CLARK COUNTY HEALTH DISTRICT

MINUTES

EMERGENCY MEDICAL SERVICES

FACILITIES ADVISORY BOARD

March 24, 2004—8:30 A.M.

MEMBERS PRESENT

Karla Perez, Chairman, Spring Valley Hospital
Donald Kwalick, M.D., Chief Health Officer, CCHD
Cory Countryman, Lake Mead Hospital
Suzanne Cram, Sunrise Hospital
Jennifer Schomburg, Summerlin Hospital
Jacqueline Taylor, University Medical Center
Mary Jo Solon, Southern Hills Hospital
Sam Kaufman, Desert Springs Hospital
Pam Turner, Valley Hospital

MEMBERS ABSENT

Kim Crandell, Boulder City Hospital
Renato Baciarelli, St. Rose Dominican Hospital
Jeff Davidson, M.D., Valley Hospital
David Rosin, M.D., SNAMHS
Helen Vos, R.N., MountainView Hospital
Ingrid Whipple, Montevista

CCHD STAFF PRESENT

Rory Chetelat, EMS Manager
Rae Pettie, Program/Project Coordinator
Jane Shunney, R.N., Asst. to the Chief Health Officer
Moana Hanawahine-Yamamoto, Recording Secretary
Jim Osti, Grant Writer
Mary Ellen Britt, R.N., QI Coordinator
Trish Beckwith, Field Representative
Shannon Randolph, Administrative Assistant
Eddie Tajima, Administrative Assistant

I. CONSENT AGENDA

The Facilities Advisory Board convened in the Clemens Room of the Ravenholt Public Health Center on Wednesday, March 24, 2004. Chairman Karla Perez called the meeting to order at 8:37 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 March 10, 2004

Chairman Perez asked for approval of the minutes of the March 10, 2004 meeting. A motion was made, seconded and passed to approve the minutes as written.

II. REPORT/DISCUSSION/POSSIBLE ACTION

A. Medical Clearance Forms
Suzanne Cram reported that a medical clearance form was developed by members of Sunrise staff and Judge Voy in an effort to decrease the number of mental health patients going through the

court system. The system is increasingly overloaded because once the 72-hour hold expires the hospitals are required to go to court to request an extension to hold this subset of patients.

The medical clearance form relates to the voluntary admission of an allegedly mentally ill person who the physician believes presents a clear and present danger of harm to him/herself based on specific behaviors noted on the form. One concern is that if the patient decides not to stay but presents a clear and present danger of harm to him/herself, then the hospital will still be required to form, and hold him/her.

Another concern is the way these patients are being counted on the EMSystem and its effect on hospital rotation as well as inconsistency in the reporting methods used from hospital to hospital. Presently, only Legal 2000s are being counted in the system but there are far more voluntary patients who are taking up hospital beds and resources that are not formally counted.

Pam Turner reported that many physicians at Valley Hospital are not using the medical clearance form because they are not comfortable with the language. This appears to be the consensus of physicians at other hospitals as well.

Rory Chetelat suggested that the committee agree on the definition of a mental health patient because an unclear definition contributes to inaccurate reporting. Ms. Cram recommended that they designate the Divert Task Force to agree upon a definition. Mr. Chetelat advised the committee that he would invite Jim Osti to attend that meeting. His data collection regarding Legal 2000s and voluntary commitments will be useful to the committee when discussing how the reporting should be noted on the EMSystem. Mr. Osti advised the FAB members that his data collection information will be available on a monthly basis.

Chairman Perez made a recommendation to refer the issue to the Divert Task Force to consider the inclusion of all mental health patients holding in the emergency room in the EMSystem tally.

B. Internal Disaster Policy

Ms. Cram reported that she, Ms. Taylor and Mr. Morley developed a definition of an Internal Disaster. It read as follows:

"The definition of an Internal Disaster is triggered by an event or condition that significantly disrupts the organization's ability to provide patient care in a manner and environment deemed safe and effective by the facility. Circumstances that qualify for Internal Disaster include, but are not limited to: Damage to the organization's buildings, communication systems or grounds that significantly inhibits the facilities ability to provide patient care and treatment or creates an unsafe environment for patients or staff. Such conditions may include: Explosions, Loss of utilities (power, water or telephone), Disruption of heating, ventilation or air-conditioning systems; Occupancy levels above available bed capacity at the facility; Inadequate staffing to provide safe patient care and insufficient equipment or supplies to safely treat additional patients. When such a situation results, the facility will no longer be able to accept patients (excluding walk-in ED patients). The Caveat is this plan is exclusive of citywide and mass casualty incidents (e.g. terrorist attack, plane crash, hotel fire)."

Chairman Perez stated that each hospital should be required to have an internal disaster policy within their own facility and within that policy define exactly what they would do in that situation and the steps that would need to be taken. Ms. Perez requested that each hospital take the definition and incorporate it into their individual hospital policy and procedure manuals. Ms. Perez asked for a formal reporting system and recommended that the Divert Task Force coordinate this effort.

Chairman Perez requested that each hospital submit a copy of their internal disaster policy to the Health District. She noted that part of the review process will be to ensure the hospitals follow their own internal disaster policies.

A motion was made to approve the definition of Internal Disaster submitted by Suzanne Cram. The motion was seconded and passed unanimously.

The major concern from most of the EMS providers was that the hospitals would use internal disaster in lieu of diversion and they strongly felt that the term disaster should be handled much more seriously. Randy Howell from Henderson Fire Department suggested that if a hospital goes on internal disaster, the entire facility should be closed and public notification should be made. Dr. Kwalick agreed with Randy Howell regarding public notification and commented that there probably won't be any EMTALA violation if a hospital closes its facility entirely due to an internal disaster. Dr. Kwalick continued that in an internal disaster, any person coming to that facility would be placed in jeopardy; therefore, in the standard operating procedures of a hospital on internal disaster, if a person walks-in to the emergency department, the facility should transport that individual to another facility that's not closed so that person may receive proper care.

Chairman Perez responded that the hospitals are aware of the serious nature of internal disaster and would not use it in place of diversion. Ms. Perez stated that during an internal disaster it is unsafe for the facility to provide additional care and therefore, the hospital must close down, but they must still allow walk-in patients. Ms. Perez advised that the hospital's emergency department couldn't close down entirely unless a certain circumstance warrants a full closure, i.e. a bomb threat. Ms. Perez advised that federal regulations mandate that hospitals at least stabilize any patient that presents him/herself to the facility.

C. Elimination of E.D. Closure

Mr. Chetelat presented material that was promised during the FAB meeting on March 10, 2004. These figures were based on information obtained from AMR between 1996-February 2004. The data compared the enroute, on scene, transport, and drop times. The enroute and on scene times did not fluctuate on average, which indicates there are enough ambulances on the street to get on the scene and provide the necessary care. The transport time shows a slight increase which is most likely related to the diversion aspect. However, the drop times have significantly increased. The calls resulting in transport and the number of hours in service parallel each other. Even with the increasing growth, the graph indicates that AMR has kept up by increasing the number of ambulances they have on the street to meet a much narrower slope of volume growth.

Mr. Chetelat stated that although he understands the pressures on 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 does not have an outlet. They cannot put 911 on hold. The ambulances are driving further trying to find a hospital that can take their patients. He understands the hospitals' problems, but those same problems exist on the EMS side. When a hospital is experiencing a disaster, it radiates throughout the community as a whole.

Dr. Heck gathered the drop time data from April 2001-February 2002 and Mr. Chetelat collected the drop time data from February 2003-December 2003. There were approximately 225,000-250,000 EMS responses in the Valley in a year. Of those, 125,000-150,000 were transports. The most significant information is the percentage of patients that were dropped in less than two hours. December 2003 showed approximately 95%, which means 5% of the patients were not dropped in under two hours, which means 6,000-7,000 patients were waiting more than 2 hours in ER's. This data doesn't even track the amount of time the patients were waiting to be seen by the doctors or nurses in the hospitals once the transfer was made from the EMS providers.

Mr. Chetelat presented additional data that depicted the average offload times and open hours for each hospital. The data clearly illustrated that the number of hours hospitals were open directly affected the offload times. January, September and December were the worst times for hospitals being closed in 2003, and the offload times spiked over an hour on all three months. When the hospitals were open, the EMS providers were able to get the patients to a higher level of care and level load the system. That was the rationale behind the idea to eliminate E.D. closure.

Mr. Chetelat advised the hospitals on the issue of paramedics continuing care on patients while they wait in the hallways of the hospitals. The hospitals need to be aware that the paramedics' licensure only covers prehospital care and if the paramedics wait in the hallways, they in essence become uncredentialed employees of the hospitals.

Davette Shea from Southern Hills expressed concern as to how the system will be level loaded. In addition, she doesn't feel that the EMS providers have a full understanding of the system. The EMTs that have gone to Southern Hills were unable to explain to her how the new protocol would be executed on the screen. Sandy Young from Las Vegas Fire & Rescue explained that the EMSystem screen is currently handled by dispatch, not the EMTs.

Currently, the EMS providers are given the wait times and category information from dispatch. Mike Myers from Las Vegas Fire & Rescue stated that the city has received funding to automate the offloading times with the connection between First Watch and the EMSystem. It'll show once an ambulance arrives at a hospital and keep a tally of them as they go available from the hospital. It will shift from green, yellow, red and black automatically rather than waiting for phone calls back and forth. He is hoping the process will be on track within 4-6 months.

Mr. Chetelat stated the new protocols will go into effect as of April 1, 2004. Simply, it is patient choice or closest facility. He also advised that the EMS providers have been training on the new protocols since January. The EMS offload will be used as an advisory to be able to communicate to the patient what the status is at the hospital. Chairman Perez asked if the system will track the percentage of time a facility is green, yellow, red and black. Mr. Chetelat responded that this

information will be posted on the EMSystem. Both the facilities and/or the ambulance companies will be updating the information on the EMSystem and it will be relayed to the ambulance companies by dispatch prior to transport. Then, the patient will be notified of this information.

Black means that the patients should expect offload times to be in the range of an hour or more. If the patient is willing to go to another facility and his/her condition is appropriate for that, he/she will be taken to the other facility. The new protocol will leave the decision to the patients and allow them to make a choice based on their needs and/or insurance coverage. As a result, it will be an informed patient choice. Since the patients will now be informed of the status of the hospitals and have a choice of facilities to go to, this should eliminate the problem of insurance companies denying claims for patients transported to a non-contracted facility.

Sam Kaufman from Desert Springs Hospital suggested that the hospitals give the EMS providers information regarding the different insurance companies each hospital accepts. Chairman Perez recommended that the hospitals furnish the insurance provider information to the Health District to forward to the EMS providers.

Derek Cox from AMR mentioned that exceptions to the new protocol are trauma and burns. There is a specific criteria for body surface area and the types of burns, i.e. thermal or trauma related burns. There was some confusion regarding pediatric patients. Mr. Chetelat advised that pediatric patients will go to the nearest facility. His recollection was that the MAB did not want to define the destinations more precisely than that. Mr. Chetelat understands that the specialists are not available at every hospital but it's a difficult process for a paramedic to begin to sort through who has or does not have the specialists. The general consensus is that the patient is better off in an emergency department than in the back of an ambulance trying to find the right specialist. The mission of EMS is to get the patient to a facility as quickly as possible and to get them stabilized.

Jennifer Schomburg from Summerlin suggested providing a reference guide that lists the types of specialists at each hospital to all of the EMS providers. Concerns were voiced regarding the nearest facility protocol because they feel if certain patients have specific needs, they should be directly transported to a facility that has the specialists. It was felt that stabilizing the patient and then transporting him/her to the proper facility for treatment is adding to the already overloaded system. Ms. Schomburg noted that she's not asking for a special divert policy based on a specific specialty but she would like EMS providers to provide this information to the patient so the patient can make an informed decision. Mr. Chetelat advised he would present the destination policy issue to the MAB to be referred to the Procedures/Protocol Committee if deemed necessary.

Mr. Chetelat stated that the specialty physicians constantly change from hospital to hospital and it would be very difficult for the EMTs to be expected to update this information on a continuous basis. Sandy Young from Las Vegas Fire and Rescue added that trying to keep track of all of the hospitals' specialties couldn't be done in the field due to high patient load volume.

Davette Shea from Southern Hills requested that the issue of a destination protocol for critical pediatric patients with the list of available services be referred to the MAB. She would also like

input from the UMC & Sunrise pediatric specialists. Susie Cram agreed that there may be a need for a destination policy for this subset of patients.

Ms. Cram requested that Mr. Chetelat submit information related to the new protocol to the FAB prior to its roll-out on April 1, 2004. Mr. Chetelat agreed to provide the policy as well as clarify the information about using the EMS offload notification on the EMSystem screen as an advisory. He stated the protocol will go into effect at 7am on April 1, 2004.

Chairman Perez made a recommendation to eliminate emergency department closure, which should level load the system, and have the destination criteria be based on informed patient choice. The patient will be informed of possible wait times at various facilities based on the green, yellow, red, and black color-coded system.

Mr. Chetelat reiterated that the elimination of closure should help level load the system as opposed to receiving a bolus of patients all at once. He proposed a 90-day trial of no hospital closure with a progress report to the MAB every 30 days.

A motion was made to adopt the Health District's plan for a 90-day trial of the elimination of hospital closure. The Health District will provide a progress report to the MAB on a monthly basis. The motion was seconded and passed unanimously.

Chairman Perez noted that during the trial period, the use of internal disaster will be monitored to determine whether it is being declared appropriately or as an alternative to divert.

Dr. Kwalick advised the board that the issues regarding hospital closure, holding times and access to care issues are all on the agenda for the next Board of Health meeting scheduled for March 25th at 8:00 a.m.

III. INFORMATIONAL ITEMS/DISCUSSION ONLY

Mike Myers from Las Vegas Fire & Rescue again requested information regarding the 800MHz Radio Commitment and the transfer of all assets to the hospitals. He received a response from a few hospitals and is waiting for the remaining hospitals to contact him.

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 9:54 a.m.