MINUTES
EMERGENCY MEDICAL SERVICES
FACILITIES ADVISORY BOARD
FEBRUARY 12, 2003 – 8:30 A.M.

MEMBERS PRESENT

Blaine Claypool, Valley Hospital/MAB Representative
Don Hessel, Boulder City Hospital
Donald Kwalick, M.D., Clark County Health District
Helen Vos, Mountain View Hospital
Jackie Taylor, University Medical Center
Karla Perez, Chairperson, Spring Valley Hospital
Sam Kaufman, Desert Springs Hospital
Suzanne Burton Cram, Sunrise Hospital

MEMBERS ABSENT

Brook Richardson-Jenkins, Lake Mead Hospital
Ken Armstrong, Southern Hill Hospital
Rick Smith, Summerlin Hospital
Sandra Rush, St. Rose Medical Center

ALTERNATES

Mary Jo Solon, Southern Hills Hospital
Leslie Paul Luke, Summerlin Hospital
Renato Baciarelli, St. Rose Dominican

CCHD STAFF PRESENT

Jane Shunney, Asst. to the Chief Health Officer
Jennifer Carter, Recording Secretary
Mary Ellen Britt, QI Coordinator
Michael MacQuarrie, EMS Field Representative
Rory Chetelat, EMS Manager

PUBLIC ATTENDANCE

Alice Conroy, R.N., Sunrise Hospital
Connie Clemmons-Brown, UMC
John Wilson, SWA
Kathy Kopka, R.N., Sunrise Hospital
Kathy Sneed, St. Rose Dominican Hospital
Larry Tricons,
Pam Rowse, St. Rose Dominican Hospital
Pam Turner, R.N., Valley Hospital
Pete Carlo, SWA
Philis Beilfuss, R.N., NLVFD
Randy Howell, HFD
Sandy Young, R.N., LVF&R
Scott Rolfe, UMC
Steve Peterson, AMR
Timothy Victoreier, VHMC

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The EMS Facilities Advisory Board convened at 8:30 a.m. on Wednesday, February 12, 2003 in the Clemens Room at the Ravenholt Public Health Center. Chairperson 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 December 11, 2002 FAB meeting minutes was made, seconded and unanimously carried.

II. REPORT/DISCUSSION/POSSIBLE ACTION

A. Discussion of New Protocols

1. Patient Transfer to Receiving Facility

Chairperson Perez referred to the Patient Transfer to Receiving Facility Operations Protocol (PTRF) handout. She requested clarification as to why II-E of the initial draft protocol was removed which read, "EMS Providers are permitted to continue patient care (airway therapy, ECG monitoring, IV therapy, medication administration, etc.) while waiting for placement of the patient".

Rory Chetelat, EMS Manager, explained the initial draft that was distributed should not have included II-E. He further explained it is outside of Clark County Health District (CCHD) jurisdiction to regulate facility activities; therefore, the language in II-E was inappropriate and consequently removed.

Chairperson Perez explained the Facilities Advisory Board (FAB) has been asked to review and approve the PTRF protocol for non-monitored patients.

The PTRF protocol reads:

PURPOSE: **To provide EMS personnel with guidelines to transfer care of patients within the confines of a receiving facility.**

PROCEDURE: **This procedure is to be followed when EMS personnel arrive at a receiving facility with a non-monitored patient (i.e. no IV's, intubations, EKG monitoring, medication administration, or other invasive techniques):**

I. Upon arrival, EMS personnel will advise the facility representative of their arrival, and the patient's status.

II. If the receiving facility is unable to immediately place the patient:

A. EMS personnel will wait for placement of the patient.

B. At thirty minutes after arrival, a charge nurse will be notified by EMS personnel that the patient has been waiting thirty minutes for placement.

C. At forty-five minutes, a charge nurse will be notified that EMS personnel will be returning to service in fifteen minutes.

D. At sixty minutes, a charge nurse will be notified that EMS personnel are returning to service, and a completed patient care report will be left with the charge nurse.

Chairperson Perez opened the table for discussion.

Blaine Claypool, Medical Advisory Board (MAB) Representative, commented that prior to the implementation of the 30-day trial PTRF protocol, EMS providers could leave patients at the facility after waiting an hour for facility Emergency Department (ED) personnel to take over responsibility of the patient. He explained that after lengthy discussion at the February MAB meeting regarding what the facilities have done over the past 2½ years to address some of the situations on flow, the outcome was this PTRF protocol. He referred to this protocol as an effective compromise and emphasized that in view of the Health District's definition of non-monitored patient, the only patients affected by this protocol would be non-critical patients; patients that could be triaged back into the lobby. This would involve a very small percentage; roughly less than 3% of patients would meet the criteria of this protocol. He pointed out that the idea of triaging patients, who arrived by ambulance, back into the lobby, was considered at the Blue Ribbon Panel. He acknowledged that although this protocol may not be the only answer to the flow situation it could be another incremental step in the right direction.

It was clarified that the PTRF protocol was effective Friday, February 7 on a 30-day trial basis.

Chairperson Perez requested input from facility representatives on the progress of flow since the protocol went into effect.

Blain Claypool reported comments were made by ambulance providers that while previously, during weekends, units were backed up at the hospital, currently providers have experienced the best flow overall on the weekend at Valley Hospital. Blaine felt the implementation of the L2K Divert Operations Protocol contributed to the improvement of flow, which spreads the load of psychiatric patients across the valley. He announced Valley Hospital has not encountered any problems and all has gone well.

Suzanne Burton-Cram, Sunrise Hospital, submitted a position statement to the FAB prepared by herself and Helen Vos regarding the PTRF protocol. Suzanne read the position statement (see attached) and thereafter stated she would like it recorded that Tuesday, February 4, 2003, Sunrise ED received the amended PTRF protocol via fax, without any explanation to the amendment.

In response to the position statement, Steve Peterson, AMR, commented the person/s responsible for writing that position statement could not have been in attendance at the February MAB or they would have been aware that the Sunrise Hospital ED physician voted in favor of the protocols. Furthermore he stated, the premise that there are not enough ambulances on the streets is erroneous. The issue is there are too many ambulances held up in hospital ED's and unable to respond to calls because the staffing in those hospital ED's is not such that ambulance providers can leave on a timely basis.

There was a request from the Board for an explanation on the roles of the MAB and FAB to the Health District.

Chairperson Perez explained both the MAB and the FAB serve in an advisory capacity to the Health District. MAB and FAB committee members are there to offer opinions and/or recommendations and to work together in a collaborative effort to solve issues regarding the EMS system. It is up to the discretion of the Health District to pass protocols that are believed to be in the best interest of public health and safety and therefore do not need the approval of the MAB and/or FAB to pass a protocol. On behalf of the FAB, Chairperson Perez encouraged the Health District to seek recommendations and endorsements from FAB when there are protocols that affect facilities, however she stressed that is not a requirement of the Health District.

There was dissension among some FAB committee members that the decision to implement a protocol, which directly impacts the facilities, was made without any input from the hospital executives. In response to Steve Peterson's comment, Suzanne Cram expressed a concern that when an ED facility representative votes in favor of a motion at the MAB, it doesn't mean the facility is able to uphold that commitment. She moreover expressed her disappointment that the executive staff of the facilities was not given more advanced notice of the PTRF protocol so that they may prepare their staff for implementation.

Dr. Kwalick pointed out that the two draft protocols, PTRF and L2K Divert Protocols, were distributed to all parties interested in the system, at the same time.

Dr. Kwalick explained the reason the PTRF protocol went into effect on a 30-day trial basis with short notice was due to the system overload, which occurred January 28, 2003. He asked Chief Myers to give a historical perspective on the incident.

In response to Dr. Kwalick's request Chief Myers, Las Vegas Fire & Rescue (LVF&R) explained, January 28, 2003 the EMS system reached the breaking point when LVF&R was put in a position where they needed to respond without a franchise transport unit because the system level status was at zero. They no longer had ambulances to respond to 911 calls as the ambulances were tied up at hospitals. He mentioned AMR did everything they possibly could; Call for resources, ask for mutual aid, and place supervisors in hospitals to release ambulances that were held up at the hospital so the ambulances were available to respond to 911 calls. A 911 call came in on a cardiac arrest, Las Vegas Fire & Rescue responded with one rescue and AMR was unable to respond. Chief Myers was obligated to make an administrative decision to have fire engines respond to 911 calls with the rescues. An administrative field coordinator was assigned to the hospital to evaluate a patient who had been seen twice by a physician. The patient was taken off the backboard and the transfer of care was officially turned over to the hospital. A patient care report was prepared and submitted to the nearest nurse available. Chief Myers' perception is the Health District and the MAB felt compelled to implement a protocol that could be utilized by ambulance providers in an effort to avoid jeopardizing the safety of the community. He emphasized the PTRF protocol was implemented on a trial basis and is still open for discussion by the FAB.

Chairperson Perez announced she was contacted by the Health District and was asked if an emergency FAB meeting should be scheduled regarding the PTRF protocol. She said after reviewing the protocol she did not feel the protocol was placing the hospitals in a dangerous emergency crisis situation and therefore, she elected to schedule a public meeting.

Rory Chetelat commented a great deal of work was done in an attempt to organize something that would work for the provider agencies, facilities and the community. He pointed out lengthy discussions took place prior to the decision to implement the PTRF protocol and the purpose of the protocol is to overt a further crisis in the community. Furthermore, he stated, this protocol was not intended to fix the problem however, it is not feasible to allow provider agencies to develop policies, independent of the Health District. Provider agency administrators should not be required to initiate decisions involving liability issues and legalities where the community at large and the EMS system are concerned. The idea of the PTRF protocol is to provide a safety valve to prevent system overload. He informed the FAB that a suggestion was made at the MAB to wait until system levels were at zero to implement the PTRF protocol. He commented that waiting until the system levels are at zero is too late to address the issue. He said the Health District researched various policies regarding wait times and was unable to find anywhere else in the country where drop times even came close to an hour. Wait times throughout other areas of the country were identified as 15-30 minutes. Therefore, he stated the Health District felt the PTRF protocol was a reasonable compromise and a good place to start to address drop times.

There were concerns expressed by facility representatives that ambulance providers are deliberately not starting IVs and monitors on patients in an effort to expedite transfer of care after an hour. Patients have been transported with a diastolic rate of 120-130 who had not been placed on monitors. An IV was attempted by the medic but couldn't be placed and the medic then rushed the charge nurse to release that patient from their care within an hour. A patient was transported to a facility with a rule out stroke without an IV in place. Patients in this condition should have IV's in place for potential medication administration. Scott Rolfe, University Medical Center (UMC) stated since the PTRF policy has gone into effect UMC has been greatly impacted with the number of patients being left at the hospital by paramedic practitioners. He pointed out that he has staffed nurses in the hallway to care for those patients. Medically indigent patients have received care in the hallway for the past five days because UMC was overloaded with patients.

Pam Turner, Valley Hospital, commented Valley Hospital has experienced patients arriving at the hospital by ambulance without IV's in place. One patient was a hypotensive and another was hypertensive. She indicated that she spoke with the agency's supervisor regarding the hypotensive patient that was transported without an IV, however the hypotensive patient was in pain and placing an IV for that patient was a judgment call of the paramedic practitioner. She pointed out that the PTRF policy has not been in effect long enough for her to determine the impact it has had on Valley Hospital, but they haven't experience any wait times over an hour since the inception of the policy. She believes the Legal 2000 Divert Policy has decreased the wait times at Valley Hospital for the ambulance providers.

Alice Conroy, Sunrise Hospital, stated the situation at Sunrise parallels Valley Hospital's. She pointed out that a heightened awareness is there on the part of the ER staff because of the focus of balancing the non-urgent patient, patients in the waiting room and the paramedics that are waiting to transfer care of ALS patients. ER staff at Sunrise are interviewing the patients and receiving feedback in an effort to maintain quality patient care.

While there has been positive dialogue between the pre-hospital supervisors and facility representatives; the pre-hospital supervisors have been supportive in having the crews stay with the patients in most instances, some facility representatives expressed concerns of compromising patient care from a pre-hospital standpoint. There is a feeling amongst facility representatives that pre-hospital providers are jeopardizing quality patient care in an effort to expedite the transfer of care to the hospitals after an hour.

Provider agencies are concerned that the hospital ED's are placing non-monitored patients in beds before monitored patients so that paramedic practitioners are forced to monitor ALS patients for extended wait times. John Wilson with SWA stated, provider agencies are providing unauthorized, inappropriate patient care inside the facility, for excessive hours, that paramedics are not credentialed for. He pointed out that SWA employees are encouraged to put patient care first.

Sandy Young, LVF&R, echoed John Wilson's statements and further commented that the field providers are receiving mixed messages when facility representatives question why providers are performing so many procedures on scene. It has been suggested at sub-committee meetings that the provider get the patient to the hospital quickly and yet when the provider arrives at the hospital the question is why are you administering these IV's because now the patient cannot be placed in the waiting room. She pointed out that the message from the ED representatives to the providers is not clear and if the field providers are not providing appropriate care to the patients the provider agency should be informed.

Chairperson Perez suggested that during the 30-day trial period the hospitals use the studies of the patients where it is believed that inappropriate pre-hospital intervention occurred, as a tracking mechanism and perhaps a committee could be formed consisting of members from the facilities and provider agencies to discuss those issues.

A concern was raised that pre-hospital providers should inform patients as to what to expect when the transfer of care occurs. Rory explained the issue concerning constant communication was discussed and it is an expectation of the pre-hospital providers to communicate with their patients.

Blaine made a motion to endorse the 30-day PTRF protocol, using the patient studies prepared by the hospitals to discuss appropriate pre-hospital care in a forum between pre-hospital providers and facility representatives. The motion was seconded.

Chairperson Perez called for discussion.

A concern was raised regarding the transfer of the patient and continuity of care. There are statutes that state the transition has to occur and it cannot just be leaving the patient.

Rory explained that the CCHD attorney pointed out the transfer of care issue was a very gray area in the regulations. When the ambulance arrives on the property of the hospital the pre-hospital provider has a responsibility to continue care of that patient until the transfer of care occurs. That part of the regulations is an undefined very gray area. However, it is not appropriate to have an ambulance sitting at a hospital for 2-4 hours.

Rory commended everyone involved in the attempts to remedy the drop time issue. He reiterated the point that the PTRF protocol was designed to provide a safety valve to prevent system overload. He pointed out this is a 30-trial and while it may not be the right solution, it is a plan worth trying. He stressed the importance of EMS providers providing appropriate patient care; inappropriate patient care will not be tolerated.

A question was raised, what are the criteria after the 30-day trial period that will determine the success or non-success of the PTRF protocol?

Rory responded the EMS office would collect data from the hospitals depicting:

- The number of patients left at the facilities by pre-hospital providers
- Whether the pre-hospital provider provided appropriate patient care
- Whether the facility staff cooperated appropriately with the transfer of patient care

A request was made to amend the motion to include an official report from the Health District within 10 working days of the 30-day trial period to the FAB for further discussion.

Blaine accepted the amendment. The amendment was seconded and the motion was unanimously approved.

Chairperson Perez suggested the hospitals and providers are prepared, in the future, to report to the FAB, any developments and/or modifications applied in their respective facilities/agencies to plan for the peak season. She recommended this become a standard practice at future FAB meetings.

2. Legal 2000 Divert Policy

Chairperson Perez explained the intent of the L2K (Legal 2000) Divert Protocol is to evenly distribute the Legal 2000 patients between the valley hospitals. There were a few hospitals that were overburdened with sharing the bulk of the L2K patient population. The idea of the L2K Divert Protocol is to level load that patient flow which would be beneficial to the entire community.

Blaine commented that exploring the potential elimination of divert was discussed at the last FAB meeting. He pointed out that keeping ED's open and level loading the L2K patient population across the Valley hospitals would facilitate the overall flow and provide more ED beds for the community. It was determined at the Blue Ribbon Committee; one of the concerns with non-availability of ED beds were the L2K patients that stayed in the hospital for two–three days. The Blue Ribbon Committee is currently working on long-term solutions to this issue however, he stressed, these are long-term solutions.

Blaine further commented the idea of the L2K Divert Protocol is to assist the PTRF protocol. If a facility receives five L2K patients that facility could then go on L2K divert at which time the L2K patients would be evenly spread between the other eight hospital giving a capacity for 45 L2K patients to be held at any given time. The number of L2K patients average approximately 23.

Chairperson Perez circulated a handout on Psychiatric tracking totals for the year 2002 and January 2003. The data consisted of total psychiatric hold hours per each facility.

Concerns were expressed by the smaller facilities that basing the level loading of L2K patients on five per hospital could put inordinate pressure on some of the smaller facilities and increase drop times. St. Rose Dominican Hospital has experienced significant issues with the volume of L2K patients at both campuses since the L2K Divert Protocol was implemented according to Renato Baciarelli. He suggested that the level loading be considered on a per capita basis versus facility because in his opinion, proportionally the level loading of L2K patients is not working effectively at St. Rose Dominican and Sienna campuses.

A request was made on behalf of the smaller facilities that Metro Police Department officers be included in the discussions regarding the L2K Divert protocol. Pam Rowse with St. Rose Hospital commented, law enforcement officers make determinations, independently on where to transport L2K patients. She stated that Henderson Police Department personnel would not be willing to transport outside of Henderson when St. Rose goes on L2K Divert.

Blaine addressed the concerns of the smaller facilities. He mentioned that level loading according to per capita was considered at the MAB. The reason it was decided to base the level loading on five L2K patients per facility is it is a plan that is easily understood by all players. There are too many factors to consider if the level loading were based on per capita:

- The pre-hospital provider would have to determine ratios per facility.
- Per capita would have to be distinguished per facility based on bed size, operational bed size, and/or size of the ED.
- Types of beds would have to be defined per facility, i.e., ED beds, or ED beds and inpatient beds, etc.

The decision to base the level loading on five L2K patients per facility was believed to be a plan that could be easily implemented, monitored and tracked through the dispatch for transport agencies.

There was a request for clarification on the hospital procedure for reporting L2K patients to AMR dispatch.

The response was the facility notifies AMR dispatch, dispatch enters the information into the EMSystem and the results are displayed on the EMSystem screen.

A question was raised regarding the drop times. The concern was are particular hospitals holding patients longer, inappropriately.

Steve Peterson responded there is hospital specific data available on drop times for AMR, which is distributed to hospital CEO's on a monthly basis. While it appears ED divert hours are down, in his opinion there hasn't been any significant changes in drop times. He acknowledged an agreement has not yet been reached on a standard for drop times.

A request was made to have statistics combined from all providers for distribution to the hospital CEO's.

Rory replied, consolidated data is available however, the data covers the period from April 2001 through October 2002. He volunteered to provide current data at the next FAB meeting.

A motion was made to endorse the Legal 2000 Divert Protocol for a 30-day trial period followed by an effectiveness report from the Clark County Health District within 10 days of the trial period. The motion was seconded and carried unanimously.

Chairperson Perez announced there is an effort by the State of Nevada to build an additional mental health hospital in Southern Nevada. While there is opposition to this effort by some of the legislators, Andrew Tiffany is advocating the building of this additional mental health hospital. A legislative meeting is scheduled for, Monday, February 17 at the Grant Sawyer building at 8:00 a.m. to address this effort. Anyone who is interested in giving testimony is encouraged to attend, notify Senator Rosin, and be prepared to present testimony at this meeting.

Discussion of Service Line Closure Issues

Sam Kaufman, Desert Springs Hospital, reported February 1, 2003, Desert Springs Hospital stopped scheduling elective general orthopedic cases at the hospital. Scheduling of all orthopedic cases except for foot, ankle and spine cases have been discontinued. The general orthopedic service line will be closed effective April 1, 2003.

He explained in the past 6-12 months 19 of the 21 orthopedic surgeons that were ED call eligible, and under the age of 55, have resigned from the hospital, leaving two ED call eligible orthopedic surgeons. Those two surgeons are expected to resign leaving zero orthopedic surgeons to cover ED calls. In the interest of safety the decision was made to close the orthopedic service line.

The current plan at Desert Springs is for the most of February and March there will be a partial ED call schedule with the orthopedic surgeons. Four orthopedic surgeons have agreed to delay their leave of absence until April 1 and each orthopedic surgeon will be required to take three days of call. This would cover 12 days in February and 31 days in March. There will be days during that time span when there are not any orthopedic surgeons available. The days when the capability or the capacity to safely care for orthopedic patients is not available, the patient will be stabilized in the ED and then transferred to the closest facility that is not on divert that has capability and the capacity. When the ED is staffed with orthopedic surgeons only cases that come through the ED will be scheduled as inpatient. Orthopedic surgeons that have scheduled elective cases prior to February 1 will be allowed to perform those surgeries and those are the physicians that are going to be taking the calls.

It has not yet been determined as to whether this is a permanent closure.

A question was raised, how does this impact transports.

Sandy Young replied, Dr. Reisch mentioned at the last MAB meeting transports would go to Desert Springs as normal, the patient would be evaluated and stabilized then transported to a different facility. There would be no difference in the transport destination.

Chairperson Perez pointed out it is suspected that other hospitals will be in similar situations as Desert Springs as there have been concerns amongst other hospitals that they are unable to fill call schedule with every specialty, every day of the month. She mentioned there is talk about hospitals going to primary care call and eliminating specialist completely. She expects radical changes to take place over the next few months regarding ED call schedules.

III. INFORMATIONAL ITEMS/DISCUSSION ONLY

Chairperson Perez distributed a copy of a Wall Street Journal article entitled “Dark Smallpox Winter”. She asked Dr. Kwalick to give a brief update on the governor’s meeting that occurred last Friday. She mentioned there were questions that were believed would be answered at that meeting which were left unanswered. She pointed out the hospitals have been actively involved in putting together smallpox pre-exposure and post-exposure plans. Hospital leaders are questioning why the plan has not been implemented.

Dr. Kwalick explained the reason the plan has not been implemented is due to several unanswered questions from the hospitals regarding workers compensation and liability issues. He expects those questions will be answered sometime in the near future or the program will not proceed. However, those questions will have to be handled on the federal level. He mentioned the Health District is preparing by identifying staff members who are capable of being vaccinated and will be vaccinated so that when the plan is implemented these people are ready to go to the hospitals to be immunized. He pointed out that the Wall Street Journal article is a summary of something called “Dark Winter” which was an exercise that was done last year taking the worst-case scenario of smallpox occurrence and what could happen to the world. The article also addresses the Union issue.

IV. PUBLIC APPEARANCE/CITIZEN PARTICIPATION

No Participation

V. ADJOURNMENT

As there was no further business, Chairperson Karla Perez called for a motion to adjourn. The motion was seconded and carried unanimously to adjourn at 10:00 a.m.

attachment