MINUTES

EMERGENCY MEDICAL SERVICES

FACILITIES ADVISORY BOARD MEETING

MARCH 21, 2001 – 8:00 A.M.

MEMBERS PRESENT

Karla Perez, Chairman (Desert Springs Hospital)
Suzanne Cram (Sunrise Hospital)
Blain Claypool, Alternate (Valley Hospital)
Michael Walsh (FAB Rep. To MAB)
Renato Baciarelli (St. Rose Hospital)
K. D. Justyn (Summerlin Hospital)
Donald Kwalick, M.D. (CCHD)

MEMBERS ABSENT

Kim Crandall (Boulder City)
Helen Vos (Mountain View Hospital)
Jacqueline Taylor (University Medical Center)
William P. Moore (Lake Mead)
Jeff Greenlee, D. O. (MAB Rep)

CCHD EMS STAFF PRESENT

Jane Shunney, R.N.
Mary Ellen Britt, R.N.
Jean Folk, Recording Secretary
LaRue Scull
Kelly Quinn
Jennifer Carter

PUBLIC ATTENDANCE

NAME	ASSOCIATED WITH
Joe Calise	Summerlin Hospital
Pam Turner	Valley Hospital
Steve Kramer	American Medical Response
Philis Beilfuss	North Las Vegas Fire Department
Michele Nichols	Valley Hospital
Karen Fairlis	Valley Hospital
Brian Rogers	Southwest Ambulance
John Wilson	Southwest Ambulance

CALL TO ORDER-NOTICE OF POSTING OF AGENDA

The EMS Facilities Advisory Board convened at 8:00 a.m. on Wednesday, March 21, 2001, in the Clemens Conference Room at the Otto H. Ravenholt, M.D. Public Health Center. Karla Perez called the meeting to order and apologized on behalf of the Health District for the agenda not reaching some members. A sign-in sheet was passed around for attendees to list their e-mail address and fax number for future communication. Ms. Perez stated 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 meeting minutes was made, seconded and unanimously carried.

II. REPORT/DISCUSSION/POSSIBLE ACTION

A. New Divert Policy

Ms. Perez said, after much debate and discussion, a new Divert Policy was approved at the last meeting of the Medical Advisory Board. The new title is *EMS PROCEDURE FOR EMERGENCY DEPARTMENT CLOSURE*. The definition is that Hospitals on Emergency Department closure cannot accept patients into their E.D. if they arrive by EMS.

Pam Turner explained the language change, department closure, is to help facilitate the open/closed concept. Several explanations were removed to simplify the procedure. The desire was for everyone to understand that the closed status is rotated not the patients. If a facility is open, they are not being forced into the rotation.

Renato Baciarelli asked if the rotation was limited to one region such as Region B or can they rotate to A and C? Brian Rogers said if an ambulance in the Region for St. Rose is around Tropicana and Eastern, they can choose to either go to Region C or Region B. If Siena and Sunrise are on divert, the EMS crew then chooses between St. Rose DeLima, Desert Springs and Lake Mead. There's nothing that says that Rescue 91 picks up a patient in Region A or C that they can't go to a hospital in Region B. These are only guidelines. They can cross Regional borders and go to whatever hospital they deem appropriate to that patient. Some of the doctors were getting a little frustrated that a person could be discharged from the hospital and three hours later turn up at a different hospital.

Pam Turner said the destination protocol is by patient choice is first and then the closest facility.

Another concern was critical care. It was decided that this really is not an EMS issue. Facilities will make the decision of whether they can take monitored patients so it will not affect the pre-hospital people.

Brian Rogers asked, under Definition, does EMS mean ground ambulances and helicopters? Originally the definition was "by EMS vehicles" which could be a helicopter. Pam Turner said if an emergency department is unable to take a ground ambulance they would not be able to accept a helicopter.

Ms. Perez asked if a representative of the helicopter program would comment. Steve Kramer said, in looking at the way the policy is written, if the ED is on divert they can't take patients.

Joe Calise asked if it was clarified in the meeting that a dispatch decision is made at the time of pick up as opposed to when it's dispatched. That makes a big difference on divert. The ambulance is dispatched and 25 minutes later they show up at the hospital that's been closed for 20 minutes. Pam Turner said that wasn't discussed at the meeting.

Steve Kramer said theoretically it should be when the ambulance gets to the patient, they decide if they're going to transport that patient and then at that point the hospital would be chosen, not when they're dispatched from the 911 call. They have no way of knowing if the patient is going to the hospital when they're dispatched. Pam Turner said that is what is occurring now and that was a concern from the Nurse Managers because they are being told by dispatch that they have been dispatched to the scene and the patient is coming to their ED, even though the ED may have requested to be on super divert. There are three or four more rigs that have been dispatched to a scene and they show up later too. Steve Kramer said what is happening is that a crew gets on scene and they decide this is going to be a transport. They ask for a bed at that point then they continue care of that patient. They may be there another 10-15-20 minutes then leave to go to the hospital. They need to ask early on to let the family members know to which hospital they are transporting the patient. Ms. Turner said that is not the understanding of all the Emergency Department Managers. Their understanding is that when the ambulance is dispatched to the scene, they're given a hospital preference. Brian Rogers said once the crew gets to the scene, determination is made as to whether the patient is critical care or ER. A request is made for a criti-

cal care or ER bed, if they're on full rotation. If they get one of those bed assignments and while they are transporting, the hospital requests to go on super divert, they will normally let the charge nurse know, or the person who called requesting the super divert, that there is already an ambulance responding to the facility with a patient or two and ask if the patient be accepted or be diverted. If the facility will accept the patient, the ambulance continues to that facility and the facility will be on super divert and not accept any patients after that. Ms. Perez said dispatch evidently impacts divert and divert impacts dispatch but dispatch is not part of the Divert Protocol. That should be eliminated because dispatch will no longer be assigning beds per the new protocol.

Michelle Nichols said, using the word divert tends to give the impression that the whole hospital is closed to any admissions. She understood that the new nomenclature is "closure" and it is addressing E.D.'s only. If they have transfers to beds within their facility it would be okay. Ms. Perez said as long as they bypass the emergency room. Ms. Nichols asked if the patient is being transferred into one of those beds, not going through the ED, will they be accepted. Ms. Perez and Brian Rogers said yes, as long as there has been physician to physician, nurse to nurse contact. If it's outside the EMS dispatch system, and is a direct transfer from facility to facility, bypassing the emergency room, it would not be governed by this protocol. There was a motion to approve this policy, seconded and carried unanimously.

B. & C. RDMX and ReddiNet

Ms. Perez discussrd RDMX and ReddiNet as they relate to communication systems for the hospitals and the EMS community. These two systems have been looked at and they are actually produced by the same company. The first is the RDMX system which is an internet based system. This system would actually replace the current divert system and as it runs off the internet, it uses a phone line. The concern regarding this system is that if the phone lines go down and the system goes down, how usable will it be in a disaster situation? The company is currently offering a trial period for six months at no cost to the hospitals. After that period of time, they'll discount the price by 70%, which will amount to $900 a year for the first three years of service. The ER Managers had an opportunity to take a look at the system.

Pam Turner advised that, because of the concerns, a small communication task force was put together at the last MAB meeting. A concern was expressed about the security of an open keyboard system in the emergency room. A system recommended by Mike Williams from Abaris Group will be demonstrated in

April. The system was built by Physicians and ER Nurses and seems to do more for a less price. The other concern was going to a cost of an internet system if the MMRS is willing to do the ReddiNet system.

Ms. Perez explained that the ReddiNet system is a microwave based system being considered by the MMRS Task Force. In a disaster situation, this system is suppose to survive, even during earthquakes they claim the satellite dishes will still function. It is a communication tool and would replace the current divert system. It would also work as a tool for communicating in a disaster. Hospitals could communicate simultaneously to gain access to bed availability, etc. Also if one hospital is seeing a lot of GI cases they could send a message out to other hospitals that there may be some health risk in the community. The biggest difference between the two systems is the ReddiNet is microwave based. There is also the cost and educational requirements involved with the ReddiNet system. The initial installation of the ReddiNet and the equipment, everything that would be involved in getting it up and running, would be picked up by the Federal government under the MMRS project. The hospitals would have to maintain the system at a cost of somewhere between $500 to $700 per month. Some of the questions raised by some members of the FAB was the concern about how much involvement the hospital's information services department would have in terms of maintaining and installing. The answer was that there was absolutely no intervention by the hospital IS department. The hospital is not allowed to touch the system except to set up one dedicated phone line. The rest is handled by ReddiNet. Mike Walsh asked what kind of response time would be provided. Ms. Perez assumed the system would have to place individuals locally. The educational requirement was defined as minimal, 1 ½ to 2 hours per user to be fully trained in the use of the system. A recent poll to current users of the ReddiNet rated the system as an 8-9 on a scale of 10. The MMRS Task Force will meet again in a couple of weeks to re-evaluate their position. Ms. Perez sits on the committee and will keep the FAB members informed of their findings.

The current divert screen is being modified to meet the open/closed system. Mike Walsh said a task force has been formed to look into the screen problems. Brian Rogers said as soon as the screen is modified, it will go to MAB for a vote and will go into affect a day after the MAB meeting.

D. Hospital Task Force

Susie Cram had forwarded the minutes from the Hospital Task Force. Each hospital looked at the review that was done on the analysis of flow problems that cause patient back up in the emergency room. The meeting was well attended by the hospitals and everyone did a great job of presenting systems they have in

place that improves the flow in the E.D.'s. The idea was to start on the general care areas, freeing those beds, the IMC's, and ICU's, then get the patients from the ED to the appropriate bed with a little more comfortable environment. The number one recommendation was to look at working with the medical staffs on how rounds are made. A packet would go to the MEC's or whatever committee's would be appropriate in any hospital to get medical staff involved. The committee will work on getting anything that's approved operational, but a consensus is needed that everybody will work on the problem because if one hospital doesn't, it is going to stand out. None of the hospital representatives felt that it would be difficult to look at certain cases where multiple testing was ordered, backing the patient up or keeping the patient there longer while the ED was on divert. Patients that are critically ill can't be cared for in the facility because of managed care companies who send patients to the ED for a work up or testing. The general consensus was that managed care companies avoid admitting patients to save beds, this is a problem. Transportation of patients to sub-acute, especially after 5:00 in the evening, doesn't seem to be adequate to get those patients out of the hospital, let alone out of the ED if they're supposed to go there and IHS. Problems also exist with the psychiatric patients being held in the ED and not cleared for transfer.

It was felt that a need to identify all priorities and then take direction from FAB to get a change in the hospital's operations to put policies/procedures together and move forward either with the medical staff or with agencies outside the hospital. Discharge times seem to be very much in the evenings. Hospitals experience less staff on the evening shift and the beds are closed causing the ED to hold patients until the beds are assigned in the morning. The medical staff needs to be encouraged to discharge in the morning in order to get the patients discharged and open beds for admission. This will mean a reversing of the order and round early in the morning freeing up the evening to make sure discharge orders are written for the next morning. Some hospitals were looking at centralizing their transports to move a patient out of the ED or take a patient to CAT Scan which could also be used for the emergency room by moving the patients up stairs once a bed was made available.

J.D. Justyn encouraged the task force to continue by focusing on the two items, rounding and centralized transport, and write a policy for the FAB to review.

Ms. Perez was encouraged that all the hospitals were coming together and actually sharing practices in an attempt to benefit the Community. She expressed her desire to continue to share any ideas that a hospital has discovered actually works and makes things better in terms of the emergency room flow.

Susie Cram said additional information is needed on psychiatric patients and the CPI.

Pam Turner advised that the Las Vegas Mental Health (LVMH) attended the Nurse Manager's meeting and made a strong commitment to assist with any problems being experienced. The Nurse Managers have been able to contact the appropriate personnel on off hours to handle these situations. LVMH has changed their intake process and is educating the facilities. Ms Turner was asked to submit a report on what the process is and how it works. Jane Shunney suggested inviting Dr. Rosin to be a member of the FAB as he represents a facility that is accepting transports.

Jane Shunney said the Medical Advisory Board requested a training for the pre-hospital people so that they have adequate understanding of the care of Chronic Public Inebriate patients. This would include understanding the legal components and the liability that is related to taking care of the individual in the field prior to transport. Ms. Shunney said she has discussed this with an individual who has considerable background and credentialing in the care of alcohol and drug abuse. This individual has put together a recommended package for this training program and is going to meet with the people from WestCare to see if a consensus can be obtained on what her package entails.

E. Report from Nursing Shortage Task Force

Ms. Perez said one of the items identified as one of the leading causes for divert was the nursing shortage. A recommendation was made to not duplicate the work of the Nevada Hospital Association who already has a nursing task force in place. A survey released stated that Nevada has the worst nurse to population ratio than any other state in the nation. It helped validate the concern on what was already known to exist but many of the regulators and legislators did not believe. At the end of the Nevada Hospital Association Conference, additional task forces were established to work on very specific problems. The first task force is going to deal with the education system in the State of Nevada. There are currently six schools of nursing, four of them northern Nevada, two in southern Nevada. All six schools, during their last semester, turned away students who wanted to get into the nursing program. They claimed the reason was that they didn't have enough resources to be able to accommodate more students into the program. The student to teacher ratio in the state of Nevada is 8 to 1. The national average is 10 to 12 students to one teacher. They could have accommodated every student that was turned away without any additional resources. One of the things that the education task force is going to be looking at is going to the legislators to mandate

increased student teacher ratios because the teachers union is not going to do it voluntarily. They also talked about looking at the millennium scholarship. It was given to seniors in high school who scored an average of B or better who were going to attend a Nevada school. The proposal is for the Governor to take a look at expanding that program to people who actually graduated within the last ten years who may not have gone on to any higher education and now nursing is a career they want to consider. They might be able to get back into the education system if they have an opportunity for a scholarship. There was discussion about the nurse practice act and the nursing licensure process.

There is also a task force that's devoted to employer and employee relations. There was a lot of staff nurses at the conference who said the real reason for the nursing shortage is because employers don't treat their employees well, they get burnt out and want to leave the profession, and they tell other people "don't get involved in nursing because you work too hard and you're under paid". The task force looked at ways in which employers and employees could relate better to improve those relationships.

Another task force looked at staff development within the hospitals and the education programs available to help build specialty programs, whether it's CNA programs, critical care courses, ED courses, OR courses, all of the different courses that are available. Ms. Perez was surprised at the few number of hospitals who actually provide internal training programs throughout the State.

A task force called the K through 12 is to look at ways in which individuals in K through 12 can be reached to encourage them to look at the nursing profession.

Another task force looked at diversity and they shared statistics about the few numbers of minorities involved in nursing which is below the ratios of the individual minority percentages within the population. They also looked at encouraging males to get involved in nursing as part of that diversity task force.

The last task force dealt with public relations in general and how to promote nursing by improving the image of nursing.

F. <u>Restocking of Ambulances</u>

Brian Rogers presented to the last FAB meeting a packet of information on an opinion from the OIG, on the issue of hospitals restocking ambulances. Ms. Perez said, from a hospital perspective, there are a lot of unanswered questions that the hospital community is struggling with related to compensation for those supplies. Since it's not a service that is being provided it cannot be billed. The hospitals

are in agreement of placing lockers or some sort of locked cabinets within the emergency rooms that the ambulance companies could stock supplies for restocking the ambulances at the time of service.

III. INFORMATIONAL ITEMS/DISCUSSION ONLY

Michael Walsh had no comment.

IV. PUBLIC APPEARANCE/CITIZEN PARTICIPATION

No response.

V. ADJOURNMENT

Adjournment 9:00 a.m.