CLARK COUNTY HEALTH DISTRICT

MINUTES

EMERGENCY MEDICAL SERVICES

FACILITIES ADVISORY BOARD

SEPTEMBER 29, 2003 – 3:30 P.M.

MEMBERS PRESENT

David Rosin, MD, SNAMHS
Donald Kwalick, MD, Clark County Health District
Gregory Boyer, Valley Hospital
Helen Vos, Mountain View Hospital
Jacqueline Taylor, University Medical Center
Jennifer Schomburg, Summerlin Hospital
Karla Perez, Chairperson, Spring Valley Hospital
Mary Jo Solon, Southern Hills Hospital
Sam Kaufman, Desert Springs Hospital
Suzanne Burton Cram, Sunrise Hospital

MEMBERS ABSENT

Boulder City Hospital Representation
Lake Mead Hospital Representation
Montevista Hospital Representation
Renato Baciarelli, St. Rose Medical Center

CCHD STAFF PRESENT

Jane Shunney, Asst. to the Chief Health Officer
Jennifer Carter, Recording Secretary
Mary Ellen Britt, QI Coordinator
Rory Chetelat, EMS Manager

PUBLIC ATTENDANCE

Brian Rogers, SWA
Davette Shea, WestCare
Dick Steinberg, WestCare
James Osti, WestCare
JoAnn Lujan, WestCare
John Wilson, SWA
Kathy Kopka, Sunrise Hospital
Lou Huff, Desert Springs Hospital
Marci Krieger, Lake Mead Hospital
Mike Myers, LVFR
Natalie Seaber, MountainView Hospital
Pam Turner, Valley Hospital
Scott Vivier, HFD

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The EMS Facilities Advisory Board convened at 3:30 p.m. on Monday, September 29, 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 July 2, 2003 FAB meeting minutes was made, seconded and unanimously carried.

II. REPORT/DISCUSSION/POSSIBLE ACTION

A. Discussion of Pilot Operations Protocol
Review Patient Transfer to Receiving Facility Pilot Operations Protocol

Rory gave an update on the Patient Transfer to Receiving Facility Pilot Operations Protocol, which was scheduled to go into effect October 15, 2003 as a 30-day pilot. He pointed out the intent of the protocol is to balance the equation between EMS and hospitals. He explained the current hospital closure policy would remain unchanged. However, to balance the equation, twenty minutes after ambulance arrival in the emergency department (ED), any patient meeting all the following criteria may be placed in the hospital waiting room or other appropriate location:

Normal Vital Signs

1. HR 60-100
2. RR 10-20
3. Systolic BP 100-180
4. Diastolic BP 60-100
5. Room Air Pulse Oximetry ≥ 94%

Subsequently, Rory continued, the third part of the protocol assists with balancing the equation and accurate reporting, utilizing the technology of the EMSystem. The hospitals will have the ability to enter trackable information into the EMSystem for L2K holds. When there are three ambulances waiting at a facility for more than 20 minutes, that would be communicated to the appropriate dispatch, SWA or AMR, at which time the indicator on the EMSystem screen will be changed to yellow by dispatch as a warning that ambulances are starting to back up at that facility. When five ambulances are waiting 20 minutes or more at a facility, dispatch would be notified and the EMSystem screen indicator would be changed to red. Ambulance attendants would then start informing patients of the circumstances occurring at the specified facilities in an effort t to deter traffic from those facilities. This method would be used to test the EMSystem to determine if it could be successfully implemented for level-loading the system.

Fourthly, transport personnel will be required to notify hospitals prior to transport of all patients by phone, radio, or EMSystem, and must determine the current hospital status prior to transport to that facility, Rory added.

Concerns were raised regarding the systolic and diastolic blood pressure ranges indicated on the protocol as normal vital signs. Rory explained, initially those ranges were set lower and were raised at the MAB.

Board members were displeased that there was no data to support the allegations that facilities were not consistently in compliance with the 15-minute triage guidelines.

Rory explained that increased drop times indicated the need to implement a procedure that would allow the EMS office to have some control for monitoring drop times. It has been stressed to EMS practitioners the importance of keeping the lines of communication open. However, after waiting 20 minutes, the EMS

practitioners have been advised to complete a patient care report and inform the appropriate charge/triage nurse that the patient is being moved to the waiting room, or designated area, and the patient care report should be placed in a noticeable area for the nurse.

Other concerns raised by board members were:

- Who makes the final determination between the nurse and the paramedic regarding the patient assessment?
- According to regulations there should be language added to the protocol to initiate verbal communication from transport personnel to the triage/charge nurse.
- Hospital authorities would like to know how drop times at their facility compare to drop times at other facilities, and would like to be informed if their staff that is not cooperating.
    - A suggestion from the board was to develop a procedure by which the paramedic calls their supervisor and the supervisor contacts the administrator on call (AOC).
- How are the arrival and departure times documented by the transport agencies?

Rory replied it is the expectation of the EMS office that the lines of communication remain open. He encouraged the facilities and the transport agencies to provide any information that could improve the effectiveness of the PTRF protocol by submitting incident and prevalent data to the EMS office. The EMS office is in the position to educate, train, regulate, and discipline paramedics, which supports the balancing of the equation. Patient Care Reports, on patients who were left at the hospitals by paramedics, will be examined and analyzed during the QA process. This will be the tool of measurement utilized by the Health District to monitor the effectiveness of the protocol.

The EMS office would consider obtaining a list of phone numbers for the AOC's of each facility in an effort to establish communication between the agency supervisors and AOC's when necessary, Rory suggested.

Arrival and departure transport times are confirmed verbally to the appropriate dispatch or through use of the MDT system, which logs data into the computer, and the data is retrievable for adequate tracking of drop times, Rory explained.

After much discussion a motion was made to add G to section II of the PTRF protocol with language that states, "A verbal report is given to the charge/triage nurse". The motion was seconded.

Chairperson Perez called for discussion.

Dr. Kwalick suggested a friendly amendment to the motion to include language that states, "An attempt was made to give a verbal report to the charge/triage nurse with refusal by (the name of the person refusing to take the report)". This would provide the facilities and the EMS office with information for approaching value added results to a potential problem.

The initial intent of the EMS office was to compare the QA report with the patient care report, Rory added. However in light of the discussion, he suggested having the paramedics maintain the checklist, including the suggested language, for the 30-day trial period in an effort to determine where the problem is. He mentioned that if the 15-minute nurse triaging rule is effective, very few patients are going to meet the PTRF protocol criteria.

Davette Shea pointed out the patient criteria for the Triage Guidelines of EMS Patients and the PTRF protocol is unsynchronized. She suggested the MAB consider revisiting the two documents in an effort to clarify the non-urgent patient criteria, and limit potential decision making complications between the nurses and the paramedics.

The friendly amendment to the motion was declined. Chairperson Perez called for a vote on the motion. The motion passed unanimously.

B. Discussion of Legal 2000 (L2K) Patient Population
Blue Ribbon Committee Views

Rory explained the Psychiatric Tracking form was developed approximately 2½ years ago and much discussion has taken place as to the accuracy of the data. He referred to an example of a report received from a facility. The report included statistics for six adult patients who were admitted for 5,9,15,12,12, and 12 hours, which adds up to 65 hours. He noted the date of the report was August 10, 2003. Two days later the same hospital reported seven patients, two were dismissed, and suddenly the hours increased from 65 to 524 hours. The individual reporting the data for the facility was under the impression that accumulated hours meant adding the hours the patient is in-house from the day before. Therefore, if a patient is admitted and is in-house the first day for 12 hours, and 24 hours the second day, it was reported as 36 hours, and so on. There were many inconsistencies with the psychiatric reporting, therefore the reported hours were skewed and not being recorded accurately.

As a result of these findings it was recommended at the nurse managers meeting to implement a temporary standard psychiatric patient-tracking sheet for which facilities could report psychiatric patient in-house hours from midnight to midnight.

A request was made for clarification from the board regarding whether the tracking sheet includes L2K patients only or all patients who are admitted with a psychiatric diagnosis.

Rory replied as the tracking sheet was newly designed only three days ago as a temporary fix until a more permanent form can be developed, which is currently in progress, discussion was open for modification.

A suggestion from the board was to report L2K patients only and to include a separate line for "total number of new adult legal holds and a line for number of psychiatric pediatric patients".

After much discussion a motion was made to change the form to include L2K patients only and to add "Total number of new adult legal holds and on a separate line, add a line for total number of psychiatric pediatric patients. 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 had a significant and profound impact, in two ways, on the number of individuals in the hospitals that are moving away from the hospitals to the CTC. One is by CTC transports of individuals out of facility EDs as well as off the facility floors, (patients in the hospitals that are discharged and transferred to the CTC). The CTC has had a total of 793 hospital referrals through the end of August. That number is now closer to 1000 as of the end of September. The CTC has also received 649 admissions through Civil Protective Custody referrals, which are those individuals who are picked up by law enforcement who are either under the influence of alcohol or drugs or they may have a mental health problem, and with some new ordinance changes the CTC is allowed to take care of those individuals directly. Those people are coming to the CTC rather than going to the hospital for medical clearance. Sometimes they do go to jail if they are not admitted to the CTC.

The third category is the Chronic Public Inebriates (CPI), Mr. Osti continued. Those are individuals who the EMS system transports and would have gone to facility EDs if there were not a diversion system in place. 100% of those individuals would have ended up in facility EDs. And at this point the CTC has 346 CPI admissions. The ordinance was changed recently to expand the parameters for CPI individuals. The original ordinance was alcohol only, now it includes alcohol and/or other substances of abuse. Therefore, the CTC anticipates there will be a marked increase in the number of CPI admissions to the CTC. CPI admissions increased 37 to 51 from July to August.

Mr. Osti further reported WestCare had an appropriation in two bills; one was an authorization bill and one was a funding bill. WestCare anticipated receiving approximately $600,000.00 for funding from the state to help with the operation of the CTC. Unfortunately, there was some type of legislative oversight and in the final analysis after a lot of legislative activity, the authorization was passed but the funding for that authorization was not. What that means is that WestCare was short from the states money that was considered to be essential for the operation of the CTC. The good news, Mr. Osti continued, is that WestCare was able to make some adjustments and reorganize so the CTC would continue to operate in a way that the community will not see any difference. The state is working with WestCare. There will be an interim finance committee meeting and this issue will be discussed and hopefully some of these fundings will be restored through other means other than through the appropriation that WestCare was seeking.

A question raised from the board was have all the hospitals contributed to their portion of the funding?

Dick Steinberg, CEO, WestCare, replied the funding mechanism that was designed almost two years ago, is one-third from hospitals, one-third from the county and the four cities, and one-third from state. The state has been all along committed to about one-half of that. Approximately one-sixth of the funding has been coming through. The papers listed 100% had not participated yet, but they are at the table with half of that. It was $677,333.00 that was to be appropriated, which went before the Interim Finance Committee (IFC) two weeks ago, for which a document on that was distributed to the facilities as an informational piece on the politics that were taking place at the time. Since that time there was an interim committee made up of two assemblywomen and two state senators. They will be reconvening October 9. Hopefully, Mr. Steinberg continued, some of that will get resolved or back before a vote on November 18th in Carson City. The counties, city, and the metropolitan police department are all lobbying on behalf of keeping the funding and putting that back in place. It has, as Jim pointed out, put a little bit of a hurt at WestCare because that is a significant amount of money that is not at the table. On the hospitals themselves, everybody has agreed to participate. The down side is that some are very current, some have actually paid all of it up front, and others are a little slow on the payments. That is definitely going to hurt WestCare a little bit at this point.

Dr. Kwalick urged everyone to call Christina R. Giunchigliani, Chairperson of the IFC Committee, and stress the importance of the WestCare facility in support of obtaining the funding through the IFC meeting in November.

Mr. Osti announced JoAnn Lujan is the new director for the CTC. He said he will be doing some consulting in the community and taking on some new roles but that he will remain active in the legal 2000 issue.

IV. PUBLIC APPEARANCE/CITIZEN PARTICIPATION

Mike Myers distributed a memorandum to the board members regarding the implementation of EMS radios on the Southern Nevada Area Communications Council (SNACC) System. He stated it has been a goal in the City of Las Vegas to globally assist in the communications from the field to the hospitals. One of the first things accomplished was an attempt to get the EMSystem to local facilities and up and running. He thanked the hospitals for participating in the recent drills and the tests, and mentioned the drills would be going on throughout the rest of the next couple weeks. The memo will indicate that the City of Las Vegas has obtained the funds to purchase 800 mhz radios for local facility EDs, Mr. Myers continued. This will allow hospitals to have 16 to 17 channels at this point. One channel, which is referred to as the talk group channel will allow all hospitals to communicate with each other and specifically with the field. If a unit is on scene in a mass casualty incident (MCI) they simply hail the hospitals by pressing an emergency button and it tones at the facility ED until someone acknowledges that radio. When it is picked up, individuals are able to converse, almost like a conference call, with the field and all the other EDs. Negotiations can occur on where patients are going to go from the MCI. This will allow for immediate, real time communication with the field. That has never been available here in the Valley.
The rest of the channels will be used for a pilot study sometime in July of next year in looking at using telemetry, Mr. Myers continued. A couple of hospitals are scheduled to open soon and the existing UHF system is in poor health. Discussions are taking place regarding the option of using the 800mhz to pilot directly hailing the hospital

without going through the fire alarm office. This will be a unique feature as well but it will take further negotiation with the CCHD to make sure it can be done. He explained the funds that are being used to put the radios in local facilities would go for a couple of things:

1. The City of Las Vegas will purchase the radios up front and pay the installation cost for putting the radios in.
2. The City of Las Vegas will pay for the initial turn on charge, which is approximately $1,459.00 per radio.

The City of Las Vegas is asking the facilities to come up with $195 to $200 per year continuance fee, in order to keep those radios live. He asked the board to consider the proposal and he will bring it up for discussion at the next FAB. He mentioned if he could get buy-in from the facilities, the City of Las Vegas would like to start purchasing the radios and scheduling installation for each facility.

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 4:52 p.m.