CLARK COUNTY HEALTH DISTRICT

MINUTES

EMERGENCY MEDICAL SERVICES

FACILITIES ADVISORY BOARD

March 10, 2004--8:30 A.M.

MEMBERS PRESENT

Karla Perez, Chairman, Spring Valley Hospital
Donald Kwalick, M.D., Chief Health Officer, CCHD
Craig Preston, Lake Mead Hospital
Suzanne Cram, Sunrise Hospital
Vicky Van Meetren, St. Rose Dominican Hospital
Jennifer Schomburg, Summerlin Hospital
Jacqueline Taylor, University Medical Center
Mary Jo Solon, Southern Hills Hospital
Tad Morley, MountainView Hospital
Sam Kaufman, Desert Springs Hospital
Gregory Boyer, Valley Hospital
David Rosin, M.D., SNAMHS

MEMBERS ABSENT

Kim Crandell, Boulder City Hospital
Jeff Davidson, M.D., MAB Representative
Ingrid Whipple, Montevista Hospital

CCHD STAFF PRESENT

Rory Chetelat, EMS Manager
Jane Shunney, R.N., Asst. to the Chief Health Officer
Jim Osti, Grant Writer
Mary Ellen Britt, R.N., QI Coordinator
Rae Pettie, Recording Secretary
Shannon Randolph

PUBLIC ATTENDANCE

Natalie Seaber, R.N.
Pete Carlo, EMT-P
Davette Shea, R.N.
Jay Craddock, EMT-P
Roy Carroll
Pam Turner, R.N.
Pilar Weiss
E.P. Homansky, M.D.
Tim Crowley, EMT-P
Randy Howell, EMT-P
Lisa Jones
Derek Cox, EMT-P
Sheryl Giordano, R.N.
Tim McAndrew

I. CONSENT AGENDA

The Facilities Advisory Board convened in the Clemens Room of the Ravenholt Public Health Center on Wednesday, March 10, 2004. Chairman Karla Perez called the meeting to order at 8:33 a.m. and the Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law. Ms. Perez noted that a quorum was present.

Minutes Facilities Advisory Board Meeting September 29, 2003

Chairman Perez asked for approval of the minutes of the September 29, 2003 meeting. A motion was made, seconded and passed to approve the minutes as written.

II. REPORT/DISCUSSION/POSSIBLE ACTION

A. Discussion of Trauma System Analysis

Rory Chetelat stated that the Abaris Group has contracted with the American College of Surgeons (ACS) to help define what a trauma system should look like in Clark County. The Abaris Group completed the pre-review questionnaire, and it was sent to ACS. The ACS has scheduled a site visit for April 18-21. A recommendation will be sent to the State for their review and endorsement.

B. Blue Ribbon Committee Update

Suzanne Cram reported that the Blue Ribbon Committee was tasked with three objectives:

1) Review and seek to improve the voluntary reporting system;
2) Discuss and recommend the pros and cons of a mandatory reporting system; and
3) Review community resources that are available to these patients, and how the hospital ERs will best utilize them.

Ms. Cram asked Jim Osti, Grant Writer for Clark County Health District (CCHD), to give a report on his project. Mr. Osti stated there is a parallel study of data that has been submitted by the hospitals to CCHD on an ongoing basis. That data will be compared to a three-month snapshot, October through December 2003, using a more specific data collection method. The original data collection asked for raw numbers from each of the hospitals. In the three-month snapshot CCHD asked for actual information about individual clients, including their length of stay, with CCHD doing the calculations. Seven of the hospitals who agreed to participate in the psychiatric patient data collection project have submitted data for a three-month period. Five hospitals have submitted good data and two have submitted partial data, and preliminary trends are already apparent. Some of the hospitals have agreed to continue to use the data collection methods implemented for the three-month snapshot on an ongoing basis. The creation of a set of standard definitions has been a great help in the data collection process, e.g. information about the disposition of individuals out in the community, and the status of individuals in the emergency departments. Mr. Osti stated that there is a much stronger sense now of what's happening in the EDs, although we still don't know exactly what's happening in the actual hospital beds in the community. Chairman Perez encouraged those hospitals that have not yet submitted their data to make sure the data gets submitted so the study can be completed.

Mr. Osti reported that the Las Vegas City Council is scheduled to meet on March 17th to vote on whether or not we would get a psychiatric facility in the city of Las Vegas. The proposed 150-bed state psychiatric hospital will be built on the corner of Jones and Oakey. It will positively impact some of the problems we've had by increasing the capacity of our community to handle the Legal 2000 (L2K) patients. Dr. Kwalick stated that the property has been state-owned since the late 1960's, so there have been mental health services on that property for some time. He added that most people won't argue the point that we need additional mental health beds in southern Nevada, but it is important to show community support for this project. Dr. E.P. Homansky asked whether someone had been tasked with

coordinating the speakers to best represent the EMS community and hospital community at the hearing. Dr. Kwalick stated that the Health District will work on the development of a program to present to the Las Vegas City Council to address the pertinent issues without being repetitious. Chairman Perez stated that Bill Welch from the Nevada Hospital Association was planning to make a statement. She suggested that the Health District contact Mr. Welch to coordinate their efforts.

Ms. Cram reported that the committee's second objective was to look at the data collected, determine if it is meaningful, and decide whether to endorse a mandatory reporting system. She stated that the committee will make a decision following the collection of all the necessary data.

Ms. Cram reported that the third objective was to put together a document using the 2004 Nevada Hospital Association (NHA) listing of resources, and to research the difference between northern and southern Nevada with regard to psychiatric beds per population to determine if the city of Las Vegas is under-served. Mr. Osti stated that it will be helpful to have data on total psychiatric beds in our community to use as a comparison to other communities. With the cooperation of the NHA, Mr. Osti conducted a telephone survey to identify both the adult and adolescent beds in the state of Nevada. He has created a spreadsheet that compares northern and southern Nevada's number of psychiatric beds per population of 100,000. He then researched the national data rate published by the Substance Abuse Mental Health Services Administration. The last data they were able to give Mr. Osti was from 1998 which suggested that the national average for psychiatric beds in a community is 97.4 beds per population of 100,000. The comprehensive view shows an actual severe shortage of psychiatric beds in our community. Mr. Osti stated he is currently studying one community on the east coast that is approximately the size of the city of Las Vegas. Williamsburg, Virginia has a population of 1.7 million. He will report back with his findings from the comparison study of the two communities. In his opinion, Las Vegas will not fare well. Craig Preston, CEO at Lake Mead Hospital, asked Mr. Osti whether there are differences when comparing the west coast versus the east coast. Mr. Osti replied that the west coast definitely has a lower bed per population average than the east coast. And unfortunately, Nevada is lower than all of its surrounding states. Ms. Cram noted that the Blue Ribbon Committee members comprise of UNLV staff, Department of Social Services, and the Community Urban Partnership Board. These entities are eliciting help from outside resources in an effort to assist our community. They are also preparing a document they say will be done in May which will list all the possibilities. At that time Ms. Cram will bring the document back to the FAB to give a final report.

C. Internal Disaster / E.D. Closure Protocol

Mr. Chetelat reported that in December 2003 virtually every hospital in the Las Vegas valley declared internal disaster (ID) at least once. He explained that when a hospital declares ID, it ultimately culminates into an external disaster on EMS by creating a "ripple effect" that impacts the entire system as a whole.

Mr. Chetelat stated that although he appreciates the concerns faced by the hospitals, his primary concern is the inability of transport units to respond to the next 911 call. He explained that unlike the hospitals, EMS doesn't have an outlet. They can't put 911 on hold. There are a limited number of resources and the phone calls keep coming in. He stated that in past meetings that took place in 2002, both the FAB and MAB agreed to arrive at a definition as to what constitutes an ID. The language discussed previously included fire, flood, terrorist act, and power or computer system failure. He stated that the definition included specific language that excluded patient overload as a reason to declare ID. However, it is his sense that patient overload is the reason some hospitals are declaring ID. Mr. Chetelat related that one of the problems is that oftentimes a hospital ED is closed, but only to EMS patients. He has

received reports that the hospital is still receiving inter-facility transfers and walk-ins during an ID. Vicky Van Meetren, representing St. Rose Dominican Hospital, stated that EMTALA rules require that the hospital must receive inter-facility transfers. She stated that her facility does everything in their power not to shut the door. However, liability issues need to be taken into account. Mr. Chetelat stated that the same liability occurs when EMS is forced to drive past one facility to go to another facility 15-20 minutes further, with a critical patient in the back of an ambulance.

Mr. Crowley gave an example of how the "ripple effect" described by Mr. Chetelat affects the system as a whole. He received a call the prior weekend that there was a motor vehicle accident in the northwest side of the valley and that every rescue unit in that area was tied up at a hospital. He noted that rescue units not only transport, they also carry extrication equipment. When there are no rescue units in the area able to respond, the response must come from somewhere else, and the responding unit may not have the capability to transport or extricate the trapped victims.

Sam Kaufman, COO at Desert Springs Hospital, asked how often valley hospitals go on ID. Chairman Perez stated they went on ID a total of 15 hours in February. Rory stated that the three-month total was 55 hours for the entire valley from December 2003 through February 2004. Mr. Kaufman stated that studying the statistics could be very important in determining trends and identifying which hospitals most often declare ID so they can work on their internal policies and procedures. He stated that due to the differences in size and staff, it will be difficult to standardize what an ID is at an individual hospital. Chairman Perez suggested that if you do not have the capacity or the capability to safety provide additional patient care then you should be able to go on an ID if you can meet that standard. She agreed that there should be some process definition. A facility shouldn't be scheduling elective surgeries and direct elective admissions when their ER is backed up and they're holding patients. She stated that you can't prevent the additional emergencies from walking in, and in some cases, you can't prevent the transfers. If a hospital that doesn't provide a service needs to transfer a patient to a hospital that does, EMTALA says they have to accept that patient if they have the capacity and the capability.

Mr. Chetelat explained that he does not want to dictate that a facility should never go on ID, but at the same time, there is a disparity in the way different hospitals are choosing to go on ID. He asked for help and cooperation from the facilities to arrive at a definition for ID so that everybody is playing on a level playing field.

Tad Morley, COO at MountainView Hospital, asked whether we are effectively using the two new hospitals in the valley. Chairman Perez stated that Spring Valley Hospital currently has 26 holds in the ER, which is effective. Mr. Chetelat stated that Southern Hills Hospital has not had to close their doors since they've opened for business. In addition, Valley Hospital has additionally increased their capacity by 20-plus beds. He stated that although we're adding capacity, some of that capacity is further away, which makes it difficult to level load the system.

Jackie Taylor commented that UMC is getting a huge amount of transfers from the other facilities because of the lack of on-call physicians in particular specialties. Ms. Van Meetren asked whether more than one facility has declared ID at the same time. Mr. Chetelat replied that has not yet happened although there have been some threats. Ms. Van Meetren commented that the hospital administrators know each other well enough to communicate and discuss their issues cooperatively. Chairman Perez agreed that certain IDs can be prevented through mutual cooperation by the facilities.

Rory Chetelat reiterated discussion that took place at the last MAB and Divert Task Force meetings. He stated that the Health District would like to be used as a conduit, and asked that the hospitals contact

either Dr. Joseph Heck or himself prior to declaring ID. They will act as a sort of gatekeeper to make the decision on whether EMSystem will be allowed to recognize the closure. In this way, the Health District will be kept in the loop as to what events are transpiring as they relate to EMS. Ms. Van Meetren stated that if the Health District is going to have the final word on whether or not to recognize a hospital's declaration of ID, they're sharing some of the liability. Mr. Chetelat responded that the liability is already shared by having to bypass a hospital on ID and drive further with a patient in the back of an ambulance. The same liability exists when EMS can't answer the next 911 call, or the next available ambulance is now 20 minutes out of position instead of 8 minutes out of position as a result. He noted that there is a shared liability on both sides.

Pete Carlo, Clinical Director for Southwest Ambulance, suggested researching federal or state law for an already written definition of ID. Chairman Perez stated she is not aware of any federal law that actually defines ID. Rather, it is more along the lines for the implementation of policies and action plans to define what a hospital is going to do during an ID.

Mr. Morley stated that the definition ID would need to include life safety issues. He commented that the fire department made several visits to his facility over the past few weeks and advised them that they can't hold patients in their hallways. Although the fire department has been very cooperative in understanding the hospital's plight, there is delivery of clinical care and life safety issues that must be taken into consideration. Mr. Chetelat stated that he commends the hospitals' efforts.

Mr. Crowley stated that the Fire Marshall in the Fire Prevention Division is in charge of building safety. Upon visiting MountainView Hospital, concern was expressed as to the egress in the ER. If the facility needed to be evacuated in a rapid manner, people would not be able to egress the hospital. It is detrimental to have patients on both sides of the hallway. Natalie Seaber, ER Director at MountainView, stated the fire department has visited her facility on three separate occasions. She thought a compromise was reached, but after meeting with administration the policy it is still unclear. Mr. Morley noted there is legitimate concern about life safety and egress on both sides. But the reality is, if EMS has no alternative but to bring patients to them and leave, the hallway is the only place that patient can go. And if patient safety or physical facility limitations don't qualify for an ID, then the hospitals are in real trouble. Mr. Crowley stated that the current Fire Marshall is Chief Ken Riddle. Also the Director of the International Association of Fire Chiefs EMS Committee, Chief Riddle has been involved in EMS for many years and is not insensitive to what goes on in the hospitals. He stated that Chief Riddle would be willing to meet with the hospitals and work with them to address the issues of egress.

Davette Shea, Director of Southern Hills Hospital, stated that from the EMS side, this is a resource issue. She commented that it's a waste of resources to have the ambulance services take mental health patients to the hospital. She stated that she will continue to discuss these transport issues with Southwest Ambulance, AMR, and Southern Nevada Adult Mental Health in an effort to free up transport units. Ms. Shea described Y2K (New Year's 2000) as a successful event where there was collaboration throughout the community in creating the MASH units on the strip. Low acuity patients were taken to off-site centers versus transported to an acute care facility. Ms. Shea stated she is in favor of pursuing the creation of transport and destination policies for low acuity patients in the community. The process would require collaboration among on-scene paramedics to make the decision to transport low acuity patients to a destination other than an acute facility, especially while a hospital is experiencing ID. She suggested that the committee once again look at alternate methods for the care and transport of these patients.

Ms. Cram asked Ms. Shea to submit a written proposal to the Blue Ribbon Task Force on alternate means of transportation for mental health and low acuity patients. If well received, the proposal will be brought back to the FAB for further discussion. Ms. Shea stated she will research the feasibility and legal aspects with regard to the current regulatory processes in place.

Chairman Perez stated that Ms. Cram will draft a definition of ID, along with a protocol that outlines the process, and send it out to the committee members for review prior to their next meeting.

Mr. Chetelat gave a report on the proposed 90-day trial of no closure for the hospitals. He stated that other communities have successfully eliminated the divert process. As frightening as it sounds, the bottom line is it doesn't make sense to bypass one hospital to go stand in line at another hospital that's in the same shape as the one bypassed. Mr. Chetelat reported that patient offload times have increased from 55-60 minutes in the 90th percentile in 2002, to approximately 75 minutes in the 90th percentile today. The average drop time has increased from 35 minutes to 45 minutes. He apologized to the committee for not having the statistics available for their review, but promised to provide them with the data prior to the next meeting.

Chairman Perez stated that she is in favor of the 90-day trial. The elimination of closure may help to level load the system rather than receiving a bolus of patients all at once. It may make it easier for the hospitals to manage patients if they are more evenly distributed. She asked that the tentative start date of March 15th be changed to April 1st to give the committee enough time to define ID so that it is not used in place of divert. Mr. Kaufman stated that he too is in favor of eliminating the divert process. He related that his company owns facilities in California who have done so with positive results. Ms. Cram also agreed that it was worth a try.

Mr. Morley stated he would like to review the transport data rather than jumping to the conclusion that the increased wait times are a direct result of being on divert. Mr. Chetelat stated that he is not exactly sure the long wait times are due to divert, and again agreed to submit the data for their review. Rory stated that the MAB voted in favor of eliminating the divert process, with one member opposed.

Jackie Taylor noted that she was not in favor of the regional system from the start. Her feeling is that the ambulance companies may need to purchase more transport vehicles to support the growing population. Roy Carroll, Operations Manager for AMR, commented that they continue to add resources to meet the increasing growth volume in the community. He stated that he agrees that additional resources would be needed if at any given point all their resources are in use running calls and treating patients out in the field, and they didn't have additional resources to run calls. However, the situation they find themselves in is they have 40-50 ambulances on the road and at any given time 20-25 of them are tied up in the ER watching patients. He stated that that doesn't tell him he needs more ambulances on the road, but rather they need more people watching patients in the ERs.

Mr. Morley stated it is important to come up with a way to define success during the 90-day trial. He suggested we develop criteria to measure success on both the EMS and hospital side. Mr. Chetelat related that the nurse managers agreed to come up with some sort of measurement from their perspective. He anticipates that things will get worse before they get better due to the initial shock factor.

The committee asked Mr. Chetelat to expand on the Health District's role of being the gatekeeper and having the final say on whether or not their declaration of ID will be recognized by EMS. Mr. Chetelat stated that the role of gatekeeper is primarily to ensure that the hospital has initiated their ID policy in

accordance with the agreed upon definition of ID. He would also like to have a reporting process that can be monitored by the FAB. Mr. Chetelat stated that although he has no authority over the hospitals, he wants to be involved in the decision process because it ultimately involves EMS.

Lisa Jones, from the State Health Division Bureau of Licensure & Certification (BLC), stated that the regulation requires facilities to establish policies and procedures for both internal and external disaster. She initially stated that there is a reporting requirement, but later retracted that statement and noted that the reporting requirement actually relates to emergencies where a facility goes over their licensed bed capacity.

Dr. Kwalick suggested that we set up a system whereby all ID incidents would retrospectively go before a QI committee made up of EMS, BLC, FAB and/or MAB members for review. The meeting will be strictly for the purpose of education rather than as a punitive measure.

Natalie Seaber suggested that a study be done that looks at how Las Vegas compares with other states in the U.S. with regards to volume and growth issues. It would give us a better indication of whether we are appropriately utilizing our resources, and tell us whether we are where we should be.

Pam Turner, ED Nurse Manager at Valley Hospital, clarified that the rotation of mental health patients will continue with the elimination of the divert process. Mr. Chetelat confirmed that this was correct. Jackie Taylor asked whether pediatric divert was discussed at the MAB meeting. Rory stated that it was not, but they would probably continue to work that out between themselves to level load the system.

Jim Osti reminded the FAB that there is already a low level acuity divert in place with the endorsement of the Chronic Public Inebriate protocol. Currently, about 50 individuals a month are being diverted from the field directly to WestCare. To his knowledge there have been no problems. He reported that WestCare recently announced that they are able to accept children who are transported to their facility, so there are some services that EMS may not be utilizing to capacity at this time.

Chairman Perez scheduled the next meeting for Wednesday, March 24th, and recommended that the date for the elimination of hospital closure be delayed until at least April 1st, to allow the FAB to review the data and arrive at an agreed upon definition of what constitutes an internal disaster.

D. <u>EMSystem Equipment Hand-Off</u>

Battalion Chief Tim Crowley stated he works under Chief Mike Myers, in charge of EMS Operations for LVFR. He explained that the State Hospital Association (SHA) has taken over the nuts and bolts of the software work with the EMSystem, which is managed through a partnership with EMSystem back east. LVFR would like to transfer the fixed assets over to each hospital. This will allow each of the facilities to be able to fix or move their computers and plasma screens when necessary. Chief Crowley stated he was unable to find an existing form that will appropriately allow him to hand the assets off to each hospital. He requested that the hospitals supply him with the serial numbers off all CPUs, monitors, and plasma screens to facilitate the process. In return, an official form will be sent from the city to transfer all assets to the hospitals.

E. <u>800 MHz Radio Commitment – Mike Myers</u>

Mike Myers, Assistant Chief over the Medical Services Division for Las Vegas Fire & Rescue (LVFR) stated that in an effort to solve some of the communication problems experienced over the past few

years, the City of Las Vegas has taken corrective steps in order to enhance the radio communications between EMS and the hospitals. Chief Myers reported that LVFR is now offering to link the Premier Radio System used here in Southern Nevada with the hospitals in a project titled the 800MHz EMS Project. The project links hospitals with the private ambulance companies and field fire department units. The primary goal is to open up communication with all hospitals using one radio channel in the ED, and in the command center if desirable. Chief Myers explained how the project will allow for real time, one-on-one communication directly from the scene, which will allow for status and planning updates to be communicated. This will consequently solve many problems encountered in past exercises. He is hopeful the system will be functional and can be tested at the next Trojan Horse Exercise in August.

Currently, field hospital units need to contact a hospital for physician's orders, which is accomplished by contacting EMS control or dispatch, who in turn links them to the hospital. Chief Myers stated that the project will allow field units to directly contact a hospital without going through EMS dispatch. In addition, it will link the private ambulance companies to fire department units, an operability that hadn't existed in the past.

Chief Myers stated that the City of Las Vegas was able to purchase the units through federal grant funding. The 800MHz radios will be paid for by license agreement with the Southern Nevada Area Communications Council, and includes hospital installation. The only cost to the hospitals is a $189/year user agreement to house the radio. If the radio is lost or broken, the facility is responsible for the replacement cost. Chief Myers asked for approval and support from the hospitals to move forward with the 800MHz project. A six-month pilot study will be conducted to ensure the system is appropriate and functional. He stated that the memorandums of understanding and secondary user agreements have been prepared to meet the aggressive timelines. Vicky Van Meetren made a motion to approve the 800MHz EMS Project. The motion was seconded and approved unanimously by the committee.

II. INFORMATIONAL ITEMS/DISCUSSION ONLY

None

III. PUBLIC APPEARANCE/CITIZEN PARTICIPATION

No response

IV. ADJOURNMENT

There being no further business, Chairman Perez adjourned the meeting at 10:08 a.m.