MINUTES
EMERGENCY MEDICAL SERVICES
FACILITIES ADVISORY BOARD
JULY 2, 2003 – 8:30 A.M.

MEMBERS PRESENT

Donald Kwalick, MD, Clark County Health District
Gregory Boyer, Valley Hospital
Helen Vos, Mountain View Hospital
Jackie Taylor, University Medical Center
Jennifer Schomburg, Summerlin Hospital
Karla Perez, Chairperson, Spring Valley Hospital
Mary Jo Solon, Southern Hills Hospital

MEMBERS ABSENT

Don Hessel, Boulder City Hospital
Renato Baciarelli, St. Rose Medical Center
Sam Kaufman, Desert Springs Hospital
Suzanne Burton Cram, Sunrise Hospital
W. Jeff Comer, Jr., Lake Mead Hospital

ALTERNATES

Dee Hicks, Sunrise Hospital
Punch Fermin, Lake Mead Hospital
Stephan Jones, St. Rose Medical Center
Tony Marinello, Desert Springs Hospital

CCHD STAFF PRESENT

Brian Labus, Epidemiologist
Jane Shunney, Asst. to the Chief Health Officer
Jennifer Carter, Recording Secretary
Kay Godby, Biopreparedness Planner
Mary Ellen Britt, QI Coordinator
Rory Chetelat, EMS Manager

PUBLIC ATTENDANCE

Alice Conroy, Sunrise Hospital
Brian Rogers, SWA
Davette Shea, West Care
David Rosin, MD, SNMHS
James Osti, West Care
Jay G. Craddoch, NLVFD
John Wilson, SWA
Kathy Kopka, Sunrise Hospital
M. Krieger, Lake Mead Hospital
Pam Turner, Valley Hospital
Philis Beilfuss, NLVFD
Sandy Young, LVFR
Steven Kramer, AMR

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The EMS Facilities Advisory Board convened at 8:30 a.m. on Wednesday, July 2, 2003 in the Clemens Room at the Ravenholt Public Health Center. Chairperson Karla Perez called the meeting to order. The Affidavit of Posting and Public Notice of the Meeting Agenda was executed in accordance with the Nevada Open Meeting Law.

I. CONSENT AGENDA

A motion for Board approval of the April 23, 2003 FAB meeting minutes was made, seconded and unanimously carried.

II. REPORT/DISCUSSION/POSSIBLE ACTION

A. Discussion of Legal 2000 (L2K) Patients
Consider Redistribution of L2K Patients Possibly by Total Licensed Hospital Beds

Chairperson Perez pointed out the Medical Advisory Board requested reconsideration of the distribution for L2K patients to area hospitals. She mentioned the current policy for distribution indicates after each facility emergency department (ED) receives five L2K patients, service providers begin the 1-9 level-loading process by which L2K patients are rotated between nine facilities. The smaller facilities are again requesting reconsideration of the current plan, as holding five L2K patients has become a burden for them. Rory Chetelat, CCHD EMS Manager, was asked by Chairperson Perez to compose an alternative plan.

Rory mentioned he received a request to consider a total bed distribution for use in factoring the number of ED beds in each facility. Therefore he solicited total licensed beds for each of the facilities from the State Board of Licensing and worked out the numbers using the square root of the total bed count to accommodate for the bed count disparity, and a denominator of 50 L2K patients. For the purpose of discussion he distributed tables, which represented the factoring of total hospital beds per facility. He explained the column labeled "rounded" is the number that is based on the percentage of licensed beds. The column labeled "adjusted" is based on the square root percentage of total licensed beds. The result of his findings is displayed in the following table.

Name	Lic. Beds	% of ttl	% of 50	Rounded	Adjusted	SQR of beds	Sqr %	Actual	Adjusted
Desert Springs	351	11.67%	5.84	6	6	18.73	11%	5.63	6
Lake Mead	198	6.58%	3.29	3	4	14.07	8%	4.23	4
Mountainview	192	6.39%	3.19	3	4	13.86	8%	4.16	4
Spring Valley	176	5.85%	2.93	3	4	13.27	8%	3.99	4
St Rose Dominican	138	4.59%	2.29	3	4	11.75	7%	3.53	4
St Rose Siena	141	4.69%	2.34	2	4	11.87	7%	3.57	4
Summerlin	171	5.69%	2.84	3	4	13.08	8%	3.93	4
Sunrise	688	22.88%	11.44	11	7	26.23	16%	7.88	7
UMC	542	18.02%	9.01	9	7	23.28	14%	7.00	7
Valley	410	13.63%	6.82	7	6	20.25	12%	6.08	6
Totals	3007		50	50	50	166.39		50	50

Steve Jones, St. Rose Hospital, stated the concern at St. Rose Hospital is at a time when L2K patient population reaches capacity; it is harder for smaller facilities to accommodate the volume. Therefore he requested consideration for an alternative plan that would allow for better utilization of the larger facilities that have the capacity and ability to accommodate larger volumes.

Tony Marinello, Desert Springs Hospital, suggested adding one to the L2K distribution for Sunrise and UMC and subtracting one from the distribution for Desert Springs, and St. Rose Siena and Dominican.

As the committee deliberated, comments made were:

- Regardless to the size of the hospital and capacity, holding the L2K patients is only one set of the patient population. Larger facilities should not be required to hold more L2K patients because none of the facilities specialize in psychiatric care. The volume of walk-in patients is huge. Therefore space is an issue.
- Some of the larger EDs are the busiest EDs. The larger EDs tend to get more patients. Larger facilities should not have to be penalized with a higher volume of L2K patients to compromise the overall patient volume. Another factor is acuity. Valley Hospital has one of the highest acuities in the system and despite having only 24 beds in the ED which are currently compromised due to construction, the idea of a formula that heavy weights larger facilities due to bed size which has nothing to do with ED size, volume or acuity, is unfavorable.
- L2K patients are outpatients, they are not in-patients and a lot of the patients that come to facility EDs are in-patients that hold for days as well as outpatients. Therefore ED size is not so much the issue as an equal proportionate share of holding L2K patients in any size ED. Currently the level-loading plan equally distributes L2K patients as all facilities are holding a proportionate share.
- There probably is not a method that would be pleasing to everyone. The current policy has been working and should remain in place at least until the opening of the new hospitals.
- A larger facility has the capacity and ability to deal with high volumes. A smaller facility does not have the space and the capacity to adjust for high volumes as easily as a larger facility. When ED volumes are high finding the space to isolate L2K patients in a smaller facility becomes an issue. With more beds it is easier to accommodate the space requirement.
- It is understandable that the larger facilities do not want to be penalized however, by virtue of the current system it does penalize the smaller facilities and stating the facilities are equal in capacity, is an unfair statement

David A. Rosin, MD, Southern Nevada Mental Health Services (SNMHS), commented while 10% of the L2K population may go to Monte Vista and Lake Mead Hospital, SNMHS can account for 90% of those patients. He expressed his gratitude to the hospital administrators and lobbyists for their support in the legislative session. As a result SNMHS has been funded for a 150-bed Acute Psychiatric Care Facility, which doubles the current occupancy.

He reported the legislature awarded fifty-six new positions to SNMHS, which enabled the following things in relation to the L2K issues. It enabled an increased bed capacity of 16 beds. In the interim, for the next two years construction is taking place for this 150-bed hospital with a 30-bed emergency room service, to relieve the stress on the EDs. Funding was received for staffing a 24/7 emergency response team to come in to the EDs to assist in dispositioning the patients that sit there extensively and then 1/3 of them leave without any psychiatric follow-up or care plan by SNMHS statistics, which means they are recycled into the EDs at a later date, and that is usually sooner rather than later. Funding was provided for an additional PAC team to work in the homeless quarter. A PAC team is a team of seven or eight licensed professionals, including psychiatrists, who would target the homeless quarter, and is housed in the homeless quarter to prevent people from getting into the EDs that could be maintained in the community.

Dr. Rosin further commented all of that is up in the air, because if the budgets get open, and there is talk about taking away positions, the current issues with the L2K patient population will remain the same as it is now. He mentioned when he arrived in Las Vegas 2½ years ago, came to the Clemens Room on his second day of the job, got nailed by the press because SNMHS was not a community participant, SNMHS

committed on that day to become a community participant and try to do something to alleviate the problem with L2K patients. There were not forty-fifty L2K patients sitting in EDs in those days, he attested.

Over the last 2½ years EDs have been faced with this almost exponential rise in L2K patients. That is not going to stop, Dr. Rosin continued. The next two years while the new hospital is under construction, without some action being taken to protect the mental health budget, SNMHS may lose that ability to service community needs in the future.

A question was raised, assuming the budget gets approved how quickly will SNMHS be able to increase the capacity and put together the EMS response team?

Dr. Rosin replied currently SNMHS is budgeted to start bringing on staff in October. The new beds will be phased in, October and February, as SNMHS is able to hire and train staff. In addition SNMHS is trying to target a psychiatrist in January or February to work several hours a day in facility EDs to evaluate patients at the facility EDs.

Pam Turner, Valley Hospital Nurse Manager, commented that Valley Hospital is reviewing the lost of revenue and cost associated with the workman's compensation injuries that occur in the ED as a result of L2K patients. The Valley Health System proposes re-implementation of the Blue Ribbon Committee to look at the L2K issue with that being the focus. Due to the fact that facilities are losing nurses due to the violence projected by L2K patients, facilities are being forced to come up with solutions as this problem is largely impacting the community. Recently there was a L2K patient in Valley ED who nearly injured a pediatric patient in an act of violence for which LVMH interjected and was able to assist with. By putting the Blue Ribbon Committee back in place there is a potential to present this issue to the legislature for consideration of deferring these patients to mental health facilities.

The FAB was in favor of re-implementing a fast track Blue Ribbon Committee that included representation from the MAB, pre-hospital, and ED physicians.

A motion was made to maintain the current distribution of mental health patients and establish a fast track Blue Ribbon Panel to focus on L2K issues. The motion was seconded and passed with 8 yes votes and 1 no vote.

Chairperson Perez asked EMS staff to contact each one of the hospitals and have each facility provide representation to the Blue Ribbon Committee.

B. Discussion of Triage Guidelines
Consider Endorsement of Standard Triage Guidelines Developed by Nurse Managers

Chairperson Perez evoked the request from the FAB for the ED nurse managers to compose Triage Guidelines for standardizing facility ED procedures of triaging non-urgent patients.

Pam Turner reported the ED nurse managers composed triage guidelines to provide standard optimal care of EMS patients to transfer care within the confines of a receiving facility. The goal of the guidelines is to decrease EMS drop-off time to 30 minutes or less. In referencing the draft Triage Guidelines of EMS Patients handout, provided in the MAB packets, Ms. Turner pointed out that the triage RN or designee would assess non-urgent patients within 15 minutes of EMS arrival. The RN or designee would determine if the patient continues to meet non-urgent triage criteria. If the patient meets non-urgent triage criteria, the patient will be removed from the EMS gurney and placed as deemed appropriate by the triage nurse or designee.

A concern was raised regarding the language in roman numeral III that read, "The triage RN or designee will have the discretion to remove the IV or cardiac monitor based upon the assessment". The statement was considered too prescriptive, operationally, from a facility standpoint. An opinion of the board was that the first sentence in roman numeral III adequately allows for a RN or designee to determine if removal of an IV and/or cardiac monitor is appropriate. The first sentence in roman numeral III reads, "If the patient meets

non-urgent triage criteria, the patient will be removed from the EMS gurney and placed as deemed appropriate by the triage RN or designee and in accordance with the facility policy".

From an EMS standpoint, removing the statement could cause a delay in the effectiveness of the guidelines if the language is not specific, and nurses choose not to do a better assessment of the patient and remove IVs and/or cardiac monitors that are started, perhaps unnecessarily, in the field. This would not alleviate the EMS drop time issue because the patients would not be removed from the EMS gurneys to allow EMS personnel to get back into the field in a timely manner. Leaving the statement in allows the RN or designee making the assessment, to determine if removal of the IV and/or cardiac monitor is appropriate.

After much discussion there was a recommendation to have the issue taken back to the nurse managers for further review.

In an effort to avoid delaying the implementation of the Triage Guidelines, the decision of the board was to remove the second sentence in roman numeral III, implement the policy without that language, and send the guidelines back to the nurse managers for further review.

A motion was made to adopt the Triage Guidelines with the deletion of the language in roman numeral III which read "The triage RN or designee will have the discretion to remove the IV or cardiac monitor based upon the assessment". The motion was seconded and passed unanimously.

The nurse managers were asked to take the guidelines back and revisit the deleted language for potential alternative language.

C. Discussion of Changes to the EMS Procedure for ED Closure
Include Spring Valley and Southern Hills Hospitals

Chairperson Perez pointed out Spring Valley Hospital is scheduled to open October 1, 2003 and Southern Hills Hospital is scheduled to open February 2004. The MAB approved a motion to add both of the two new hospitals to region A. Region A would then consist of six hospitals for which two hospitals could close simultaneously. Regions B and C would remain as they currently exist. Some of the concern regarding the change to region A is that both UMC and Valley could be closed at the same time, Chairperson Perez continued. It also means that Summerlin and Mountain View may be on closure simultaneously. She mentioned, a counter proposal was to consider allowing one large facility and one small facility to close simultaneously and not allow for closure of two large facilities at the same time.

Concerns from an EMS standpoint were:

- If two large facilities in the same region were on closure simultaneously, it would shut down that entire side the city for rotation. The transport agencies were opposed to two facilities in region A going on closure at any one time. The purpose of the closure zones was rotation of closure amongst the hospitals, to allow continuous rotation geographically in an effort to provide facility access to patients within their geographical area.
- Allowing two large facilities to close simultaneously would have a negative impact on EMS drop times. The larger facilities are better equipped to absorb the patient load than smaller facilities, when another large facility is closed.

Arguments from a facility standpoint were:

- When two large facilities are adjacent to one another and one or the other closes, the open facility gets overwhelmed with patient volumes and it takes a long time to recover.

Another proposal was to consider an east/west I-15 split of the zones.

After much discussion a motion was made to add Spring Valley Hospital to region C temporarily. The motion was seconded and passed unanimously.

Brian Rogers, Southwest Ambulance, recommended facilities inform EMS when wait times are long at which time EMS could attempt to divert patients to other facilities.

D. Appointment of New MAB Representative

Sam Kaufman was nominated. A motion was made to have Sam Kaufman serve in the position of MAB Representative. The motion was seconded and passed unanimously.

E. Discussion of Election for FAB Chairperson
Elect FAB Chairperson for July 2003-June 2004 Term

Chairperson Perez was nominated. A motion was made to have Chairperson Perez continue to chair the FAB. The motion was seconded and passed unanimously.

III. INFORMATIONAL ITEMS/DISCUSSION ONLY

A. Update on the Community Triage Center (CTC)

James Osti reported the CTC has been operating for approximately six months after start up in the middle of January 2003. He presented a packet of charts to the committee members.

- The first chart represented overall admissions to the CTC, which were in excess of 500 admissions. The CTC's goal is to have 600 admissions per month.
- The second chart represented Chronic Public Inebriate (CPI) transfers in 2003. Mr. Osti announced there is a proposal in place to broaden the CPI protocol for transporting patients directly to the CTC. The proposal has been submitted for consideration by the MAB. Broadening the protocol would allow EMS to transport individuals who are medically stable and in need of substance abuse or mental health services directly to the CTC.
- Civil Protective Custody is the vehicle for the police to transport individuals from the street to the CTC. Currently Metro Police Officers are receiving mental health training that is coaching officers to transport appropriate individuals to the CTC rather than to the EDs. Sixty officers have received the training and another sixty officers are scheduled to receive the training in August and September 2003. The goal is to have 300 officers trained when the training is complete.
- The "Hospital Transfers to the CTC for 2003" chart represented non-L2K individuals transferred to the CTC from facilities. The CTC received 147 transfers from facilities in May 2003.
- Another chart represented a 2.23 average length of stay for CTC patients in the month of May. As an acute stabilization facility the CTC stabilizes patients, evaluates them for services throughout the community and discharges them. Some patients stay longer and those are balanced off by the short-term stays of less than 24 hours.
- Mr. Osti pointed out the community expressed concerns about whether individuals who arrive at the CTC are at a greater acuity than what the CTC would be able to handle. The chart labeled "911 Calls by Total Admits" represented a less than 4% call back of patients who were admitted to the CTC and referred back to the facility for a higher level of medical care. There are individuals who have medical crisis or who may have a psychiatric or substance abuse crisis that are beyond the capability of the CTC. However the CTC is effectively treating the substance abuse and non-L2K patient population, having only to refer a small percentage of those patients back to the facilities, Mr. Osti attested.

The CTC staff is conducting in-services to facility EDs on the appropriate types of referrals for the CTC, Mr. Osti continued. According to a handout of a chart submitted to the committee by Mr. Osti, facility admissions fluctuate between the different facilities. Some facilities slightly increased the number of

referrals to the CTC while other facilities showed a decrease. The CTC recently conducted training at Sunrise Hospital for which the chart indicates a marked increase in the number of referrals from Sunrise Hospital to the CTC.

Mr. Osti encouraged facilities to utilize the CTC trainings in an effort to learn more about how the CTC may be helpful in assisting facilities with high patient volumes.

B. Presentation on Epidemiologic Syndromic Surveillance

Brian Labus, MPH, CCHD, Office of Epidemiology, gave an overview on the Syndromic Surveillance System, which has recently been developed at CCHD. He explained, the basic purpose of the system is to enhance and complement existing surveillance activities; detect disease outbreaks (i.e., natural outbreaks, bioterrorism incidents); track disease spread; and monitor seasonal disease changes. Routinely the Office of Epidemiology surveys a number of diseases, including diseases that are not normally seen in the community, as well as diseases that could be a result of a bioterrorist incident. The Syndromic Surveillance System is designed to help detect disease outbreaks, natural outbreaks and bioterrorist incident related outbreaks. The system is capable of tracking how diseases spread throughout the community.

Currently the University Medical Center (UMC) is the only hospital participating in the project. Data is automatically transferred from UMC on a daily basis and stored in an electronic format, Mr. Labus continued. The transferred data consists of:

- A report on all patients seen within the previous 48 hours at any UMC care center,
- Chief complaint of the patients, and
- Patient demographic information such as where they live, age, gender, etc.

ICD9 codes were considered as part of the data transfer but because often times there is a delay between patient coding and when the event occurs, ICD9 codes would not transpire within the 48-hour window.

There are five different syndromes currently being observed by epidemiologists:

- General syndrome
  - Total complaints of fever and total number of patients being seen at quick cares and pediatric and adult emergency departments (ED)
- Influenza like illness
- Dermatologic illness (i.e., fever and rash)
- Neurological illness (meningitis as well as gastroenteritis)

The system was built on three years of historical data. That historical data was analyzed and used to decide what sort of syndromes should be observed, and to establish baselines and thresholds to help determine at which point some sort of response would be required.

Once the data is received, it is electronically processed, and each day a report is produced with a number of graphs and maps. Mr. Labus displayed a graph of Adult Influenza-Like Illness, which exhibited statistics observed in Clark County over the past six months. He explained how the graphs represented moving averages, which were the average number of patients seen each day; and alarming thresholds which were red circles indicating exceeded expectations for a specific time period, based on historical data. When the red dots exceed the threshold, epidemiologists research previous surveillance systems and reports received from hospitals and laboratories. Once the alarming thresholds warrant suspension of potential outbreaks, the appropriate response is entered into the system.

The Syndromic Surveillance system has been operating for three months and there has not yet been an occurrence of major events. Work is being done to figure out what the appropriate response is to each event, Mr. Labus announced. The trends can also be broken down by Clark County zip codes, to look for geographic clustering of syndromes.

Future plans for the system are to continue refining and adjusting the thresholds and baselines to adjust to changing patterns in the data; monitor success of outbreak detection; and include additional data sources (other hospitals and other agencies to try and get community-wide data into the system which would provide better representation of what is going on in Clark County).

Mr. Labus passed out a pamphlet to the committee members that describe the system in detail and provided answers to frequently asked questions.

Dr. Kwalick urged all facilities to participate.

IV. PUBLIC APPEARANCE/CITIZEN PARTICIPATION

No response.

V. ADJOURNMENT

As there was no further business, Chairperson Karla Perez called for a motion to adjourn. The motion was seconded and carried unanimously to adjourn at 10:02 a.m.