

MINUTES
EMERGENCY MEDICAL SERVICES
FACILITIES ADVISORY BOARD
APRIL 23, 2003 – 8:30 A.M.

MEMBERS PRESENT

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

MEMBERS ABSENT

Brook Richardson-Jenkins, Lake Mead Hospital
Jackie Taylor, University Medical Center
Ken Armstrong, Southern Hill Hospital
Sandra Rush, St. Rose Medical Center

ALTERNATES

Sandra Cromwell, St. Rose Medical Center
Connie Clemmons Brown, University Medical Center

CCHD STAFF PRESENT

Jane Shunney, Asst. to the Chief Health Officer	Michael MacQuarrie, EMS Field Representative
Jennifer Carter, Recording Secretary	Rory Chetelat, EMS Manager
Kay Godby, Biopreparedness Planner	

PUBLIC ATTENDANCE

Brian Rogers, SWA	Jim Osti, WestCare
Davette Shea, WestCare	Pam Turner, R.N., Valley Hospital
Flip Homansky, MAB	Steven Kramer, AMR
Jeff Davidson, MAB	Tony Barticello, Desert Spring Hospital

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The EMS Facilities Advisory Board convened at 8:30 a.m. on Wednesday, April 23, 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 February 12, 2003 FAB meeting minutes was made, seconded and unanimously carried.

II. REPORT/DISCUSSION/POSSIBLE ACTION

A. Update of New Protocols

1. Patient Transfer to Receiving Facility (PTRF)

Rory Chetelat, CCHD, EMS Manager, reported a PTRF survey was distributed to all local facilities and transport agencies, requesting feedback on how the PTRF protocol is working. The response received from the survey was minimal during the 45-day timeframe for which the PTRF has been operational. Due to the lack of response to the survey, the assumption would have to be, the protocol has had a positive effect on the system.

2. Legal 2000 Divert Protocol

Rory provided information regarding data sheets that were submitted to the EMS office from local facilities and transport agencies. Of approximately 142 data sheets, six indicated problems with patients who were delivered to hospitals inappropriately. An investigation of those six cases determined that three cases were a matter of the hospitals delay in updating the board on the EMSsystem; and three cases were a matter of the transport agencies failing to verify the EMSsystem status at the hospitals.

B. Discussion of Legal 2000 (L2K) Patients

L2K Patients From Five Patients Per Hospital to a Per Capita Basis

Rory announced the MAB requested that the FAB reflect on different plans for level-loading L2K patients in the community rather than five per facility, in an effort to be considerate of the smaller hospitals.

Chairperson Perez requested statistics on the volumes of L2K patients received by each individual hospital, since the implementation of the L2K Protocol.

In response to the request Rory commented the EMSsystem is the only tool currently available to him for tracking volumes of L2K patients received by each facility. Based on the information uploaded to the EMSsystem by facility staff, all facilities are receiving five L2K patients, virtually all the time. Therefore, in his opinion, the level-loading of L2K patients throughout the valley has been successful. However, Rory mentioned he was asked to voice concerns on behalf of Henderson Fire Department

(HFD) regarding St. Rose Dominican and Siena Campuses. It was brought to his attention that due to smaller emergency departments (ED) the St. Rose Campuses are overburdened with processing five L2K patients per day. Consequently, HFD is requesting consideration of level-loading L2K patients at a number less than five for the smaller hospitals.

Blaine Claypool noted past discussions regarding this issue included the idea of level loading L2K patients on a per capita basis. During the discussions it was determined that calculating a formula for per capita would be unmanageable due to the fact that it is too cumbersome to define the types of ED beds in each facility (i.e., observation unit, fast track, clinical decision unit beds, ED beds, etc.). He recalled a representative from one of the Henderson hospitals mentioning how small their ED was, while that facility has more ED beds than Valley Hospital ED. Therefore, he pointed out, the decision to go with five L2K patients per facility was made because five is easy to manage and maintain both for the facilities and the transport agencies.

Rory commented that when he requested data from the facilities on ED bed counts, he received three phone calls back from different people with same hospital, reporting three different bed counts.

Sandra Cromwell, St. Rose Hospital, represented the St. Rose Hospital campuses. She commented on behalf of Renato Baciarelli and Sandra Rush, St. Rose Hospital's Fast Track Units for the Siena and De Lima Campuses have been converted into the Chest Pain Unit, which has become the overflow area for IMC and ICU. This conversion would allow more beds for inpatients by moving six beds out of the Chest Pain Unit, into the inpatient areas. She mentioned, based on the St. Rose Hospital statistics, they are averaging seven L2Ks, which places a burden on their EDs, which they have 27 ED beds at the Siena Campus and 22 ED beds at the Delima Campuses. Therefore she requested consideration for the L2K level-loading to be changed to three per campus for St. Rose Hospital.

Mr. Claypool commented, carving out EDs to allow for more inpatients, raises suspicions of ED size. He mentioned all facilities have small EDs, which is why the decision was made to level-load five L2Ks between nine hospitals, covering forty-five L2Ks across the valley, and an even distribution to each facility. He further commented that with 2-3 new hospitals opening within the next eighteen months, the current level-loading plan would allow for a level-loading capacity of sixty L2Ks throughout the valley.

Dr. Davidson gave a historical perspective on the L2K patient overload. When the Chronic Public Inebriate (CPI) project gained its momentum in the past six months, the Medical Advisories to the CPI held a meeting. Several directors of emergency departments met with CPI representatives and one of the big issues discussed was the L2K patient over-crowding issue. Data was collected, compiled, and summarized from the past twenty-four months to determine that peak L2K volumes were 40-50 maximum throughout the valley. It was decided, as a baseline for rotation purposes, to take the nine current facilities, divide that into forty-five, arriving at five L2K beds per facility.

He reiterated the point that it is difficult to formulate level-loading of L2K beds based on facility size due to the various ED specialty areas per facility. In an effort to attain a balance, Dr. Davidson continued, the final sum number of fifty L2K patient beds has to be maintained throughout the valley. Therefore, if for example, three facilities drop to three L2K patient beds, three other facilities would have to commit to increasing their bed count to six or seven. He stressed there has to be a minimum 45-50 bed level-load capacity for L2K beds maintained in the city.

He asked the FAB to continue to endorse the current L2K level-loading plan of five beds per facility, and mentioned that he believes the plan would also be supported by the CPI program, West Care and the MAB.

Dr. Davidson commented the Divert Task Force would be discussing the current system of rotation at the May 7 meeting, in an effort to clarify language in the current policy regarding the regions. The Eastside/Westside division has created confusion with the L2K patient circulation, causing some facilities to get inundated, when L2K patient volumes are excessively high. He mentioned, addressing this issue, the West Care developments, opening of new hospital EDs, and continued efforts to improve policies and procedures; attempts are being made to minimize discomforts and to improve the system.

Chairperson Perez submitted, hearing no recommendation for change; the L2K Divert Operations Protocol will stand as it currently is in place.

C. Discussion of Draft Hospital Divert Protocol
Proposed Protocol to Alleviate Long Drop Times

Rory presented two draft operations protocols; Patient Transfer to Receiving Facility (PTRF), and Hospital Divert Policy (HDP).

DRAFT	OPERATIONS PROTOCOL
PATIENT TRANSFER TO RECEIVING FACILITY	
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 <u>ambulatory</u> 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.	<u>EMS personnel will wait 15 minutes to transfer the patient to hospital care.</u>
B.	<u>After 15 minutes, the patient will be moved to the triage area or waiting room and a completed patient care report will be left with hospital staff.</u>

OPERATIONS PROTOCOL
DRAFT
HOSPITAL DIVERT POLICY
PURPOSE: To establish a protocol to divert ambulances from Emergency Departments that are overcrowded and to level load the system with patients.
PROCEDURE: This procedure is to be followed when EMS personnel arrive at a receiving facility.
I. Upon arrival, EMS personnel will make contact with the charge nurse/triage nurse to determine an estimated wait time for transfer of the patient to the emergency department. When wait time reaches <i>15 minutes</i> and it does not appear that the patient transfer will happen within the next <i>15 minutes</i> then:
II. EMS personnel will advise their dispatch center they will be waiting and the number of ambulances in a holding status at that facility.
C. Ambulance will notify their dispatch center when leaving to update the hospitals' current wait status.
III. Southwest Ambulance will update the EMSsystem of the hospitals within their region as to the number of ambulances waiting.
IV. American Medical Response will update the EMSsystem of the hospitals within their region as to the number of ambulances waiting.
V. Ambulances will check the status of the EMSsystem prior to transporting to the hospital.
A. If the status of the hospital is <i>3 to 5</i> waiting the patient should be advised and every effort should be made to select the next available hospital with less than <i>3</i> ambulances waiting.
B. If the status of the hospital is greater than <i>5</i> waiting the hospital will be closed to ambulance traffic until ambulances waiting reaches <i>5</i> or less.

He asked, on behalf of the MAB, to have FAB committee members consider the recommended changes to the operations protocols.

On the PTRF Draft Operations Protocol, suggested new language is italicized and underlined. Rory suggested the original language which read "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" be changed to the new language reflected on the draft PTRF. He explained that the time taken by transport personnel to monitor ambulatory patients is prohibiting transport agencies from having appropriate resources for responding to 911 calls. He stressed, patients with no IV's, intubations, EKG monitoring, medication administration, or other invasive techniques, should be removed from the gurney and placed into a triage area or waiting room, freeing up the ambulances to get back on the street. He pointed out the mission of EMS transport is to be ready for the next call. Therefore, Rory recommended a 15-minute time limit for transfer of ambulatory patients from EMS personnel to hospital care.

Rory mentioned he received data from the transport agencies, which indicated 25-30 percent (approximately 2000 patients per month) of the patients transported meet the ambulatory patient criteria. He referred to the "Comparative Drop Time Data" handout. According to the data reported by AMR and SWA, drop times have increased, and the implementation of the PTRF and the Legal 2000 Divert protocols have not contributed to decreasing drop times.

Facility representatives were concerned with the accuracy of the data presented, as they recognized the low "total patient counts" were inconsistent with their records.

Rory explained the data was received from AMR and SWA. AMR reported seven weeks of data and SWA reported two months of data. Nevertheless, Rory commented, statistically the numbers presented are large enough volumes to represent average drop times.

A suggestion was made to have patient count reports, broken down in categories of high acuity, medium acuity, and low acuity, submitted from each facility, to the EMS office.

Chairperson Perez asked the transport agencies if drop times were different between hospitals with protocols for triaging patients back into the lobby versus hospitals that do not have such protocols.

Brian Rogers, SWA, replied, there is absolutely a 100% difference. He mentioned triage nurses at hospitals where the protocol is operational, have appropriately instructed him to remove IVs from ambulatory patients, and those patients were transferred to the waiting area.

Chairperson Perez then requested disclosure of those hospitals, which do not have protocols in place for triaging patients back into the waiting area, in an effort to compare drop time averages.

Pam Turner, Valley Hospital, reported it was understood, at the Nurse Managers meeting, that all hospitals were supportive of triaging ambulatory patients, who meet the criteria, back into the waiting areas. Therefore, she stated if there is lack of support in this area, it is imperative that the respective nurse manager is notified. She suggested the nurse managers prepare a guideline for standardizing the process of triaging patients that would be submitted to each facility.

A motion was made to have the Clark County Nurse Managers group develop and distribute a standard guideline, designed for transfer of care of ambulatory patients, for all local facilities. The motion was seconded and passed unanimously.

Agency providers reiterated there has been a rapid increase in drop times within the past month, causing major problems, as they are unable to respond to 911 calls.

Facility representatives questioned whether adequate communication efforts were being applied effectively with hospital administrators.

The agency providers stressed concerns that while the efforts are being made to communicate with the hospital administrators, and the hospital administrators have been very helpful, resolving patient backlog issues in the EDs, the agency providers try to maintain a positive working relationship with the ED staff. Calling the CEOs and COOs of the hospitals, jeopardizes those working relationships.

Agency providers were encouraged to notify hospital CEOs and COOs in the event of patient backlog in the EDs, when ED staff are unable to efficiently move the patients off the gurnies and allow ambulance providers to get back into rotation. Blaine Claypool commented that the agencies and/or the nurse managers should not feel threatened by having the hospital CEO or COO called to the ED for help. He further commented that on occasion the backlog in the ED could be caused from a delayed flow upstairs, in which case the CEO/COO would have to intervene.

Brian Rogers asked the board to consider the possibility of having ED staff assign ancillary personnel the task of monitoring L2K patients, in an effort to relieve ambulance providers of extensive wait times.

Chairperson Perez reaffirmed the motion of having the CCHD Nurse Managers group develop a standard guideline for triaging ambulatory patients. She asked the nurse managers to also consider L2K patients in the process.

In reference to the draft Hospital Divert Policy, Rory pointed out that local facilities have provided positive feedback regarding the current level-loading plan for L2K patients. However, there was a recent incident where Sunrise Hospital had eighteen ambulances waiting outside their door at which time there were hospitals with virtually no ambulances waiting.

Chairperson Perez requested clarification of section V-B on the Draft HDP, which read "If the status of the hospital is greater than 5 waiting the hospital will be closed to ambulance traffic until ambulances waiting reaches 5 or less." She asked what happens if all facilities have 5 ambulances waiting.

Rory explained the number 5 is nebulous and is open for discussion. However, whatever that number is determined to be, and all hospitals reach that level, he suggested forcing all hospitals open.

Blaine Claypool voiced concerns that a lot of effort went into eliminating divert in the past 2 ½ years and the Draft HDP is very similar to super divert. He said he is fearful the divert system that took so much effort to eliminate, is going to be recreated. He suggested having the Divert Task Force consider total elimination of closure, or elimination of the regions and allow one hospital in the valley to close for an hour at a time. He feels these are good plans for level-loading the system. He pointed out, ED closures cause the EDs that remain open to become overburdened.

Rory mentioned the Draft HDP is only one idea. He said he is open to other ideas, but something has to be done to avoid ambulances backing up at hospitals.

Rory announced in an effort to improve EMS communications, EMS office staff is working to organize a task force of qualified individuals to develop a system-wide means of communication, possibly a base station or something through the FAO.

A motion was made to have the Divert Committee consider alternatives to the Hospital Divert Policy, including the elimination of regions and allowing only one hospital in the valley to close at a time. The motion was seconded and passed unanimously.

Mr. Claypool announced he will be relocating to Seattle Washington the end of July 2003. The COO is retiring at the hospital he worked formerly, and Mr. Claypool has accepted the position.

Chairperson Perez commented a new MAB representative would be appointed to the FAB and she encouraged anyone interested serving in that role to notify her. She mentioned the appointment of the new MAB representative would be an agenda item for the next FAB meeting.

III. INFORMATIONAL ITEMS/DISCUSSION ONLY

A. Update on the Community Triage Center (CTC)

Davette Shea, WestCare Consultant, passed out a copy of the ED in-service that she would be conducting with each of the facility departments. She mentioned the purpose of the in-service is to provide updates and awareness of what the CTC is able to do at this point. She referenced the last

page of the in-service packet, which was an algorithm that pointed out how a client is processed through the CTC from “Point Of Entry” through “Appropriate Disposition”. She explained the individuals that are processed by CTC are clients who need alcohol and substance abuse detoxification, mental health evaluations that include those who are not on a Legal 2000 (L2K) form, and those requiring further evaluation after L2K has been removed. She reported the CTC has updated their medical staff with three physicians and a psychiatrist in addition to physician extenders and providers to handle some of the medical assessments. She handed out a brochure outlining the WestCare services for children and adults.

Jim Osti, Vice President of the CTC for WestCare, reported a two-prong approach has been taken to reduce the number of individuals in the EDs. One is a confirmed transport from the facility to the CTC. That started in February with the CTC’s 24 hour 7 day per week transport system. In March the CTC had 49 confirmed transports from local hospitals. Estimates for April are approximately 90 individuals transported from local hospitals. The second prong is to increase the number of diversions that happen before the individuals ever get to the EDs. That is measured by looking at total admissions to the CTC.

Chairperson Perez pointed out dollars were allocated for the CTC program through government of federal and state funding, and part of the issue that is now being challenged is the government funding. While they have appropriated the dollars and committed to funding the CTC, they are not releasing those dollars until the hospitals make commitments to participate. She encouraged hospital executives to support the funding efforts of the CTC. She mentioned some of the hospitals are reluctant to do so until other hospitals have made a commitment. She stressed the importance of the support from all hospitals, as this funding will determine the success of the CTC program.

B. Update on Smallpox Education

Smallpox Training for Hospital Personnel

Kaye Godby, RN, CCHD Biopreparedness Planner, announced she received an update from USA Today that Los Angeles (LA) County is announcing the start of their second round of smallpox vaccination, despite the weak response. LA County plans to start vaccinating their fire fighters, policeman, and emergency workers.

Kaye gave an overview of a smallpox vaccination incident with an RN from Texas who arrived in Desert Springs Hospital ED, April 5. The RN was vaccinated on March 25. When she left Texas she had lesions on her right deltoid in addition to the vaccination site on her left deltoid. She consulted with the Health District on the morning of April 4th prior to leaving Texas to see if it was all right to leave. She was instructed by the Health District to go to the nearest ED and request Vaccinia Immune Globulin (VIG), if she obtained additional lesions. The nurse arrived at Desert Springs Hospital at 12:20a.m. April 5 and complained of a reddened, itchy, non draining lesion on her arm, back, abdomen, torso, face and neck, and she requested VIG. She had approximately 30 lesions all over her body. She was immediately placed in isolation. All hospital staff members wore total Personal Protective Equipment. The vaccination site was oozing and covered with a dressing. The Health District Epidemiologists were notified five minutes later. The staff was not sure what to do. Desert Springs Hospital staff remained calm. They did an excellent job with the limited knowledge they had. The Health District Epidemiologists and Dr. Kwalick made connection with the doctor at Desert Springs, and they connected with the CDC clinician hotline and the State of Epidemiologists. The RN was discharged with a diagnosis of Vaccinia and released three hours later with all of her sites bandaged, and she took a plane back to Texas.

This incident has demonstrated the importance of adverse events treatment education in the community, Kaye mentioned. The Health District's role is to fill the educational need of the community hospitals and essentially provide training on the adverse events treatment that is needed.

Beginning April 28, 2003, the Health District is sponsoring a one-hour educational presentation on smallpox plan efforts, Kaye announced. The presentation will include the stringent contraindications through the smallpox vaccination, the adverse effects of the immunization (with pictures), and a discussion of the treatment that needs to be rendered. Instructions will be given on reporting mechanisms that are required by the Health District. There will also be a brief session on the information available at the CDC clinician hotline, which may be accessed by physicians. A five-page adverse events algorithm, which points out different indications of what needs to be done in different events, will be provided. The target audience for this presentation is the morning and midnight shift ED staff including staff nurses, charge nurses, house supervisors and any physicians that are available. She mentioned six hospitals have signed up for the presentation, there are three hospitals pending, and one hospital has declined to sign up.

Kaye gave an update on the April 18, 2003, Morbidity and Mortality Weekly Report. Currently there are 54 jurisdictions giving the smallpox vaccine. This accounts for about 33,000 civilian health care and public health workers as of April 13th. Nevada is the last state in the union to give the vaccine. The case at Desert Springs is the one and only generalized vaccinia case that has been reported so far. As of April 13 a total of 10 cases of mioparycarditis have been reported and seven cases have added inadvertent inoculation.

Dr. Kwalick commented on the Poison Control Hotline. He mentioned approximately four years ago the Health District took on the Poison Control Hotline from Sunrise Hospital. The cost of that hotline is going up to \$175,000 beginning July 1, 2003 and the District's budget will not be able to support the expense. He proposed, \$175,000 split between nine-eleven hospitals for the cost of the hotline, which is a valuable resource to the community, would be more manageable. He stated the Health District is in the tightest budget in the history of the Health District.

IV. PUBLIC APPEARANCE/CITIZEN PARTICIPATION

No response.

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 10:02 a.m.