hospitals kind of varied but these are the two extremes. But it is very reflective of what we found. I think all of us can agree that we've got that same problem. The impact of that diversion between the time of admission and the time of discharge in all of the hospitals and what we're seeing obviously it increases our folds in the ER and can lead to increased closure hours and impact the time that AMR or Southwest is waiting in our ER because we're waiting for beds. It'll decrease the hospital staff inefficiency for obvious reasons, we're staffing for patients that are there until 8:00 and then they may or may not be backfilled because our EDs have had problems moving our patients through and so that makes the staffing a little more inefficient. Obvious decrease in patient satisfaction, both the patients that are leaving and the patients that are coming in. The patients that are leaving are ready to go home. Their doctor has said or someone has said you may be discharged tomorrow. They're waiting until 8:00 at night in order to have that and they have to call their family in order to get those things to occur. So they're leaving later in the evening and there is an excessive wait for beds upon admission. People are sitting and waiting for beds and this has a big impact on it. Hospitals aren't the only ones impacted by this. We talked about it's going to take a partnership to solve some of these problems and you'll see, based on the data and we'll see what I'm talking about when we get there. But the diversion on admissions and discharge also impacts the physicians. It can slow down our operating rooms because we've got increased holds in the PACUs (Post Anesthesia Care Unit). We have beds that are unavailable for direct admits from the offices because we have beds tied up until later in the evening. These are the obvious things that we came up with and the problems but why is this occurring and let's get past the subjected data and look at what we did. Kathy Kopka and Shannon Mackamore from Sunrise hospital have developed a tool through their Central Transportation Department and they were tracking late discharges. We pushed this out for everybody else to collect the data and look at any patient who left the hospital after 7:00 p.m. and then had some major broad categories to say why did this patient leave post 7:00. The total population of patients in this study is 1554 that we're getting ready to look at so we have a pretty good size sample of patients across the board it mimics across hospitals. Here's the meat of the whole thing. The reasons for the late discharge. Late rounds were classified as rounds by physicians after 6:30 in the evening. Of those patients

who left after 7:00, 31% occurred due to late rounds by physicians. This is pretty universal. This is the anecdotal that we all thought was going to be 90% of our problem - well it's not. You can break it apart and see there is a number of major indicators in here. IHS Med-ride delays is probably the second largest or between that and family unavailable but waiting for Med-ride either to their homes or to a SNIF or to a ALTAC, waiting for the ride. There are also problems on time of day when they're calling for their ride because if it's a Medicare patient and we've not been able to get the authorization, and it's post 5:00 p.m., it's difficult to get the authorization and you can't get a ride. So we've got some real issues there and that constitutes nearly a quarter of these patients. Family unavailable, 25%. Summary on that, 80% of the direct control is outside the direct control of the hospital when you break it apart. We talked about physicians directly impacting 32% of the delays and that's between the 31% on late rounds and waiting a consult discharge where you may have multiple consultants involved on the case and someone may write, it's okay to discharge if okay with cardiology, if okay with pulmonary, if okay with internists. So, all total you've got 32% that are impacted by the physicians. Again much lower that what we expected to find, it really was. 23% waiting on Med-rides, 25% family unavailable at that time. Patient may have had a discharge order ready, family is not available to pick them up and we have delays. 5% were due to inpatient bed delays and that would be classified someone going from the ICU to Med-Surgery to open up an ICU bed or and that would push this along so 5% of those are based on just not having the availability of an inpatient bed to move them to and 13% were pending test results at the hospital or pending medical treatment before the patient could be discharged. What are some proposed solutions? The very obvious one is we all have discharge policies and timing of discharge policies and to look at enforcing the timing of the discharge policies could assist us. What we believe as a group is this data could be shared with each of our individual MEC's (Medical Executive Committee) and start there because it's going to take a cultural change at least for 32% of these late discharges and to share this information with our MEC's and ask for some of their guidance on which direction that we could go with this and to share some hospitals specific data. I will say that Kathy's done a lot of detail over at Sunrise on carving down some of this data per physician. And those are things that we could do as a group to help hospitals that want to present to their MEC's and show them what they were able to do over there and give the actual data by physician and try and work on some of those hot spots.

Karla - an interesting twist to the late discharge, we obviously have done studies as well and felt that we had a late discharge problem and I approached the largest group of primary care physicians who happens to admit at our facility who appear to have the
worst issue with late discharges. What was interesting is this same group also has the lowest length of stay - keep that in mind because - their reasoning was while most physician's will come in and make rounds, either in the morning or either at night, their group rounds twice a day. So in normal situations, patients would be rounded on in the morning, a decision would be made or rounded in the evening and that's when the decision is made to discharge. They round in morning and come back at night and if the patient is ready to go they discharge that patient where in most cases that patient is waiting until the next day and be discharged in the morning. He's actually seeing it as being even more efficient by getting that patient out a half a day earlier. It's an interesting twist. We happen to have a very low length of stay as a result of that. But it does obviously cause late discharges. Blain said it causes problems and it causes late discharges. On the discharge delays, he'll argue that it's an early discharge.

Blain - and that's the type of specific data we can bring those in when you've got specific hospitals, groups to refer to, some larger groups that practice that way that will cause that. In other regions of the country – having been up at the Puget Sound region where we had a length of stay that teetered right around two and below that's what we found also with our late

discharges when we did a similar study. If you've got it specific by physicians, you'll be able to call that data out. The more quantifiable data we can put out here the better it's going to be for us. One of the other suggestions that we have was providing rounding sheets to the physicians when they come in in reverse order. In other words, versus starting in the ICU, going to the IMC, going to the Med-Surgeru as a community working with our physicians to looking at reversing that order. That is starting on Med Surg, IMC to ICU. What that does is clears out the lower acuity beds and gets those people that are more likely to be discharged to start that process and then you know you've got beds cleared as they go to the IMC and go to the ICU. That reverses our flow and reverses some of the typical practice flows. We wanted to kick it to the FAB to discuss the transport issue with Med-ride and what we could do as a group to try and reduce those delays and throw that out there to us and say either give us some direction on which way you want us to head or do we want to take it up as a topic here at the FAB. Where do you want to go with that. It's not something that we can't work out. I think it's a solution we can arrive at but where do we where are we going to go.

Karla asked Blain if he quantified that to be ambulance versus Medi-Coach or Medi-Car transport? What was the primary need?

Blain - No we did not have that carved apart. I think Kathy probably does specifically but not all of the hospitals have that carved out. Last thing, in this set of discharge expectations with the families at the time of admission and with the patient at the time of admission and to let them know that this is our expected discharge time and when we call the delays what they can push and educate our families on what happens when they say well I'm not available or I won't be there until 9:00 just to try to get their assistance again. A lot of this requires a tremendous amount of cooperation on behalf of external factors at the hospital. When you look at 80% of that outside of our direct control, it's going to take a lot of cooperation and working together with people to help solve our problem. We've got some of the tracking mechanisms in place and we can continue to track our discharge and admission time and report our progress to the MEC. We're willing to sit down and report to the FAB showing our progress at determining intervals if you want us to come back quarterly or every 6 months once we roll this education plan out. Then we can cart it down to individual data to be shared with physicians versus their peers. That's pretty much a summary of what we found. Again, going into this, I think that everyone in the group immediately made the assumption that our late discharge time was predominatey caused by physician rounding and I think we were all surprised and I think what it gave us was three different directions we could work in and three manageable objectives in working with both the families trying to come up with something on the rides and then working with our physician groups. It benefits the physicians if we're able to get these out and that's why because it doesn't slow down our OR, it increases patient satisfaction and it gives them more beds available for their direct admissions. The group worked very hard on this. Kathy really did a nice job on coordinating this data and setting up the document on how we were going to track and collect this information.

Karla – Any further questions? Any further discussions on that report? Before we move to the next agenda item, kind of just an offshoot of the Blue Ribbon Committee. I know there was a lot of questions that were raised at the last Medical Advisory Board meeting about the FAB's role and further pursuing the actions that were recommended by the Abarris Group. So, what I've done is I brought those key steps action items today and I want to go through them very quickly just to kind of get a status check of where we are in terms of the Blue Ribbon Committee and our activities in relationship to those action items. The first one was a strategic analysis by an ED Saturation/Divert Blue Ribbon Committee of the problem and it's drivers as needed and of course we did establish that Blue Ribbon Committee. It was broken down into four different

task forces, and all of those task forces did meet. The only that is continuing to meet is the hospital task force and that is who you just heard the report from and they will continue their work in identifying problems that are unique to the hospital itself and working together with the hospitals to try to solve some of those issues. The next recommendation was a 911 triage and dispatch process should be evaluated to consider allowing alternative disposition of caller request response systems, non-emergency resources and destinations for ambulances, for example, urgent care, assuming a strong medical control and review model. Consideration should be given for this change to be implemented within 30 days and obviously that has not happened. In fact, I need to throw that one out. Does anyone have any comment on any alternative destination. We'll table that one then.

Jane Shunney commented that the CPI educational program is in process and the expectation is that 75% of the EMS training will be completed October 1. Those who have completed the training will be able to transport to WestCare.

Karla – okay so that is in process then. The next item was to develop, monitor and enforce a standardizing uniform divert policy for adoption by our hospitals. I believe that we have done that and I believe that every hospital is following the uniform definition of divert. The next was a communication system should be installed to assure hospital notification of all arriving ambulance patients. I know that one did have a great deal of discussion at the last MAB and I believe that they're still looking on developing that communication system. Anyone have any comment on that action item.

Ken Riddle said the installation of the new communication system is in progress. The equipment has been ordered and is coming in. The goal is to have it in place by the end of the year.

Karla - and we are going to move towards complete notification when then for all rounds when that is installed is that correct or is that a later update wasn't it. Karla – okay, any discussion on that item? The next one was a comprehensive recruitment campaign should be adopted for medical personnel where there is a shortage, for example, nurses, to include collaboration and cooperation with the process by all hospitals, business community and the chamber of commerce and I think that we have put together a nursing shortage task force that's actually a state wide task force with the Nevada Hospital Association that is still meeting on a regular basis. There have been several forums that have been held both in the North and the South on the topic and I know that every hospital is working very diligently to attempt to recruit nurses. The next item was the Nevada Revised Statute should be revised to reflect the needed flexibility on this issue. For example, ED patient destination, medical nursing functions in the ED. We heard the update on the CPI. I don't believe we've made any progress at this point in actually changing medical nursing functions in the emergency department, in fact, I'll just skip ahead on the agenda for just a moment. There was also a recommendation at the Medical Advisory Board that hospitals look at providing additional medical assistance in the emergency rooms through the use of paramedics and I know that we had lots of discussion on that in the past about what the role of a paramedic in fact could be in an emergency room. I don't believe there have been any statutory changes that have affected that at this point but when we get to that point on the agenda item we can certainly talk about perhaps there's other roles that the paramedics can play in the emergency room. The next item was to evaluate the potential to simplify the diversion protocol to a simple open or closed model. We've moved in that direction as well. It appears as though, from the action items that were brought up at the Abarris Group that we are working very aggressively towards those action items. Some of them are still in progress but I don't think there is any that we have not addressed in some extent or that we're still not working towards. Karla asked "Ken did you want to make any additional comments, I'm sorry. You were the one who raised the

concern at the MAB, did you want to make any additional comments?" Ken Riddle said I think some short term solutions was the one that raised those concerns at the MAB, do you want to make any comments.

Ken Riddle – I think short term solutions from the Blue Ribbon Committee are encouraging from the hospital end but obviously some of the long term changes are good but I still think we'll need to look at alternative destinations process through a central dispatch center where we categorize calls in four categories through 911 there is one category, the first category, and 20% of those calls are not emergency calls and those people don't need to be taken by ambulance to a hospital unless they have to ride in an ambulance because they have no other means of transportation and if you leave them they're going to get worse and obviously we may need to look at those types of patients being transported to doctor's offices. And then there are issues of reimbursement on the ambulance side and there is a fear factor that most urgent care centers don't like people coming in by ambulance. They are used to seeing people come in by car and walking in. There needs to be some discussion about call screening. We had discussions several years ago with some people from Sierra Health and actually looked at implementing a program similar to a Nurse Help Line where we actually felt the goal to include all of the managed care organizations and discourage those patients from calling an ambulance and have the nurse call in a prescription or make an appointment to see the physician the following day. So I think that longer term there are some discussions that need to occur at least on a task force or whatever and short term, the big issue for the providers is still the wait time in the ER. I understand that one hospital, I think it's North Las Vegas, watch the patient until there is an ER bed available.

Steve Peterson – I understand that the wait times at Lake Mead are considerably better and I'm not sure if the paramedic initiative is helping that or if it's patient acuity, but it seems to have improved.

Karla – Sheila can share with us what you are doing.

Sheila Osterhuber – unfortunately I can't. I don't know that we're using paramedics in the ED so I don't know what the answer is but we can look into it.

Brian Rogers said they are not being used as paramedics, they are being used as helpers. They do not do invasive procedures.

Jackie Taylor said let me just share something, when we tried to use them at UMC the Nursing Board stepped down on us and basically said they are performing nursing activities even taking a blood pressure. You need to be cognizant of that.

Ken Riddle – I think we need to investigate that because I know I worked as an ER Tech for several years, not as a paramedic and I could take a blood pressure or clean a wound. I think you just need to be careful what you call them.

Jackie Taylor said well and I don't disagree with that because I think something should be done differently than what's acceptable these days but you need to be cognizant of that and deal with the State Board of Nursing.

Brian – Abut you know where you can go with that now is mutual liability because now it has been brought to our attention on the pre-hospital side, if we are in any facility and we do

anything to take care of the patient, it's our liability because realistically we're not covered to do anything once we hit that door. Now you're in a no win situation for either one of us.

Karla – but if you're standing there with the patient, you're pretty much helpless anyway because you can't do something.

Brian – all you are at that point is a body standing there holding a guerny. Not that that's ever going to happen because we're going to take care of the patient, but that creates a huge liability.

Dr. Kwalick – But if they're no longer your staff operating as a ER Tech then there is no liability. That's the issue.

Brian – But that's why the issue has really come to light now because pre-hospital providers don't want to just stand there and watch the patient decompensate in front of them. They would prefer to be in a situation to take care of them.

Karla – Any further discussion on that, that was actually an agenda item so if there is any other discussion about how we can use paramedics in the emergency room. Joe you said that you were using them?

Joe Calise said we wrote a job description specifically for emergency room technicians. We made the qualifications to be that you had to have an EMT certificate as a precursor to apply for the job. We go through a process where we have a specific job description of the things that they are allowed to do under the supervision of the nurse.

Karla asked are they assisting in your ability to get patients off gurnies in a faster time frame?

Joe Calise said they can take a patient from a medic and put them on a stretcher hook them to a monitor get the nurse or go find the nurse for the medic.. They know what they're looking at so they know to grab the nurse. The real fear I think for the medics isn't so much sitting there with the person with the ankle sprain for two hours in the ER because they're not worried about too much happening. I think when they're with a patient that's really sick – when it's your third/fourth ambulance in a row and that patient decompensates, they feel they have to do something. Legally they can't do anythingonce they've passed that door and if you can't find a nurse or doctor at that point then they are going to be held liable and so will the hospital. Because I think the way the law is written, once they pass our door, they are ours. So my EMT Tech, which they are really not called EMTs. To be a nurse manager, you have to have a nursing license. They know to run and go get someone and they will drag a nurse to the bedside or they will find a doctor and get the right help to the patient. So it helps us in that since we are a lot small ER. UMC is about 50,000 square feet where you really have to hunt down someone. But they could use a system where they beep the doctors or something which might help that situation. But it's not going to help the guy with the sprained ankle or with belly pain.

Karla – OK, any other discussion on that item?

Jackie Taylor said I just need to express some concern. I've seen some of the statistics on open and closure numbers and probably for the last 3 or 4 months even since the inception of the program and I was under the impression that the pod, UMC's in the pod with Valley, Summerlin and Mountain View and yet the hours tend to be elevated towards UMC and Valley and the other two facilities may be down for two hours in the month. What does that mean with that rotation? It seem like the big hospitals are the only two allowed to close and they can only close for an

hour so they keep forcing the other hospitals to open and yet these other two hospitals in Summerlin – it's not the rotation – wasn't that the original intent?

Blain Claypool said the only time the rotation comes in is when exactly, say UMC is on divert, closure, excuse me I'll use the right term, then if another hospital needs to go on UMC – Jackie, it's usually Valley, goes on for an hour – Blain, because of our proximity, but Summerlin and Mountain View, if they are open to take patients, we encourage them to stay open. You would go into a 4 hospital rotation in the event all 4 hospitals were slammed and all 4 hospitals were saying we need to go on closure and that's when they would rotate. So the closure really is controlled by you at your hospital and if Mike doesn't need to go closure at Summerlin and they don't need to go on closure at Mountain View, I would like to say that the program is somewhat successful because we're keeping people open longer.

Jackie Taylor said why are the hospitals forced to open when there are other facilities in the pod that can accept those patients, explain to me the rationale for that.

Joe Calise said one of the things that we've noticed was that there was a drop for us because when you look at the circles, the concentration of patients are inner city so when we're talking about the purpose of those areas is to keep the patients in that area, Valley being a block away from UMC is closer so they're going to get that patient rather than drive up. Why don't we instead of slamming one hospital area, whether it be Desert Springs and Sunrise when they're closing to go to UMC and Valley which is in the other the district because part of it comes from the statement patients are given the right to go wherever they want. So the ambulances take them there. That's what we're told. It seems to make sense because they're having a greater satisfaction when the patient's going to an area where they want to go.

Jackie Taylor said I think being forced open is creating an unsafe situation for the hospital that is constantly forced open with other facilities that are in that pod and quote, I don't know what the quote is.

Joe Calise said it's just my opinion, but the way you are presenting this is that it's Mountain View's and Summerlin's fault.

Jackie Taylor said no it's not. I'm not pointing fingers at the hospital, I'm pointing fingers at the system that was developed and approved and the system was introduced by the ambulance providers.

Blain Claypool said question, I also question if you're on closure and the way we've defined it, you're unsafe. Hospitals close when it's unsafe is what you're saying.

Jackie Taylor said no I'm not saying it's unsafe. We can not accommodate any more patients and we need to go on closure. But if Valley goes on closure, we're forced open and the other two facilities still can take patients and the ambulance companies are not going in that direction because it is inconvenient to travel the distance. Two hours a month is not acceptable.

Helen Vos said I can say for Mountain View, 2 hours a month – I'd like to be at that but we are at 1 to 2 to 3 hours a day, we're not at 2 hours a month. And I understand that it's still less than UMC but we're not doing two hours a month.

Blain Claypool said if you're closed – I mean when we close for an hour and we shut ourselves to any and all ambulance traffic, we're usually pretty well able to recover, if we're not we, then we'll take our step again. Are you shutting down all ambulance traffic during your closure?

Jackie Taylor said most of the time we are, even quick cares – that's your question. Don't think it doesn't make some people unhappy about that.

Blain Claypool said then I'd have to ask the ambulance companies are they taking transport under closure.

Ken Riddle – If they are closed we don't transport there. The way I understand it if you are closed an hour you don't have to open unless somebody else bumps you off. The facilities can go back and forth every other hour, unless someone else needs to close.

Dr. Kwalick said that's when the rotation kicks in.

Jackie Taylor said that's when the rotation kicks in?

Blain Claypool said when it's more than one.

Jackie Taylor said we have no other choice because of the way this program has been written to be forced off – we don't have a choice. I'd like to stay closed longer. UMC has to continue to take patients because no one else in this area accepts those type of patients.

Karla said that's incorrect Jackie, we all take those type of patients, except the traumas.

Jackie Taylor – It's just not traumas.

Blain Claypool said I can show you.

Brian Rogers – If we could go back to that question. We have made a lot of advance about the quick care patients. UMC has a quick care divert at the same time they go on ER divert, which happens about 50 to 60 % of the time.

Jackie Taylor said did you hear that. I want him to hear it. Blaine Claypool said I heard it, he said 50-60% of the time. Jackie - He isn't done yet. I want you to listen to what he's saying.

Karla - Clarify that if you would. You're saying that they go on quick care divert. What does that mean?

Brian Rogers said it means they don't take their quick care patients.

Blain Claypool said so 50 to 60% of the time, they're on closure.

Karla – so 40-50% of the time they are taking their quick care patients when they are on divert. Is that what you're saying?

Jackie Taylor - We're required by Emtala to continue to take those patients. Joe Calise said not if you're on divert. Jackie - We continue to take some of those patients and it's based on their level of acuity. Joe said not if you're closed and on divert.

Blain Claypool said but you have defined yourself as unsafe, you can't take patients.

Joe Calise said so if you're unsafe, you can't take patients.

Jackie Taylor said I'm not quite sure – when you keep saying that every time you close that you're unsafe.

Michael Walsh, Mtn. View - you say you're unsafe when you ask to close. That's the way the program works.

Jackie Taylor said you're putting words into my mouth. Mike – no that was the definition. Jackie - I said when we are closed we cannot reopen but we are forced to open and at times it is an unsafe situation.

Blain Claypool said but 50% of the time you are still receiving patients.

Michael Walsh asked Dr. Davidson if he could refresh our memory on the definition of closure.

Dr. Davidson said I think what the MAB, FAB agreed to when we opened up this policy in general was for during one hour of closure you are not to accept any traffic other than from a private traffic in other words or private vehicles pulling up. You were closed to EMS traffic whether it be ground or air. You were to use that one hour of time to reorganize and regroup and open up the next hour. That was the definition of closure per our plan. When we developed the open/closure program, if three facilities were going to and continue rotate. There is still a patient destination protocol and patient preference and so there is a patient right when a facility is closed, say UMC, if the patient says I do want to go in that area because that's where my physicians and charts are then based on the patient's preference saying I don't want to travel up the northwest or the west and they can do that. That's why we're trying to keep patients in their immediate treatment areas so to speak where they may have years and years of treatment. And most patients do that. There are very few patients who say I live in Summerlin, transport me to Siena because all the hospitals near me are closed. It's really hard to know if the one hour is enough time and if the facility can reorganize and regroup. If the facility continues to get patients on the hour, it would be very difficult. You're right, you're already full and you're already maxed out and you are already close to where you can't provide adequate care it can put you over when you accept patients from anywhere whether it's the air or ground. Direct admits or what not. I can see where one hour might be difficult.

Blain Claypool said granted the new system has not been tested, truly tested in the winter. We're coming and it's coming quickly, when you look at our volumes right now. If you look the hours that hospitals were closed this year since we instituted it and the hours that hospital was closed last year, ultimately one of the things we said was that this was going to be a very bitter pill for the hospitals to swallow. It was going to be difficult for us and we told the ambulance companies we're doing this, we know it's going to be hard. I think that was discussed here. But, what we've got is the public and we need to remain open and we need to be able to accommodate and bring some of those patients in and I think when you look at the hours closed across the Las Vegas valley, they dropped which has improved access and has allowed people to go to hospitals close to their home and we don't hear as many of the horror stories of a person living on Mountain Charleston traveling all the way down to Henderson any more which are some of the examples that were given to us when we talked about doing the three concentric rings. So, granted we haven't been tested by the winter yet but as a whole we've reduced the hours that the hospitals are closed and that was one of our major objectives.

Michael Walsh said at Summerlin we've dropped dramatically in the amount of time we've been closed but we haven't lost a lot of ambulance rides. We're still getting the same number or very close to the same number that we were getting before so I think, at least from our perspective, we're doing this in volumes. I'm not sure that it's hurting, it's just making our ER available to everyone a lot more hours in the month.

Karla Perez said I think there has to be a spirit of cooperation as well. I have an example that occurred just a couple of weeks ago. I received a phone call from AMR because they were concerned that they had paramedics waiting in Desert Springs emergency room for an extended period of time and why didn't we bump Sunrise off their hour of divert and go on divert ourselves because Sunrise was now into their second hour. When I went down to the emergency room, I discovered that our ER manager had talked to the Sunrise ER manager and they assessed the situation between the two ERs and there was a decision made that Sunrise was in worse shape then we were so they really needed that second hour more than we did – we were holding 8, they were holding 30 and we worked together and they took that second hour and then we went on. I think if we all work together in that kind of spirit of cooperation. There's going to be times where you're going to be forced open but I think if we worked together and found out who's worse and who's in worse shape and we helped each other out. We're helping the community out in the end.

Ken Riddle – I think if we are looking at a long term solution, we need a coordination point, whether that's in the Fire Alarm Communication Center where this person knows what the status is community wide and can track that and provide feedback because I don't think the hospitals are calling one another to see what's going on and that way you can keep the crews a little better informed. When a hospital is forced open, that pretty much tells the paramedics you may not want to go there and they tell the patient they are really busy and if you go there you may have to wait hours – if you're not closed and you're forced open when we know what forced open means, it means your really busy. I think simple coordination point for resources would help. My second question is regarding hospital closure and divert from a national perspective. We had 300 people in 57 cities participate. This is obviously not just a Las Vegas problem. One of the questions that came out and I just asked Brian the same question what do you guys do when there is a mass casualty incident and all of a sudden there's 8-10 beds available. What changes, what makes the beds available?

Joe Calise – we have a protocol in the hospital we would downgrade certain people who should stay in the hospital if they could but when you have mass casualties, they are on their way out the door, doctors are called in for triage. Those late 32% discharges, doctors or Chief of Medicine in the hospital, discharge at that moment. That's a totally different scenario. You can't enact that every day.

Ken Riddle – when we have multi casualty incidents county wide and we've got complaints from hospitals that we only got 3 patiens or we only got 4 patients. Remember information isn't always that great early on. But it was just interesting that all of a sudden all these beds appeared and people were upset that they didn't get the people they thought.

Karla – does anyone have any comments on that?

Pam Turner – let's go back to what Jackie was saying and what Blaine said. I think it's important that with Valley and UMC we bounce back and forth a lot. I like the idea of communication, maybe that's something we should implement however our stance is that we are

very proactive. You have to manage the open closed status very closely and we are very proactive. We started our DIRT team originally last year but it has really grown. We implement the team very quickly even before into something much more and we call it still the DIRT team, but it really is the flow of the whole hospital. We know we're going to have to go on closed status, and sometimes it's 8:00 in the morning just because of the flow of the whole hospital. We're at capacity and we're holding, we know that so we start being very proactive in doing that so the sooner we start to do that I think that it's the management of open and closure that we need to look at. How you manage it and how successful you'll be and sometimes we're full there's no where to go and we don't have a choice but to close but we try to stay off closure – we should have a more open communication between our two facilities.

Blain Claypool said I think Pam's right. I can't tell you the number of days that I've got a call at 8:00 in the morning from Pam that says we don't need to get the DIRT team together but if we don't do something, based on how traditional volumes go by 3:00 we're going to be in trouble. So we're able to pull our crew together, put a call out and say we need to work on this, this and this, so she's right we proactively manage. I think it's what every body's been doing since we all really sat down and said we're going to have to live under this new system. In doing that, we're going to have to change the way we do things. So I think everybody's being proactive. Checking down in the ER, in fact the managers are talking to each other. I think the new system is really building that cooperation.

Jackie Taylor - I do need to add it isn't that we haven't changed internal procedures, we've hired two bed czars, we've opened up a discharge lounge. We have nurse managers meeting twice a day in order to see what the activities going to be during the day and we've also opened up new ICU beds. I'm sure all of the hospitals are doing it but it tends to be a problem for that one hour shut down for UMC I'm going to say it again.

Karla - Any further discussion on this topic.

Dr. Davidson said the only comment I would like to make is we made this comment months ago that before we ever considered putting paramedics in the ED we talked about relief teams so the paramedic crews can get back out there. I'm not saying that person could perform any type of medical intervention but that person could continue to monitor what's going on. That was one comment I had. One of the reasons the whole protocol was developed was because in the October 1999 issue of the ACEP which is the American College of Surgeons recommendations is that when all hospitals are closed, all hospitals are open that still stands to this day. That's recommendation for every city. I'm doing a presentation in November and that is the crux of the entire diversion topic, when you're all closed you're all open. That's the only way to keep the flow moving in the community. Usually when all the hospitals are tight it's not because we're so full it's because the community continuously requires the need and we have to provide the needs.

Steve Petersen – let me respond with regard to the paramedic supervisor or oversee-er, we do pretty aggressively monitor where our crews are and typically send out our supervisors to bottlenecks in the Ers. We have also resorted of late to calling whoever we can wo seems to have some influence and Karla thank you for helping us the other day. We don't make those calls all the time but we do whatever we can to break up the log jam. I think maybe what Jeff was talking about was whether it would be prudent for the companies to put at times of high capacity or high volume a paramedic person in charge within the hospital Ers to look at that perhaps. Frankly I'm not sure that's an EMS responsibility particularly given what we have just heard regarding practice issue whether any of those individuals are credentialed to perform

procedures in the hospitals. So I'm not sure that's the answer, but having paramedic level or EMT level personnel in your Ers I think is something that might help the current problem. Later in the month of October the Interim Health Care Committee is going to be meeting and one of their topics to address is hospital divert rather than re-inventing the wheel, it would be nice to summarize and provide some recommendations particularly if it relates to Legislative solutions to diver crisis rather than starting all over. I believe that's Senator Rawson's committee.

Karla Perez said I agree and certainly we can solicit the assistance of the Nevada Hospital Association as well to assist us on some of those. They have Lobbyist up there that work on those types of things on a regular basis so we can work in that direction as well. Any other comments, questions and concerns.

Helen Vos said I just have a request that if we find out the date and time of when that committee is going to meet, if this committee could be notified.

Karla Perez said definitely. Moving on to the next item on the agenda then. Louise Halpren from the Junior League is here to talk with us about the Safe Haven guidelines.

Amber Jicobo said I just wanted to come today and make sure that you were all familiar with the safety law that was passed in May. I'm with the Junior League of Las Vegas which I'm a volunteer with the organization just to give you a quick background on why I'm here. Junior League is a community service organization of women who focus on issues dealing with women and children. One of our committees is designed to advocate for women and children, called the PAA committee, Public Affairs and Advocacy. Each time the Legislature meets, we come up with a bill that we want to get passed and this is one of the bills that was passed in May. It's called the Safe Haven Law and in many other states they call it the Baby Dumping Law. This was designed so that no more children will be left in dumpsters primarily which is what you hear about a lot. The handout has some background information. We are working on getting a brochure together. There's no money associated with it and the only way people find out about this law is through word of mouth or PSAs or whatever is being developed through donations to get the word out. I just wanted to come here today and make sure that you had all the information, you knew what was required of the hospitals so that no hospital staff would every receive a baby and not know what to do.

On the second and third page of the handout is the legislation nuts and bolts it says, the parent must come in and voluntarily deliver to the provider the child. The parent must not express an intent to return for the child. The parent who delivers the child to provider of emergency services and they can only deliver the child to provider of emergency services but it's not necessarily just a hospital, it might be a fire department. So a fire department may call you and say a baby was left with them as well. We're actually working right now on putting together some kits for fire and police departments of necessary items so that they can at least temporarily take care of the baby until they can deliver it to a hospital. The parent who delivers the child to a provider of emergency services shall leave the child either in the physical possession of a person at the hospital who they believe is an employee there. Or they can leave it on the property. I just want to mention later, say they were to leave the child on the doorstep there is no liability against your hospital until one of the employees has actually received the child physically. In Clark County, a parent can also call 911 although we don't anticipate that happening a lot because the whole issue is that these parents want to remain anonymous. The next page defines emergency services so it could be to UMC or a quick care. Once an emergency care provider has received the child, they are suppose to inform the parent (they're not allowed to ask any questions of the parent) but they are to inform the parent that by allowing the provider to take possession of the

child, the parent is presumed to have abandoned the child and that by failing or refusing to provide an address, they will not be notified of a hearing that will be coming up unless the parent contacts a local agency that provides protective services, action will be taken to terminate their parental rights. They need to have some information, the hospital staff, as to what they would tell the parent when they drop off the child. The provider of emergency services shall perform any act necessary to maintain and protect the physical health and safety so that's where it would come in if the baby were dropped off at a police or fire station that they would contact the hospital and then they need let Child Protective Services know within 24 hours that they've taken possession of the child. Eventually the child is turned over to Child Protective Services and they will then put a notification in the paper for three consecutive weeks at least once a week to let any parent know that this child has been abandoned.

Karla Perez said just a clarification question, if a baby is left at a hospital by law we have to register that child and begin to create a medical record if we're going to provide any kind of care to that child even if we're not really providing care but we're just maintaining them for any period of time. So we would just identify them as a Jane or John Doe with no address or any other identifying information. That's all we would do then at that point.

Amber said you're not allowed to ask any questions so it would be just as if the child were dropped off and you just found it.

Karla Perez said so we don't take any history or attempt to get any information from the mother about this child.

Jackie Taylor said only if the mother wants to provide it is my understanding.

Amber said right it has to be voluntary.

Ken Riddle – you can ask questions based on pertinent history. You can't ask name and address and things like that, but it's my impression also that you can attempt to identify the person if there is a potential for child abuse.

Amber said that is correct. Thank you for bringing that up.

Karla Perez said I would think that we would need some kind of medical history particularly if the child is having difficulties in some way.

Amber said it's actually my understanding they're not allowed to ask any questions.

Ken Riddle said we're a designated site and because the stations are not manned at all times because they may be out on a call. We have a little sign out front and we actually have a protocol which we will share with all the fire departments in the Valley. We will transport those babies up to 30 days of age to the hospital unless we are given some other direction. In reviewing the law and putting our standard operating procedure the only question you can ask are related to medical history. If there is important medical history of the parent you can pass that along. But they don't have to if they don't want to.

Michael Walsh asked how does one establish that it's the parent who is bringing the baby. It's mentioned in the criteria.

Amber said I have wondered that too. I don't have an answer for that. Basically you're just supposed to accept the baby – I don't anticipate that someone would steal a baby then take it to a hospital but I suppose that could happen.

Ken Riddle – several other states have this in place and I know we developed our protocol after Miami, Florida's and they have only had one in two years.

Sheila Osterhuber – question on public awareness and what's the status on that?

Amber said we are currently on the first page where it says education campaign, there are a couple of update on what we've had done. It doesn't say on here, but a billboard has been donated by Lamar Advertising. Everything is just through donations and the recent last baby was dumped , there was a lot of interest and we got a lot of press coverage and that was great and a lot of people came and said we'd like to help out. We took what we could and worked with who we could and then it just dropped off. We depend on the kindness of strangers to help us out with this. Joyce Advertising is putting together brochures and then we have to find somebody to print it. We want brochures because a lot of this information we assume will get out by second hand knowledge – you might know somebody who is pregnant and not sure what to do and you might let them know. We also want to have business cards that hopefully we'll be able to work with the School District and give to the nurses and the school police so they can hand those out which would be less conspicuous. We're putting together some PSAs for the radio. We have a PSA for the television. They were doing really great about running it and now, with all of the other things that have been going on, it's slowed down a little bit. We have speakers that go out and talk about it if it's requested workshops for service providers. Cox Communication has said that they will let us have space for bill inserts but we have to print those so we're still working on that. Stickers and signage is something some of the individual places, like the fire departments, have said that they will go ahead and print and put themselves onto their trucks or in their stations. I think UMC said they would do that as well. If any of the individual hospitals want to – we can give you the artwork and if you want you can make your own stickers to indicate that you're a safe haven site. We would certainly welcome that. There is a person who is developing a website for us.

Ken Riddle said I like to make one other comment, there is an 800 number and in a follow-up meeting with our own staff we felt and maybe you can bring this back to whomever they have a log that has been developed and maybe stickers can actually be placed on dumpsters.

Amber we are working with Republic to see if they will allow us to do at Cox Communication is putting stickers on all of their vehicles and they have said if we can Silver State to put those stickers on the dumpsters that they will donate the bumper stickers and they're vinyl so that last a long time. But they're not really too thrilled about that.

Ken Riddle said I know the one in the media a couple moths ago the lady was aware of the law.

Amber said I don't think she was fully aware of that – the anonymity that that gave her though because otherwise I don't know why she would still have dumped her baby in a dumpster.

Karla Perez said the next item on the agenda is something that I know is of concern to all of us is the mental health patients and Blain you want to start off the discussion.

Blain Claypool said we got a lot of work on the CPI and looking at that and I think that's progressing as far as assessing in the field and taking to the location. We still have an issue with

mental health patients needing to be assessed by a medical provider and coming to our hospital. What we see is a real growth. I've gotten a call from a couple of other facilities, I got a call from a physician in a facility close to me asking what we were doing because we've really seen a real clogg in our emergency room due to patients waiting on an assessment or even after they've been assessed, waiting for a bed. When you look at what we've done in the hospitals to try to clear up our holds and clear out our ER to keep the flow going, one of the ones that we've not been able to break loose on is the mental health patients. Pam Turner put together a little of information that she got for a month's worth of data – we've got an average of about 534 psychiatric patients seen a month in these 4 hospitals. 38% of these are transferred to mental health facilities. Again, this is just a sample of calling of a few people and what it broke down to. Discharges were 62% that were discharged from our facilities. The question is – is it our intention and is this something else we want to look at along the same as the CPI that they can be assessed in the field and taken to Las Vegas Mental Health or taken somewhere else versus coming to our emergency room, sitting in our emergency room not getting the care of the psychiatrist, waiting an excessive amount of time. We're trying to find solutions.

Karla Perez said did those statistics show how many of those patients actually came by ambulance versus private vehicle?

Blain said no.

Karla said obviously if we're going to go to something like that that would only.

Davette Shea said if we look at those statistics in 1999, when we started the CPI task force, we had the 1999 data related to mental health and I chose to work with the CPI task force. We still have that 1999 mental health data which was pretty dramatic as far as cost. I think the current issue here is with mental health patients and what mental health has come back to us repeatedly and I think everybody has heard this. The issue about mental health screening with Dr. McCourt with the UMC group finally has published his statistics on the cost and lack of necessity and I really would like to give that out to everybody. He gave me this draft. He did a presentation before the Assembly about that. I mean it's dramatic, there is just no sense how these people have these huge workups because there's no bad outcomes. I don't know if Dr. Greenlee has seen that report as well. What we're working with in the CPI program, we recognize that this is just a piece of the pie and many of the CPI patients are dual diagnosis who have mental health overlay but you don't know that until they get sober or you get the drugs cleared from their system. If we're looking at the program at Westcare. Westcare has a real interest in having a receiving point. We're pushing hard to get funding right now and we're really in a positive manner. They've hired a new Vice President of Operations who really I think is going to be true asset to this community above a multitude of issues.. But the problem is mental health doesn't want to take on the responsibility of screening and as long as they hold firm to that position then they can refuse those patients and the law right now provides them the opportunity to do it. You need somebody that can do that intake and clear these people to go forward just like we need it for the CPI. Starting at the paramedic level the CPI, the current recommendation, the CPI was the easy fix because they are an easier to screen. The mental health is such a complication issue and Sheila has the expertise and she did field evals for both Charter and Montevista so that becomes a very, very complicated. I think a solvable problem but I think you have to get back to the table we've got to push like we did for the CPI issue. I don't think I'm speaking out of turn, but WestCare has a real interest in housing a place where everyone could be brought to have the initial screening. The gentleman they hired is a nurse and he has his masters in public health.

They hired a nurse practitioner that's about ready to come on board. We also have a contract that's being approved by Dr. George Kaiser to be the medical director and he's very interested in providing this screening up front. But again, it's those dollars are not forthcoming from the Mental Health community as we all know. The problem for our community, emergency departments, if you will, and the Facility Advisory is keeping these people channeled in different directions so our beds are open and that's the one point if we can have a point of entry for these people who need medical screening that the physicians have a comfort level with and we can open more facilities to transfer them out then we're going to be in good shape but it's going to take that group coming together again. Getting those statistics together again from the hospitals, looking at the dollar amount. I believe it's doable and I believe that Westcare would like to extent what they can do as far as the screenings and then transfer to mental health.

Karla Perez and I know that the issues have been further complicated with Montevista's announcement last week that they are now going to start charging the hospitals for every assessment that they do at a $125.00 a piece. That goes into effect October 1st. I know for my facility alone that's $120,000 a year so we have to come up with an alternative because that's not acceptable and we can't afford to do that.

Dr. Rosen said I would like to have the floor for a few minutes and try to bring people up to date on the mental health position. Perhaps clarify a few misconceptions I just heard that I heard in February when I was on the job for two days and was in this room. I would like to reclarify some of those misconceptions. Since I don't have a sign, my name is David Rosen, I'm the medical director at the mental health state run facility and I'm also the state medical director for the division of mental health. I would like to first made a broad sweeping statement and clarify that issues from mental health are not that the mental health community does not want to do medical screening or I think that's what you said. SB636 which goes into effect on Monday, was initially drafted so that the mental medical screening would be done at the local Mental Health facility and that was not carried through on the final version of the bill and that was a cost factor because the facilities that are available at this time. The funding for these facilities would not permit that to happen without a tremendous infusion of funds. I think it's an issue of massive funding rather than I want to or I don't want to issues. Back in February, the whole issue of the amount of time that mental health clients were in the emergency room was taken up in this room and as a result of that we recrafted our entire procedure as to how we managed mental health clients from the valley emergency rooms and I think until mid August we were successful in managing folks without any excessive or very few excessive delays. There was a mark change in the feedback we got from the local valley hospitals EDs was very positive. One of the steps that we did to accomplish that was administratively transfer people from our 10 bedded emergency observation area administratively into our psychiatric hospital. That had consequences to the psychiatric patients inside the hospital because we were mixing populations and putting people into circumstances where they had to have certain levels of care and where before, we were able to return roughly 60% of the people in our emergency services to the community without admission. That figure has just gone out the roof. So what happened was we did have beds because we were just getting into time in the Spring where the hospital census were reduced so we had beds to use and we used those beds until they were gone. Mid-August, right about the same time Valley closed, in our analysis we cannot say it had to do with Valley closing their unit, in our own analysis, but mid August but we basically became a full facility. So our acute inpatient beds and our 10 bedded PES have been pretty much full and we have been on closure with exception this morning we started with four beds in the facility and we had three or four beds in our emergency services. That has not happened since August, period. Whereas in the past year, we have been on closure twice, I think we've been off closure maybe twice or three times since this happened. What has happened as a net result is that people once again are

being held excessively in the emergency room because our services have been just maxed out with our personnel and our facility. We had attempted to increase our emergency services beds to 20, we had attempted funding at the last two legislatures, we were not successful. We do have a 20 bed unit which is closed and that is closed because of a hospital retrofit that we're undergoing that is taking a long time. It is not predicted to be through until the end of March however, when it is finished, it is our intent to increase our emergency service beds to the community to 20. At this time, unless we can reduce our hospital census, however, we do not have funds to staff it. So that is still an issue that will remain to be seen.

One other misconception I want to address and that is the cost that the hospitals incur in the work up for mental health clients. At the February meeting, my second day on the job, I had already learned that in November of 2000, we agreed with UMC to Dr. Carrison's protocol and we have lived by that and it has worked. So that UMC is not exposing mental health clients to that excessive funding and we found that it worked. So we made an offer to all the valley hospital emergency departments sometime maybe in March that we would extend that protocol as long as we had an understanding that it would be followed and as long as we were not having problems we would extend that to the valley. To date, I think that Valley Hospital who rapidly accepted that, there maybe one other hospital than Valley that has accepted our proposal. So it may true but it's not because mental health is not aware and is not willing to work with the community. So I wanted to clarify that.

Joe Calise said I know we didn't get anything like that and I would appreciate the offer.

Dr. Rosen said we went out twice and it did go to all of the emergency department. Joe said not to us. Dr. Rosen said it did, I'm sorry because I personally was responsible in sending it to all of the emergency room departments.

Joe Calise – you sent it to me and Pam at Valley Hospital.

Dr. Rosen responded that they were doing it at Valley.

Joe Calise – they are doing it because Dr. Davidson spoke to Dr. McCourt. We're not arguing, Im that it came out. I'm sorry that we didn't get it initially. If there's a way we can get it, I would appreciate it.

Jackie Taylor – I believe it was presented at the MAB for their choice to accept it because Dr. McCourt came.

Joe Calise said it was only for UMC to use until it was approved by mental health.

Dr. Rosen said since March we had said that we were satisfied and that it's available to all the hospital emergency rooms as long as there was an agreement from that emergency room that they operate by that protocol.

Karla Perez said would you redistribute that to all the hospitals.

Dr. Rosen said you may have to get a copy from Dr. McCourt but we certainly would be happy to do that.

Karla said send it to the CEOs as well as the ERs.

Dr. Rosen said finally, inspite of a psychiatric shortage that I'm sure are aware of from the newspaper coverage that we are currently experiencing although we are recruiting very aggressively, we have made the decision to take some of our resources from our outpatient clinics which are now currently under staffed anyway and we have created a triage team involving a half-time psychiatrist and a half time social worker on a trial basis and we have applied for privileges both at UMC and at Valley Hospital and I think that's going to be extended to some of the Valley affiliates. For a period of two months, we're going to attempt on a half-time basis with that two person triage team to come into the emergency rooms at those two facilities because we know where people are sitting when we get the faxes every morning (on Monday morning there were 13, yesterday morning there 4) we know where people are sitting and waiting in the emergency rooms. We're going to at least try our trial basis to have those resources team go to those two facilities that are very high volume for us and see if we cannot evaluate some of the people there that are already on hold papers not picking up the piece that Montevista is dropping because we don't have anywhere near the resources for that but at least to try to do assessments on some of the folks that are sitting in your emergency rooms waiting for transfer of whom perhaps could be medicated, perhaps could be evaluated and released, if necessary seen one day and then seen the next day and released because they can make rounds on a daily basis in your emergency rooms. I wish we had the resources to extent that to the entire valley but we're at least going to make an attempt for a couple of months to see how we could impact mental health situation within those emergency rooms that I mentioned and then look at our resource allocation after that.

Karla Perez said any other questions or comments regarding this subject.

Jackie Taylor said I do need to add to what's been presented, we consider it deeply appreciated that the medical staff is going to take on this as an emergency project and credential both individuals so we can establish and initiate the program next week.

Dr. Rosen and I believe that Valley is also working on that as well and so I think both our will be equipped to start somewhere between Monday and Wednesday.

Karla Perez said just as a point of clarification though, you talked about this not taking the place of the Montevista assessment so you're assessment or your triage will be for those patients that are going to your facility only, you're not going to do routine assessment of all mental health patients in the emergency room to make a decision as to whether or not they need to go to a facility.

Dr. Rosen said that is correct.

Dr. Davidson said either way it's going to make a tremendous alleviation of the problem in most emergency departments. I think this is a great project and I hope it takes off and you get the funding or whatever you need to teat those patients. I'd say in most emergency departments in the city that most patients have been legaled and are sitting there supposedly to go to LVMH and so we all know they can sit around for 4-5 days and so it now. If we can treat those patients and get a portion of these patients on medication or outpatient whatever you are already going to alleviate a big problem.

Dr. Rosen said the purpose for the social worker on the team is to assist the hospital discharge planners with resources and be able to help out in getting those placements done rapidly.

Jackie Taylor said we have a psychiatric social worker that's assigned to the emergency department – so she'd be able to work very closely with yours.

Dr. Greenlee had a few comments for Dr. Rosen. I think that you facility does a good job with lack of funding, lack of staff and frankly lack of support from the State which you mentioned at the initiatives that didn't get funded this year. So I want to compliment you. I'm pleased about the new program where you're going to send somebody out to Valley and our facility at UMC, that's going to help us a lot as well. To address the protocols that Dr. McCourt had studied and brought forth and were approved by your facility, it helped us a great deal so I encourage other facilities to utilize them because now instead of mandatory labs on all patients, we get to select who and with training of just the staff and physicians we can do that accurately almost all the time. So it's cost saving – time saving and helpful.

Dr. Rosen said and it has worked and our concern had been that under the pressure that emergency rooms face in dealing with the multitude of people that somehow that process wouldn't take place but we have found that the emergency room participating have in fact done a good job in the triage and we're very satisfied with it.

Kara Perez asked for any other questions or comments and then moved on to the informational items. She asked Mike Walsh to give a report on the Medical Advisory Board meeting. Mike responded the report had already been covered during the course of the meeting.

She asked for any other items to be heard before the Board. There being non, she asked for a motion for adjournment.

Meeting adjourned at 9:30 a.m.