FACILITIES ADVISORY BOARD

MINUTES

April 1, 2002 - 3:00 PM

MEMBERS PRESENT

Karla Perez, Chairman, Desert Springs
Brook Richardson-Jenkins, Lake Mead
K.D. Justyn, Summerlin
Blain Claypool, VHMC
Jeff Davidson, MAB Rep.
Suzanne Burton Cram, Sunrise
Jackie Taylor, UMC
Donald Kwalick, MD

ALTERNATE MEMBERS PRESENT

CCHD EMS STAFF PRESENT

Jane Shunney, R.N.
Joe Heck, D.O.
Jennifer Sizemore, PIO
Jennifer Carter, Recording Secretary
Mary Ellen Britt, R.N.
LaRue Scull
Kelly Quinn

PUBLIC ATTENDANCE

Brian Rogers, Southwest Ambulance
Steven Kramer, AMR
John Wilson, Southwest Ambulance
Connie Clemmons-Brown, UMC
E.P. Homansky, M.D., VHMC
Alice Conroy, Sunrise
Philis Beilfuss, NLVFD
Pam Turner, VHMC
Pete Carlo, Southwest Ambulance
Kevin Huenard, Lake Mead

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The EMS Facilities Advisory Board convened at 3:00 p.m. on Monday, April 1, 2002 in the Clemens at the Ravenholt 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 February 8, 2001 meeting minutes was made, seconded and unanimously carried.

II. REPORT/DISCUSSION/POSSIBLE ACTION

A. Review Draft Operations Protocol, Patient Delivery to Emergency Medical Facilities

A motion was made not to accept the Operations Protocol for Patient Delivery to Emergency Medical Facilities, seconded and motion carried.

B. Drop Time Statistics

Karla Perez, the Chair, asked Dr. Heck to discuss his findings on the drop time statistics. The Health District reviewed drop times data compiled and submitted by both Southwest Ambulance (SWA) and American Medical Response (AMR) from April 1st to February 2nd. That data was then put into graph form to be evaluated at the meeting. The first graph shown was the number of system transports defined as the patients transported by AMR and SWA during the particular time frame listed. Except for the large jump from April 1st to May 1st patient transports remain relatively constant at 8000 patients per month. From that point forward there are around 8000 patient transports with the largest change being from October 1st to November 1st which was a change of about 600 patients in one month. That may seem like a large number of patients as a monthly change, however, when looking at 30 days per month transporting to nine hospitals it's only about 2 patients per hospital per day statistically speaking. If all patients showed up on one day that would be a big swing, but across the month it would amount to about two patients per day. A hospital call volume graph was then shown and Dr. Heck stated that the call volume stays relatively constant as far as the distribution of patients to each hospital and the overall call volume remains relatively constant. There are no large swings in patients arriving at one facility compared to another. The next chart was total drop times broken down into drop times of less than 30 minutes between 30 and 60 greater than 60 and then greater than 120. Interestingly, the system handles 90% of all transports in less than an hour. The other thing noted is in the last three months December, January and February these last two drop times, the greater than 60 minutes, have increased significantly. We were looking at a total of maybe 5% of long drop times to now a total of 10% long drop times. And that is in face of a call volume that is actually diminished. If you look at the total call volume from the first chart, the call volumes for the last two months total transports have actually gone down from previous months. The long drops in the last two

months, especially the ones between one hour and two hours are over 10% or approaching 10%. This accumulative bar graph shows for the most part each hospitals' drop times in each category has also remained relatively constant, plus or minus less than 5% of the total patients transported. It was noted that in the last two months close to 800 calls, 10% of that 8000 volume, have been greater than one hour. This represents the long drops based by hospital. Here you start to see a shift in where the long drop times start to occur. The final graph shows the percentage of long drops per hospital versus the total number of patients transported there. The number of drops greater than 60 minutes versus the total number of patients transported during this entire period from April to February show that some hospitals are above that 7% range, St. Rose Dominican is showing the best rate at less than 1% for their total long drops. The big message here is that we're handling 90% of calls in less than an hour, and is what would appear to be a standard within this community. This information should guide the discussion of defining what would constitute a reasonable time for transition of care from EMS to the hospital.

E. Report on Pilot Studies from AMR and SWA

The Chairman asked AMR and SWA to report on the pilot study where both companies provided a paramedic to care for patients dropped off. According to Brian Rogers of SWA they don't have exact numbers but the first month was very successful. SWA had medics in hospitals and they watched patients and those drop times decreased. SWA can no longer get staff to do this because they were overwhelmed by watching nine people. The pilot program shows that if there is somebody watching patients it is very successful and it gets medics out of the hospital in a very reasonable period of time. The Board indicated interest in seeing numbers because it would be helpful in planning the next step. John Wilson indicated SWA collected data for about two weeks doing first in, first out units to watch the patients. This data is significant and shows that on an average at Desert Springs we were able to successfully watch up to eight relatively stable patients. Beyond eight got to be quite a challenge. The hours that SWA made the biggest difference were between 2pm and 8pm. SWA has two weeks worth of data. The times that SWA were able to have somebody over there and didn't overload the beds units were out of there in less than 20 minutes on a consistent basis. The challenge was after the hospital system got used to having patients being watched in the hallway then what happened was that people who were sick that were in the waiting room were being brought around those people who were in the ambulance triage area. It was no longer the press, as hospitals would call it, because one person was there watching this group. So we found that the wait time that we would have watching those people in the hallway started escalating fairly dramatically. And it just depended on the charge nurse and the facility and what was happening there. But it has been very successful when we were able to do it. It is dependent on us taking a unit out of the system and sending our crews to the hospitals.

Karla echoed what John said, their intent at Desert was to actually employ the paramedic. We've actually only been able to hire one because paramedics don't want to sit in the hallway and watch people, they want to be out on the streets where the action is. So we

are having a very difficult time and unfortunately the one person we have is a per diem who can't work 24 hours a day, 7 days a week.

Brian Rogers explained for the first two weeks of the pilot study at UMC and two weeks later at Valley AMR's and SW ambulances tracked about 160 patients for that one month time frame. Going into the second month SWA had the same problem of trying to get people to watch these patients because of the amount time that they were required to sit there and wait with the one specific patient that they were not being moved into the ED as freely as before. SWA has scheduled some intermediates from another division to the hospitals. The hospitals are so crowded that they are starting to utilize the beds that were in the holding areas for ambulances. Administration has to be called to get the beds again. Intermediates are at Summerlin and Mountain View also. You can see from Dr. Heck's charts these are the facilities starting to hold us up more and more. We have seen an overall decline in our drop times between 2 and 3 minutes as an average for the month. When talking about 6500 transports, an average drop time of 3 minutes less is pretty significant. Going from February to March, when we weren't able to staff it as effectively as we wanted to, our average drop times jumped from 36 minutes to over the 40 minute mark. Now that's an increase of 4 minutes, again, that's significant when talking about 6500 transports for a month.

Jackie Taylor asked for an explanation on the 160 patients, to which Brian responded, it was both UMC and Valley and this process is very significant to help the hospitals. This comes out of the mix when looking at drop times for the crews because the crews that now leave a patient with somebody in the hospital waiting area go back out and their time is now stopped. So, in the calculations here don't include the next hour to 1 ½ hour that the patient is still actually waiting on a hospital bed with one of our employees, this was not the first-in-first-out methodology, this was one of AMR's employees there for 12 hours a day, seven days a week.

Karla Perez asked if there was any data that would suggest an advantage over staffing versus the first-in-first-out. Obviously, with the first-in-first-out there is one crew that stays but with the other methodology someone is still being taken who could be in an ambulance to serve the hospital.

Brian responded having an EMT intermediate, in the hospital rather than having a paramedic and intermediate sitting there which takes an ambulance out of service that normally responds to a 911 call means one less unit on the road. This hurts service to the community.

The best solution would be having a hospital staff member there. Each time the ambulance company puts somebody in there it's costing them 12 hours, 7 days a week for this person at two facilities that is very costly. The benefit outweighs the cost, yes. But how long can this go on? How long are we able to get staff to physically do that, two facilities is one thing but staffing 4 facilities or 5 facilities divided between AMR and SWA is not realistic financially for either company.

The Committee reviewed the draft operations protocol with reference to the national standard as 23 minutes. However, research did not reveal the source of this 23 minute national standard.

Dr. Davidson stated the draft protocol was a combination of input from the Health Department and the ambulance agencies to attempt consensus on a reasonable transition time. The focus should be the data that was presented by Dr. Heck identifying the standard in this City.
That would be the best way to look at it and then come back in six months or a year and review the findings. If it seems to be that 90% of our drop offs can be within 60 minutes then maybe that should be our goal, 60 minutes. If it's 45 or 30 minutes then develop a reasonable standard that we can live with on both sides, EMS and the hospitals, that was the purpose of the data.

Dr. Heck was asked if he had, by individual hospital, the average drop times. Dr. Heck stated the numbers are reported as less than 30 minutes, less than 60 minutes, etc. The numbers of 47 minutes is not reported. Members wanted that number to place where they are so they know the target.

Dr. Heck said the current data shows that 90% of the calls are in 60 minutes, which is a reasonable time for turnover/transfer. If it is said the average overall is 47 minutes, is that 13 minute timeframe going to create something that is not attainable. I think that when we look at 90% we are talking about an impact of 10% of call volume or 800 transports per month. We should be able to fit those 800 calls in that less than an hour timeframe. This is possible based on data from AMR which reports it in 5 minute increments. Exact averages in 5 minute increments are possible from AMR, but for all the transports I don't have that data.

The Chairman felt regardless of what that number becomes whether its 23 minutes, 30 or 60 minutes, the issue is what happens at that point. Whatever that magic number is, if the intent is, that the patient is left at that point and it is now the hospitals' obligation, that's where the issue is.

Suzie Cram said it is not appropriate for an EMS person to go to a charge nurse and say they are leaving when they have no idea what the hospital situation is regarding census in the ICU or PACU, etc. Perhaps an alert system when the ambulance company is reaching zero, the hospital could be informed. But to leave an EMS to decide what happens to our patients in a system where they don't even know what's going on in the system is wrong.

John Wilson said they agree with you which is why we have to come up with a comprehensive plan and how do we do the alerts. When we hit zero ambulances, we work with our supervisors and if we have two ambulances sitting at a hospital for more than 30 minutes, that supervisor is making contact with the charge nurse to figure out what is happening. Your charge nurses in the ER do not necessarily appreciate it but when we call the hospital administrators things miraculously happen. We can be trying

to work with the charge nurse and for whatever reason their hands are tied but miracles happen in every one of your facilities when we deal with the administrator on call.

Administrators can work miracles for you but that is not always good for other patients in the hospital, surgeries, open hearts are cancelled. So, I can work miracles, they may not be the best miracles for some groups of patients, however. So, what may appear to be magic to you is not so magical on the other end in house.

The ambulance companies stated their magic is the ability to respond to the next 911 call that may be in an uncontrolled environment. Cancelled surgeries are patients in a controlled and safe environment. We have a very high responsibility to those people who are in an uncontrolled environment. In the 60 minute standard we are failing today. Failing because we are running out of ambulances, we are calling for mutual aide and there are no ambulances available. So to say that is an acceptable standard, we find it not acceptable but it happens about every week.

The Board wants to look at this because daily they run out of beds and staff and can't help EMS. On the other hand the ambulance companies can go from having four available units on the east side of town to no ambulances and are then calling for mutual aide.

The Chairman asked if there is a standard for how many ambulances are needed per population.

John Wilson explained that it is based on the standard of call volume. When we did the analysis with AMR we showed an increase of 7% in call volume and over 22% increase in ambulance resources on the road. So when you talk about the system overall, where we get stuck very clearly is the long holds at the hospital. We did an analysis for the last 3 months and had over 1600 hours where we were in the hospitals over 30 minutes. You need to understand the financial under pinnings, you understand your financial under pinnings, and what you need to hear from us is our financial under pinnings. We are rate regulated, we don't have the ability to change our rates. The whole system is based off of what we call unit hour utilization. It's the transports we can do in one hour. For us just to give you a thumbnail picture, fully loaded costs for an ambulance unit hour is about $102/hour. That's all administrative costs, all overhead, rent on the vehicles, payroll the whole nine yards. So when you factor one paramedic shift, 12 hours a day, 4 days a week that's about a quarter million dollars a year to staff one paramedic unit. Our entire system is based on theories behind system status management and deploying resources to match demand in the system. We know that between 2 and 10 the system is backed up, so we add more ambulances. During the day we scramble additional ambulances. We put our managers out on trucks. The fact of the matter is we are trying to put our least expensive folks in the ER's to help with patients. If units are pulled out of the system obviously that's a great deal of money to us that is unfounded. I think what you are hearing from AMR and ourselves is that financially our margins are not huge and we can't go any more with adding additional resources to make this whole thing work. When you talk about a national standard we are right in the mix as far as high

performance EMS systems go. Could we have the best system in the world where you put a paramedic on every street corner at every telephone booth, that would be wonderful but you would have to be able to pay for that. We could go to an hour wait time at a hospital if we could significantly increase our rates. But the politicians are not going to go for that. That is what we are faced with. We are faced with some confines, our fee rates go up 2.28% this April for cost of living. We also have been hit by the Medicare fee structure which hospitals have gone through and that is going to have a significant impact on our bottom line. Not your problem, but it is our problem and so when we talk about what we are able to give you, frankly speaking for the ambulance providers 30 minutes is about the outside of what we can financially afford to do. I just want to give you that historical perspective so you can understand that piece of it. We are trying to work with everybody. We are working with each of the facilities but the reality is it can't be maintained. Initially, the rates that were set were based on the fact that we would be able to get ambulances out and back on the road in less than an hour. You have to remember that we've already spent 40 minutes on the front end and that number hasn't changed. Once we get the call we respond to the call, we are on scene and we transport. On average it is about 40 minutes and then it is the additional time at the facility. We can do it based on our "unit hour" and we are currently running just under what is known as a ".4 unit hour utilization" so that is less than one transport every other hour. AMR is probably in the same ballpark. That's how the system works. We are making it financially, we are not going to be rich off of this but we are doing what we can.

Jackie Taylor wanted to know if there is data available on times significantly increasing or decreasing waiting times since the creation of the regions.

Blaine Claypool said that would couple with the question that I have, do we have an overall average waiting time at a hospital.

SWA said in January they were averaging 36 minutes at one point. Jackie Taylor again reiterated that it is impossible to clear out a crowded ED in an hour. The Group acknowledged what is now occurring in the hospitals is "internal disaster which has become the new "super divert". This is being used to stop the flow of traffic to the ED because another hour is needed to clear up the system. When one hospital goes on internal disaster the other facilities in that region have to open and this causes a domino effect. This has happened where three facilities in a region talk about either actively going on internal disaster or talking about going on internal disaster. This causes system failure.

The ambulance companies have done some unpopular things in the last month, i.e., pull units out of hospitals without somebody there in attendance. When there is no mutual aide there is no choice left. It is understood when this happens within 10 minutes of departure or less the hospitals have been able to find somebody to watch those patients. In one hospital, the Chief Nurse came to care for the patient. On the other hand the ambulance company sends the general manager and the director of operations and clinical services out on a truck.

The ambulance companies feel there is not much more they can do to help this situation within the hospitals. When the hospital has beds and they are able to transition off, it works for them. They have used either one person or one staff member to watch a number of patients instead of tying up ambulance crews for multiple hours, that has worked. Financially, we can't continue to do this over the long haul.

Dr. Davidson suggested using the EMSystem. The transport agencies could post their status level, 0, 1, 2. We could know when the system is very busy if they are at their maximum capacity and we're starting to back up ambulances. The statistic you need to look at is, has the ambulance volume changed percentage wise for any facility in town. The answer to that is no, then it's not the divert system, it's the facility that is full. It's the traffic volume that has proportionately increased in the community and the facilities cannot handle the influx. That's the stat you need to look at. Dr. Heck presented that stat.

Steve Kramer agreed with John Wilson, that this system never met a 23 minute drop time standard. Over 3 to 4 years, that time frame has gone up to 38-40 minutes. We put 22% more ambulances into the system and we are still not meeting the need. This tells you it is not an EMS problem. Every single facility is at capacity with holds, every single bed is filled up. One facility said they admit 70% of the ambulance traffic that comes into their ER. The acuity levels of these patients is higher than a couple of years ago. What we are saying is that we are getting the call, we need to respond to this call because that's the franchise agreement, we respond to 911 calls and nobody stops calling 911. And the hospitals have the same issue, people don't stop coming to the hospitals either, they are coming directed by physician's offices. The onslaught continues. Currently the transporting agencies are triaging out somewhere between 3,000 to 3,500 patients per month at the scene and not transporting them to ED's. Imagine and additional 3,500 patients per month distributed through 9 facilities.

Another issue in the system is internal disaster being declared by a hospital when full capacity is reached in their ED. This effects all other hospitals in the region and others not in the region. Those hospitals who use internal disaster because of excessive patient load aren't any worse off than the ED's who are full that are staying open.

C. Internal Disaster Review

When someone calls AMR, as gatekeeper of divert, and requests internal disaster statistics, the administrator at that hospital must call the administrator on call at AMR and give them the reason for internal disaster. If it is patient load, it will not be honored, that hospital will not be able to go on internal disaster.

Blaine Claypool brought up the point that when this internal disaster discussion came up at the MAB everybody saw it as a potential problem. The MAB would like to approach this from an educational standpoint each time a hospital goes on internal disaster review just like we review an MCI (Multiple Casualty Incident). What happened, how did it get resolved. This would be a learning tool for the system. What pushed that hospital over

the edge. But if we look at it and study the parts, we can learn how to avoid it the next time we come near the edge.

Suzie Cram thought this review would help establish a system where when the ambulance services are nearing a certain level a notice goes out on the screen, ambulance system is at Code level, get the COO, CEO, and chief nurse prepared for the overwhelming situation. We have holds, hallways full, ambulances are at zero level. We need to look at this in the same arena and have everybody playing fair. We're all in trouble and we need to plan together.

Some on the board would like these internal disasters reviewed within 48 business hours of the event.

Brian Rogers said he will bring before the MAB this recommendation: When a hospital in a region goes on internal disaster all others in that region have to be open. Go back to all closed means all are open. That says that region is in bad shape. Blaine Claypool said this is why a review is important if a hospital taxes the system by going on divert then they need to explain. Discussion followed about defining internal disaster, identify criteria, outline how everyone else plays by these defined rules during this time. Put the Blue Ribbon Committees back together to work this issue through.

Further discussion followed over the term "super divert". It doesn't mean anything here or in the rest of the County. Internal disaster and super divert are not the same. It cannot be used interchangeably and are not equitable. Several members thought internal disaster was reported to the State because it is a licensure issue. Some also feel that a hospital needs to be accountable for taking this action because to close for two or three hours is not fair to the system.

There was agreement that Dr. Davidson is right that the two are completely separate that the hospitals need to be accountable when they go on internal disaster. A critique in an educational forum is a positive step forward.

Blaine Claypool reminded the Board of two motions the first being that the FAB approve the proposal from the MAB to develop and educational critique of any hospital that goes on internal disaster to be presented at a the next regularly scheduled MAB. Motion seconded. After much discussion, an amendment to the original motion was that it would come to the FAB and the MAB. The motion was seconded. Further discussion on the motion was called for by the Chairman and resulted in the motion to read in the event a hospital goes on internal disaster they will report to the MAB Education Committee within 48 hours and the FAB at the next meeting with an educational opportunity to critique. There was a second and carried unanimously.

The second motion would be that the FAB establish a subcommittee to set criteria and to develop a protocol in the event an internal disaster occurs.

Suzie Cram thought there to be a need to include the ambulance systems also because they are having what could be called internal disaster when both are unable to respond to anymore 911 calls. Review their situation the same way. From the ambulance side they need to tell us when this X happens we're going to call this disaster it would be a double response when we have a disaster internally, how do we define it when the ambulance services are in trouble, how they define it, when they call whatever alert and then how we respond to it, our individual responses and it should be reviewed here also.

Karla – Suzie are you making that recommendation as a counter to this?

Suzie – Yes

Karla – I would say rather you not approve this but that we go to that type of a system first. Is that what you are suggesting?

Suzie – Right

Karla – That was a very long motion.

The Chairman stated the fact that there are two motions on the floor and is there a second to the first, To establish the criteria for internal disaster. A question was raised as to establishing a new sub-committee or having the Blue Ribbon Committee review the internal disaster criteria. Susie Cram noted the only Blue Ribbon Committee left is the hospital flow. The Chairman agreed to re-establish the Blue Ribbon Committee. The motion was seconded and carried.

The second motion was to review the ambulance status level and help develop criteria for some kind of system for when they are at peak overload. Motion seconded. Discussion followed about the need to have system alerts and hospital responsibilities and uniform ways of responding. Motion carried.

D. Internal Disaster Critique

E. Mental Health Update

The Chairman directed the meeting to the next item on the agenda, Mental Health Update. This is very pertinent to the conversation because all of our facilities agree that the psychiatric holds in our ED's is really contributing to the disaster that we are currently in and we really need to solve this as a community. The Mental Health Task Force meeting that Sheriff Keller put together with the intent to try and solve this issue for our community includes city representatives, county representatives, the mental health hospital representatives, the Health District, Metro, all of the entities who are really involved in the process. The State Mental Health Facility is in the process of opening ten additional observation beds and the way that their system works is when a hospital calls them for a transfer they will accept the patient in their observation unit first. They don't automatically admit patients into their center. They will hold them in observation.

Sometimes those patients can hold 2-3 days in their observation unit before a decision is made to admit them. Their goal is to admit as few people as possible and to get them set up from that observation unit into an outpatient treatment program. Get them the medications they need and get them released back in to the community with appropriate medication and hopefully appropriate follow-up. So their goal was to decrease their inpatient beds and open up more observation beds this month. They have not received any additional funding in order to do this. The Committee told the State mental health facility that 10 additional observation beds is not going to solve this problem and it is a very small band-aid on a much larger issue. The intent is to really get additional funding for the State mental health so that they can keep their 10 inpatient beds open increase their outpatient beyond just the 10 and actually expand them further. What Sheriff Keller has asked us to do is to gather additional statistics. A worksheet was developed. All of your facilities should now be collecting the data. The data asks how many psychiatric patients are seen in your ED how many of them are adult and how many are pediatric. The reason for that break down is we have no pediatric psychiatric resources in this community at all. From a State Mental Health standpoint they were concerned that we needed to do something in Las Vegas from a state standpoint. So it is important that we gather those pediatric statistics as well. We then asked how many patients were transferred out and where did they go, how many went to Monte Vista, how many went to perhaps Lake Mead or Valley or other psychiatric facilities, how many are being released from your ED straight back out in to the community whether its home or some other type of facility and then how many were being held at midnight, and how many total hours those patients who are being held. We asked that the statistics start at the time that the decision is made for the disposition of that patient. For example if an ER physician determines that this patient needs to be admitted into a psychiatric facility, that's when the clock starts ticking on how long you are holding that patient beyond that point. If we can ask every one's cooperation in gathering those statistics there is a contact and a fax number on the form. If we could ask every one to send them in to the Health District on a daily basis and the Health District is going to gather that information for us. The information will be sent to the legislators, the Governor and the Mayor.

The next meeting is tentatively scheduled for May 1st at 8:30a.m..

Dr. Kwalick – Before any body else leaves we're thinking about and I want to get you support on it before we do it, declaring an emergency as far as health care providers and look to try and get retired nurses back into the field. They would have to be retrained, recertified, possibly even have their licensure waived a certain way, the fees anyhow by the BON. Would you all be part of that program to assure that retired nurses could get in maybe do a shift a week, a shift a month, supplement their incomes, do the kinds of things that right now the paramedics are doing because what we are talking about is the traffic that is coming in the front door, not the traffic that's coming in the back door or the EMT's. Those ambulance units have got to get out in the field to assure that we are able to respond to 911 and they are being held up as you are well aware. Do you think it is a good idea to go in this direction. There may be 100's of them, we don't know, but to try and get retired nurses back in to the system for a shift a week, a shift a month.

Karla stated whatever we can do to get more resources into our community, assuming they maintain their competency level. We have refresher courses set up. There is also a bill draft for mutual recognition which would allow neighboring states nurses to come here to practice which we are actually pushing through Homeland Security. As everyone knows Las Vegas is supposedly a target for terrorists attacks and we have been told by the Federal Government to get prepared with our bio terrorism plans and all and certainly as part of Homeland Security having a mutual recognition program would allow nurses from neighboring states to come in and assist us if that were the case. And that was actually prompted from New Jersey who had made that recommendation that had they had mutual recognition they would have had more resources available to them and would have been able to provide greater assistance during the disasters. So that's kind of the angle that we are working on.

Jane Shunney mentioned that's actually a part of our thinking, if we could tap the resources that are available and are not currently being used we need to build a reserve force of some sort of nursing personnel to be available in a time of a bio terrorism disaster and be part of a back up plan.

Dr. Kwalick commented that means not volunteering, they are going to get paid by the hospital. Karla said I think we would all agree with that.

Meeting Adjourned 4:50pm