

**MINUTES
EMERGENCY MEDICAL SERVICES
MEDICAL ADVISORY BOARD MEETING
FEBRUARY 5, 2003 – 3:30P.M.**

MEMBERS PRESENT

Allen Marino, M.D., St. Rose Siena Dominican Hospital
Blain Claypool, Valley Hospital
David Daitch, D.O., Boulder City Hospital
David Watson, M.D., Sunrise Hospital
Donald Kwalick, M.D., Clark County Health District
Donald Reisch, M.D., Desert Springs Hospital
E. P. Homansky, M.D., Valley Hospital
Jeff Davidson, M.D., Chairman, Valley Hospital
John J. Fildes, M.D., University Medical Center
Frank Pape, D.O., Summerlin Hospital

Asst. Chief Mike Myers, Las Vegas Fire & Rescue
Scott Rolfe, R.N., University Medical Center
Pete Carlo, EMT-P, Southwest Ambulance
Philis Beilfuss, R.N., North Las Vegas Fire Department
Chief Randy Howell, Henderson Fire Department
Richard Henderson, M.D., St. Rose DeLima
Steven Peterson, CEO, American Medical Response
Jon Kingma, EMT-P, Boulder City Fire Department
Bryan Lungo, M.D., University Medical Center

MEMBERS ABSENT

Todd Jaynes, EMT-P, Mesquite Fire & Rescue

CCHD STAFF PRESENT

Rory Chetelat, EMS Manager
Jennifer Carter, Administrative Secretary
Joseph Heck, D.O., EMS Operations Medical Director
David Slattery, M.D., EMS Asst. Medical Director

Michael MacQuarrie, EMS Field Representative
Rae Pettie, Recording Secretary
Jane Shunney, R.N., Asst. to the Chief Health Officer

PUBLIC ATTENDANCE

Syd Selitzky, EMT-P, Henderson Fire Department
Margaret Williams, RN, MountainView Hospital
Rodney Gamble, EMT-I, Motorsports Medical
Scott Klepzig
David Nehrbass, EMT-I, American Medical Response
Fergus Laughbridge, State EMS
Steve Patraw, EMT-P, Southwest Ambulance
Rick Smith, RN, Summerlin Hospital
Kathy Kopka, RN, Sunrise Hospital
Lou Huff, RN, Desert Springs Hospital
Pam Turner, RN, Valley Hospital
G. Papez, RN, Valley Hospital
Patti Glavan, RN, Boulder City Hospital
Steven Kramer, American Medical Response
Jacqueline Mador, RN, University Medical Center
Kathy Sneed, RN, St. Rose Dominican Hospital
Diane Spear, RN, Lake Mead Hospital Medical Center
John Wilson, EMT-P, Southwest Ambulance

Shawn White, EMT-P, Henderson Fire Department
Charles Scott, EMT-I, American Medical Response
Ed Matteson, EMT-P, Clark County Fire Department
Sam Wilson, EMT-P, Specialized Medical Services
Lynda Courtney, Clark County Bureau of Licensure
Nancy Harland, RN, Sunrise Hospital
Chief Jeffrey Morgan, EMT-P, Las Vegas Fire & Rescue
Ken Taylor, EMT-P, Las Vegas Fire & Rescue
Chief Mike Myers, EMT-P, Las Vegas Fire & Rescue
Debbie Coffee, RN, Summerlin Hospital
D. Blomstrand, RN, Valley Hospital
Michael Zbiegien, M.D., Sunrise Hospital
Gerry Hart, American Medical Response
Alice Conroy, RN, Sunrise Hospital
Brian Rogers, EMT-P, Southwest Ambulance
Pam Rowse, RN, St. Rose Dominican Hospital
Virginia DeLeon, RN, St. Rose Dominical Hospital

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The EMS Medical Advisory Board convened in the Clemens Room at the Ravenholt Public Health Center at 3:30 p.m. on Wednesday, February 5, 2003. The meeting was called to order by Chairman Jeff Davidson, M.D. He stated the Affidavit of Posting, Mailing of Agenda, and public notice of the meeting agenda were executed in accordance with the Nevada Open Meeting Law. Dr. Davidson noted that a quorum was present.

I. CONSENT AGENDA:

- A. Minutes Medical Advisory Board Meeting December 4, 2002
- B. Review of Draft Changes to the Official Ambulance and Firefighting Agency Inventory
 - 1. Addition of AED as a Required Item on ILS Units
 - 2. Minor Housekeeping Changes
- C. Approve Revised EMS Procedure Manual
- D. Endorse Draft Changes to EMS Regulations

Chairman Davidson asked for a motion to approve all items on the Consent Agenda. A motion was made, seconded and passed unanimously.

II. REPORT/DISCUSSION/POSSIBLE ACTION:

A. Procedure/Protocol Committee Report

1. Review of Draft Protocol Samples

Dr. David Watson reported that the Procedure/Protocol Committee members provided sample formats of the Respiratory Distress in the Conscious Patient and Chest Pain protocols. It was agreed that the protocols should easily differentiate basic, intermediate and advanced procedures. In addition, the protocols should be easy to follow, to teach, and to memorize. Following review and discussion of different protocol submissions, the committee unanimously agreed to pattern the Clark County protocols after the Maryland Institute for Emergency Medical Systems format.

2. Review of Nitroglycerin Protocol

Dr. Watson stated the EMS office was asked to reconsider the requirement for an IV to be started prior to Nitroglycerin being administered to a patient. There was a concern that the basic life support Nitroglycerin protocol permits basic practitioners to assist with the administration of Nitroglycerin with no requirement to establish an IV. However, the current intermediate life support Nitroglycerin protocol states, "IV should be established" prior to administration, and the advanced life support Nitroglycerin protocol states, "IV access required" prior to administration. Dr. Watson reported the committee discussed the importance of having IV access in the event the patient suffers from hypotension. In addition, there is the potential for further ischemic changes as a result of the hypotension, and possibly stroke.

The Procedure/Protocol Committee's revisions were summarized by Dr. Watson as follows:

- a. The BLS Nitroglycerin protocol was deleted from the EMT-Basic and EMT-Intermediate Protocol Manual.
- b. The "Contraindications" in the ILS Nitroglycerin protocol was revised to parallel the language in the ALS Nitroglycerin protocol.
- c. The words, "unless ordered by a physician" were deleted from "Contraindications" in both the ILS and ALS Nitroglycerin protocols.

- d. The "Special Notes" in the ILS Nitroglycerin protocol was revised to read, "IV access required prior to administration".
- e. The reference to prior history of coronary artery disease was removed from the "Indications" in the ILS Nitroglycerin protocol.

Pete Carlo made a motion to approve the above revisions to the BLS/ILS/ALS Nitroglycerin protocols. The motion was seconded and passed, with three opposed.

B. Drug & Device Committee Report.

Review Petition for Addition of Flex-Guide ET Introducer

Dr. Henderson stated that he chaired the meeting in Dr. Marino's absence. The committee was in agreement the Flex-Guide ET Introducer is a life saving device. It is also very inexpensive. A motion was made to endorse the FlexGuide ET Introducer and add it to the Official Ambulance and Firefighting Agency Inventory, with the requirement of two per transport unit, following a 90 day training period. The motion was seconded and passed unanimously. The committee will request that the MAB refer the issue to the Airway Management Task Force for development of the educational component, and to obtain pediatric input for the inclusion of age determinants.

C. Review of Draft Protocol for Patient Transfer to Receiving Facility

Rory Chetelat stated the draft Patient Transfer to Receiving Facility (PTRF) protocol was developed to address the long drop times in the emergency rooms. He related that the EMS office was alerted to a situation where the prehospital providers were at a system level status of zero, meaning there were no available ambulances in the community to respond to the next 911 call. When the system level status is at zero, the burden is now shared by the fire departments. If there are no fire department personnel to respond to fire or other emergencies that arise, it jeopardizes the entire community. Rory empathized with all parties involved. He stated the EMS office, as the regulatory agency, felt it was necessary to develop a protocol that allows the prehospital providers to get back on the streets to be able to respond. Rory stated that he researched system-wide drop times in an effort to arrive at a reasonable time that the prehospital provider can transfer care of a patient within the confines of a receiving facility. According to the statistics, drop times greater than one hour occur in 7 - 8% of the total number of patient drop offs. He indicated that approximately 60% of the drop times occur in less than thirty minutes. Rory stated he is aware there are a variety of issues. However, the system is broken, and a solution must be found.

Dr. Dale Garrison, director of the emergency department at UMC, expressed concern that the draft protocol is simply a band-aid. In his view, we are attempting to fix the problem in a way that may jeopardize patient safety. Citing the current system-wide issues of emergency department over-crowding and shortage of nursing personnel, he questioned the rationale of putting a system in place where critically ill patients would possibly be left without any supervision. He indicated that a major issue is our policy of transporting everybody who calls 911. He added that most of the major metropolitan EMS systems in the U.S. have a patient transportation policy which states an emergency medical condition must be present to justify transport. Dr. Garrison expressed doubt we will find a solution to the current situation without addressing this underlying problem.

In response to a remark made that Steve Peterson, CEO at AMR, was quoted in the Las Vegas Sun newspaper saying 80% of 911 calls are "frequent fliers", Steve replied that the subject of that comment was the chronic public inebriate and the Legal 2000 cohort of transports, and that 80% of those transports were "frequent fliers".

Sandy Young, EMS Quality Improvement Officer at Las Vegas Fire & Rescue (LVFR), gave a historical perspective with regard to the dual response system, where the fire department provides mutual aid to the private transport agencies. She reported that on January 28th there came a point in time where transport units were tied up in hospitals for greater than two hours because they were very busy. Ultimately, the system level status reached zero. There were no available ambulances to respond to the next 911 call. After a 2-1/2 hour wait by a LVFR transport unit, an executive decision was made to leave a patient at the hospital to respond to a call.

Sandy stated that the transport agencies have a responsibility to provide service to the community, and they can no longer jeopardize public safety. She asked the MAB to consider the draft PTRF protocol as an operational guideline for the transport agencies.

Steve Peterson was in agreement with Dr. Garrison that the use and/or abuse of the system is a problem that certainly deserves focus. He stated there are two other critical underlying issues. The first issue is capacity. He referred to capacity in relation to the nursing shortage in hospital emergency departments. He indicated he is well aware there is a nursing shortage, however, on many occasions it has been suggested that there are other ways of staffing hospital emergency departments other than with nurses. He contended that if it is appropriate for paramedics to provide emergency medical services in hospital hallways, then the hospitals should be looking at retaining some of those people to act in that capacity on their behalf directly as employees, as opposed to shifting that responsibility to the transport agencies.

Steve stated that the second issue is ownership. He indicated there is a continuous ping-pong battle over the ownership of the patient. It is his understanding of federal statute as it relates to EMTALA (Emergency Medical Treatment & Active Labor Act) and COBRA (Consolidation Omnibus Budget Reconciliation Act) that the transfer of ownership of the patient starts when the transport agency's wheels roll onto hospital property. He made it clear that he does not advocate a 15 minute drop-and-run policy, however, he is willing to discuss the draft PTRF protocol and arrive at a reasonable time that is necessary to transfer ownership of the patient in a professional manner.

Dr. Homansky remarked that everyone is looking at the current problem from their own point of view. The role of the MAB is to incorporate all aspects and do what's best for the community in terms of patient flow. Addressing the statement regarding the transport of non-acute patients, he stated that this population should simply be taken out of the ambulance and placed into the waiting room. Dr. Homansky noted that many aspects of our system could be improved, but a policy needs to be put into place as soon as possible to insure the patients are well taken care of.

Dr. Watson noted the draft PTRF protocol does not specify system level. Rory stated that both the transport agencies' and the hospitals' system levels change rapidly. If we wait until we reach a certain system level it may be too late to address the problem. Brian Rogers, managing director at Southwest Ambulance, agreed that system level is very dynamic in that it can fluctuate from a level 6 to a level zero in a matter of ten minutes, and vice versa. Definitions such as "soft" and "hard" level zero are frequently used. "Soft" meaning that transport units are in hospitals. "Hard" meaning that transport units are all responding.

Blain Claypool, COO at Valley Hospital Medical Center, reported that the Facilities Advisory Board (FAB) would like to discuss the draft PTRF protocol prior to implementation. He stated that the facilities want to work together, in partnership with the MAB, to arrive at a viable solution. He related there are a number of issues that need to be addressed, primarily the mental health patients, who take up a great deal of the E.R. beds.

Deputy Chief Jeffrey Morgan, stated LVFR has an organizational objective to respond to 90% of emergency calls within six minutes or less. LVFR transport units provide transport for the EMS community, are used as a technical resource for calls that other agencies can't handle, and provide support at large scale emergencies. When there is a fire, LVFR needs to provide medical support, with triage and treatment capability on the scene. LVFR must always be aware of the status of available resources in terms of response time with the appropriate unit. They cannot mount an offensive attack on a building fire without a rescue unit on scene.

Asst. Fire Chief Mike Myers, stated the EMS system reached the breaking point when LVFR was put in a position where they needed to respond without a franchise transport unit because the system level status was at zero. He stated, "Put yourself in the position where your responsibility is to protect the public, and there's a citizen out there who is having a cardiac arrest, and there are no available resources to run on that individual." He related that AMR did everything they possibly could: Call for resources, ask for mutual aid, and place supervisors in hospitals to release ambulances that were already at the hospital so they could get them back into

service. Chief Myers stated he had no alternative than to release his ambulances and enable them to respond to the next 911 call. He agreed with Dr. Homansky that non-emergent patients should be taken to the triage center or the waiting room. Chief Myers stated that his main concern is the critical patients in the field. He stated, "I must reserve the right to have a unit able to protect the public. And I can't be put into the position not to do that."

There was some discussion regarding choosing specific timeframes to institute the draft PTRF protocol versus a 24/7 policy. Dr. Harrington noted that too many IVs are started on relatively minor patients by EMS personnel, which makes it difficult to send them out to the triage area.

Steve Kramer, operations supervisor at AMR, stated system demand is going to control when the draft PTRF protocol is used. He stated, "Paramedics don't want to just walk away from a patient and leave him unattended, that's not what they're trained to do. By the same token, when they can't respond, and they know somebody needs help, that hurts them even more." Steve related this has been an ongoing problem that is getting progressively worse every year. Everyone is aware of the many issues facing both the facilities and the prehospital providers. But the problem at hand is, what will be done when the situation occurs more and more frequently where nobody can respond to a call? At that point in time, you have to leave the patient at a facility that has medical capability to care for that patient, to respond to the patient out in the field who has no medical attention. Steve stated that AMR, as EMS providers, have provided staff to monitor patients. They have one crew that monitors 5-6 patients at one time, sometimes on AMR's gurneys, sometimes in wheelchairs, sometimes on hospital gurneys. They understand the hospital situation and can assist. They will continue to do that. On the other hand, the draft PTRF protocol must be endorsed so a policy is put into effect the next time the system is left with no units to respond.

Rory Chetelat reiterated that the Health District has an obligation as the EMS regulatory body to insure that the community is safe and protected. His fear is that if the draft PTRF protocol is not endorsed, people will start to define the rules themselves. They're going to start making decisions that may not be in everyone's best interest. And while they have an obligation to respond, the EMS office has an obligation to address this problem. The draft PTRF protocol is offered as one possible solution. Rory agreed with Dr. Garrison's assessment regarding the transport of non-emergent patients. He stressed the need for community-wide education as to what constitutes an emergency. For instance, when to go to an emergency room versus waiting to see a personal doctor, or going to an urgent care.

Dr. Davidson suggested the MAB endorse the draft PTRF protocol for a 30-day trial period. Blain Claypool once again urged the MAB to allow the FAB to meet and have a chance to respond prior to implementation. Dr. Kwalick indicated that a crisis has arisen that needs to be dealt with immediately. He stated that following endorsement of a 30-day implementation period the FAB could meet for discussion. Any consensus the FAB arrives at could then be brought back to the MAB.

Brian Rogers reported that call volume has increased by seven percent over the last year. As a result, AMR and SWA put 30% more ambulances on the street. He emphasized that the provider agencies are not looking to institute a drop-and-run policy. He feels the draft PTRF protocol is a compromise. They want to work with the facilities. Brian agreed that a big issue is the mental health patients. He suggested they initiate a protocol to spread the mental health patients more evenly among the hospitals. Brian reiterated the importance of making an immediate decision. The transport agencies do not want to act without an approved protocol in place. However, he indicated that the decision to leave a patient will be made, with or without a protocol, because it is the transport agencies' responsibility to the community.

Steve Kramer commented that the decision to leave a patient will not be arbitrarily made by the crew. A supervisor or manager will make the decision to evaluate the patient, talk to the crew and talk to the hospital staff. Phone calls will first be made to charge nurses, nurse managers, administrators on call, or to the facility's CEO stating that there are problems and assistance is needed.

Jane Shunney presented Psychiatric Tracking charts for the years 2001, 2002 and 2003. The charts depict the number of mental health patients taken to area hospitals and their disposition. The charts also depict the total number of hours these patients were held in their respective emergency departments.

Referencing the Psychiatric Tracking totals, Dr. Watson noted a huge discrepancy in hold hours when comparing each facility. He suggested that a rotation process be considered so one hospital isn't deluged with nothing but psyche patients. Blain Claypool agreed, stating the hospitals have been working towards the concept of level loading the system. It is their belief that the more efficiently the work is spread throughout the system, the more capacity each individual hospital is going to have. Dr. Davidson clarified that the population of people included in the psychiatric tracking totals are the Legal 2000 mental health patients. It was clarified that the chart does not include inebriates, substance abuse patients, or patients with altered mental status.

Dr. Richard Henderson expressed concern that the Legal 2000 patient issue was not addressed on the agenda. Dr. Kwalick responded that the mental health patients are part of the problem, therefore, it is an appropriate issue for discussion. Dr. Davidson apologized that the psychiatric tracking hours were unavailable prior to the meeting. He noted that sharing the burden of caring for the mental health patients may serve to offload the facilities, and ultimately help during them peak times. Dr. William Harrington suggested encouraging the legislature to act on the governor's initiative of creating a mental health facility in southern Nevada.

Dr. Harrington stated it has always been our policy to take trauma and neo-natal burn patients to the closest appropriate facility. Charles Scott, EMT-I with AMR, asked whether the language "closest appropriate facility" could be added to the protocols to enable them to make the clinical decision to transport a patient to a hospital based on services the hospital can provide. Dr. Davidson responded that the way the diversion protocol is written, there are certain exclusions: trauma, neo-natal, OB/Gyn, labor and delivery, and burn patients. He emphatically stated that the MAB does not support bypassing a hospital. He added any E.D. is a higher level of care than an EMS vehicle. All hospitals have very capable E.D. physicians 24/7, with appropriate back-up support.

Rodney Gamble, co-owner of Motorsports Medical Services, a volunteer ambulance agency, stated that he has five ambulances that are often not in use on weekdays. He stated he wasn't certain of the legality issues, but he offered his services to assist area hospitals in monitoring BLS/ILS patients as an option.

Charles Scott stated he has seen similar protocols adopted in various EMS agencies around the country. He agreed with comments made earlier that using system level as a gauge would not be logistically feasible. He suggested the procedure on the draft PTRF protocol be revised to exclude critical patients and mental hold patients.

Pete Carlo, director of operations at SWA, presented a revised version of the draft PTRF protocol with additional verbiage stating, "If system overload is present, EMS providers are allowed to leave the patient at the hospital prior to the one hour limit". He explained that adding this verbiage enables the paramedic to leave prior to one hour, if directed by his supervisor, without risk of repercussion that he has not followed the protocol. He stated that SWA is also taking the standpoint of saying, "Not responding is not an option". Pete also suggested adding a paragraph at the end which states that EMS providers are permitted to continue care, airway therapy, EKG monitoring, IV therapy, medication administration, etc., in accordance with Clark County Health District protocol, while waiting for placement of the patient. He stated it is important to address the continuation of flow of medical care.

Scott Rolfe, RN at UMC, expressed appreciation for the cooperative effort he has witnessed by the EMS providers. He recommended that EMS supervisors and nurse managers meet to brainstorm alternative solutions prior to implementation of the protocol in question. He commented that the draft ER Technician job description has been approved by the State Board of Nursing and the Nevada Health Association. The ER Tech is an adjunct to the RN, to help them care for patients. These individuals would be available for utilization by any hospital.

Chief Myers related that AMR and SWA have expressed that they have done everything possible to address this issue, including purchasing more vehicles, increasing staff, and paying out more overtime. He stated that if an ER Tech position exists, and the hospitals are electing not to staff this position, it is disappointing.

Dr. Watson made a motion to revise the “Procedure” of the draft Patient Transfer to Receiving Facility protocol to read as follows: “This procedure is to be followed when EMS personnel arrive at a receiving facility with non-monitored patients during system overload.”

Chief Myers stated that during normal operation hours, or normal system load, there isn't an issue of waiting more than an hour. Dr. Davidson stated that a facility may be internally experiencing a lot more stress than is witnessed by everyone around. With this in mind, if a transport unit is tied up at a facility for more than an hour during normal system load, but enough care is being provided in the community, there may be a reason, in that specific emergency department, why that transport unit cannot leave. So both sides need to compromise.

Rory Chetelat stated he liked the inclusion of the non-monitored patient to the draft PTRF protocol. However, he once again questioned their ability to effectively determine system overload.

Blain Claypool once again requested that the FAB be given a chance to meet prior to implementation. Dr. Davidson commented that the EMS providers are going to independently make decisions, with or without the MAB's comments, if not given any direction.

Dr. Watson's motion was seconded.

Dr. Harrington made a motion to add language to Dr. Watson's motion to read, “This procedure is to be followed when EMS personnel arrive at a receiving facility with a non-monitored patient during system overload, beginning with the patients that have been waiting the longest, as determined by EMS supervisors.”

Dr. Slattery noted: 1) The facilities are saying that the best scenario would be that whenever we have a bed, a patient can be put there; and 2) EMS personnel, according to EMTALA (Emergency Medical Treatment & Active Labor Act), and by law, can drop the patient off when they enter hospital property. He feels the addendum of the “non-monitored patient” is a huge compromise. He remarked that the process should not be made too logically difficult for EMS or hospital personnel to implement. EMS personnel has indicated that defining system level is an impossible criterion to meet, or to define, at any one point. Dr. Slattery suggested the MAB focus on the revised draft PTRF protocol, which does not include the critical patient. It is a compromise he feels will make a big difference to the EMS system in helping to unload ambulances.

Dr. Kwalick reiterated that the only reason this issue was brought forth was because the fire department was left with no units to respond. In his opinion, system overload should be defined as that point in time where there are no units left to respond to the community's needs. Dr. Henderson remarked that the transport agencies should be entrusted to make the right call. Chief Myers stated that, as an administrator, he does not take these decisions lightly. He will ultimately be held responsible for his actions, and he is willing to accept that accountability. He added that it is unlikely he will be put in that operational position very often.

Randy Howell, Division Chief at Henderson Fire Department, remarked that the language of the draft PTRF protocol is actually debilitating. If there are no units to respond, and the transport agencies need to leave prior to the one hour period because a cardiac arrest call comes in, they will be unable to do so according to the way the protocol is written. In his opinion, it is not a compromise. Dr. Lungo stated the draft PTRF protocol was written as a preventative measure. He suggested adding language that states that when the system is at overload, the protocol goes into effect immediately, and the paramedics who have been waiting in excess of 60 minutes are free to leave the patient.

Dr. Watson defended his motion, stating the purpose was to incorporate confines. If the transport agencies just start dropping patients that are un-monitored it can create a huge burden with regard to how the facilities respond.

Rory Chetelat commented that everybody is beginning to lose focus on why the draft PTRF protocol was being presented. He stated that it is to provide an outlet before we reach system overload. He further stated that we're not trying to fix the problem after it reaches system overload. Rather, we're trying to prevent it from getting to the overload situation. If we put the overload language in the protocol, we are defeating the intent. He remarked that the transport agencies have already made it clear what will happen once system overload is reached. We're trying to prevent it from ever reaching that point.

Dr. Homansky stated he is deeply concerned about the kind of protocol that we are going to put in place right now for the short term. He agreed with Rory that everybody has lost focus. There have been so many proposals and amendments to motions that perhaps it would be wise to step back and let the FAB meet for further discussion before implementation. Randy Howell commented that the Health District's immediate concern is that the transport agencies will not be operating under any kind of policy when the decision to leave a patient is being made in the field. They would like the assurance that the transport agencies are operating under some sort of procedure, as opposed to no procedure at all.

Dr. Watson rescinded his initial motion.

Dr. Slattery reminded everyone that the drop statistics show that 97% of the patients are being taken care of within an hour. Thus, only 3% of the patients would fit into this category. And if we look at only the non-monitored patients, it would be an even smaller percentage. He agreed that it is a good idea to have the FAB meet for further discussion, but he feels the MAB needs to make a decision tonight so they will at least have a policy put into place. Dr. Reisch agreed that the important issue is to insure transport vehicles are running on a regular basis, and are able to pick up sick people who need our help.

There was discussion that each facility would need to independently decide on how each emergency department will receive and triage a patient, due to differences in triage capability, physical space, staffing, etc.

Chief Myers suggested adding language that states the patient care report will be left with the nearest nursing staff or nearest RN, rather than with the patient.

Dr. Reisch made a motion to: 1) Revise the "Procedure" of the draft Patient Transfer to Receiving Facility protocol to read, "This procedure will be followed when EMS personnel arrive at a receiving facility with a non-monitored patient."; 2) Add "E. EMS providers are permitted to continue care, airway therapy, EKG monitoring, IV therapy, medication administration, etc., in accordance with Clark County Health District protocol, while waiting for placement of the patient.; and 3) Add language stating the patient care report will be left with a charge nurse. The motion was seconded and passed with 15 in favor, one opposed, and two members abstained.

It was agreed that at 0700 on Friday 7, 2003 the draft Patient Transfer to Receiving Protocol would go into effect.

Dr. Davidson recommended that the MAB consider endorsing a protocol to address the large number of patients being held in the area emergency departments. He suggested a 30 day trial period during which time mental health patients, specifically those on a Legal 2000 hold, would be rotated between the emergency departments based on the number of patients currently being held at each emergency department. Dr. Vanduzer stated he was concerned that paramedics might bypass the closest facility with a patient who had taken an overdose and could potentially compromise patient care. Dr. Davidson clarified that the only patients who would be rotated would be those who had a Legal 2000 initiated in the field. An overdose patient would be dispatched and managed differently. Dr. Marino stated he felt this issue would fall under the auspices of the Facilities Advisory Board. Dr. Garrison responded this issue clearly affects the EMS system when the emergency departments have one-

quarter to one-third of their beds occupied by mental health patients for extended periods of time. He added that we have a mental health system that is inadequate to meet their needs. He feels we need a rational policy that will help distribute these patients on a more equitable basis so that the entire EMS system will benefit. He added the statistics of psychiatric patients being held in the emergency department that were provided to the MAB indicate that UMC and Valley have much higher number of hours of psychiatric patients being held in their emergency department than the other hospitals.

Jon Wilson stated that according to Dr. Davidson, on any given day there are about 45 patients who are on a Legal 2000 hold in the area emergency departments. It was suggested that each facility could hold up to a maximum of five patients. When a hospital reached the maximum number, they would enter that information into EMSystem and the transport agencies would not transport any additional Legal 2000 patients to that facility. He recommended dividing the valley into east and west sections. When a transporting agency picked up the next Legal 2000 patient they would transport them to the closest facility that did not have five patients being held. Dr. Henderson asked why a hospital with 20 ED beds should hold the same number as a hospital with 40 beds. Dr. Davidson responded that following a meeting with WestCare, it was determined that typically there are about 30 patients on Legal 2000 hold in the area emergency departments on any given day and that the maximum is about 45. Given this information it was felt the way to approach it was to spread out five patients to nine facilities. The current problem is that on any given day there are approximately 30 patients being held with 17 at UMC and 12 at Valley, which seriously impacts the center of the city for management of medical patients.

Dr. Homansky asked if Southwest Ambulance or AMR had a problem with implementing this plan. Jon Wilson responded that if they can stay within their region it would be best. Blain Claypool stated he felt the east/west division was an effective proposal because it would keep the ambulances within their regions as much as possible.

Dr. Homansky made a motion to implement a plan that at the point where a facility has five Legal 2000 psychiatric patients being held in their emergency department that they can go on Psychiatric Hold Divert. When the nine main facilities each have five holds, the system will go on psychiatric rotation which will be balanced on an east/west basis. The motion was seconded.

Steve Peterson asked who would take the accountability for managing the status of the rotation. Dr. Davidson responded the information would come through the Fire Alarm Office and AMR's dispatch system and would be posted on EMSystem. Steve Peterson asked who would be responsible for putting the information into EMSystem. In the past, divert status was handled by a central gatekeeper as opposed to the individual institutions. He expressed concern that setting up another class of patient divert and depending on the institutions to govern their own actions and put that data into the system is a different philosophy. Mike Myers said at present the emergency departments are not authorized to enter information into EMSystem and it was their preference to have a central gatekeeper.

Steve Kramer asked for clarification on how the patients were to be distributed. Pete Carlo suggested it should be done by geographic location as set forth in the franchise agreement. Dr. Davidson responded, it really didn't matter as long as the patients were distributed according to the plan. Rory Chetelat commented that he was concerned about paramedics bypassing a hospital with a potentially medically unstable patient. Dr. Davidson stated the patients that would be affected by this plan would be Legal 2000 patients who do not typically require medical interventions. He would defer to the paramedic's judgment regarding the appropriate transport destination based on the patient's condition.

Steve Peterson asked if it was premature to make a decision about this issue without a fully developed protocol. He is interested in WestCare's role in the transportation and destination management of these patients. Dr. Davidson said that at present they are not handling Legal 2000 patients. He reiterated that the purpose of the proposal is to break up the log jams and to more evenly distribute the burden throughout the community.

Dr. Davidson restated the motion which was when a facility has five Legal 2000 holds, that facility will be placed on Legal 2000 closure until all facilities have five Legal 2000 holds, at which time a rotation will begin among all nine facilities. After a brief discussion regarding how the rotation will be handled, Dr. Homansky amended his motion to allow Southwest and AMR to determine the best method for rotation when the system reaches the point that all nine hospital are on Legal 2000 divert. Dr. Davidson added that this operations protocol would be in effect for a 30 day trial period. Input will be requested from the Facilities Advisory Board and there will be a Divert Committee meeting next month to write the formal language which will provide the guidelines for the procedure. The protocol will go into effect at 0700 on Friday, February 7, 2003. The vote was 12 in favor, 4 opposed and 1 member abstained.

III. INFORMATIONAL ITEMS

A. Update for Community Triage Center

James Asti, Administrator for the new Community Triage Center, reported they have 52 beds and their census for the day was 31. They plan to start their own transportation system with one crew on duty 24 hours a day, seven days per week, beginning February 15, 2003. By March 1, 2003 they plan to have two crews to transport people to the triage center. Dr. Davidson invited Mr. Asti to come to the March MAB to provide an update on their progress.

B. FAB Report

Blaine Claypool reported the FAB would like to work with the Divert Committee to address future plans to continue to minimize divert hours. Dr. Homansky asked if the FAB could meet on Friday, February 7, 2003. Mr. Claypool agreed to contact Karla Perez, FAB Chairperson to determine if they could meet.

C. ED Nurse Managers Report

Scott Rolfe stated the ED Nurse Managers discussed BDR 826 which is designed to enhance criminal penalties for violence to health care workers. The individual hospitals have been asked to provide letters of support to John Oceguera, the assemblyman or Sandra Rush, CNE at St Rose to help move this forward.

D. QA Report

Tabled until next month.

E. ED Divert Statistics

Included in MAB packet.

IV. PUBLIC APPEARANCE/CITIZEN PARTICIPATION

Dr. Reisch stated it was recently reported in the newspaper that Desert Springs Hospital would be losing its orthopedic surgical coverage. The effective date will be March 1, 2003. At this point, he is not asking for any specific changes in the EMS transport system. He is not expecting EMS providers to triage orthopedic patients and bypass them to go to another facility. When the patient arrives at Desert Springs they will triage and treat as necessary.

IV. ADJOURNMENT

There being no further business, the meeting was adjourned at 5:51 P.M.