MINUTES
EMERGENCY MEDICAL SERVICES
MEDICAL ADVISORY BOARD MEETING
FEBRUARY 6, 2002 – 6:00P.M.

MEMBERS PRESENT

Allen Marino, M.D.
Blain Claypool
Bryan Lungo, M.D.
David Daitch, D.O.
Chief David Kalani
David E. Slattery, M.D.
David Watson, M.D.
Deputy Chief Kenneth Riddle
Donald Kwalick, M.D.
Donald Reisch, M.D.
E. P. Homansky, M.D.
Jeff Davidson, M.D., Chairman
Jeff Greenlee, D.O.
John J. Fildes, M.D.
Jon Kingma
Karen Laauwe, M.D.
Kenneth Riddle
Michael Walsh
Michael Zbiegien, M.D.
Nicolas Han, M.D.
Pam Turner, R.N.
Pete Carlo
Philis Beilfuss, R.N.
Randy Howell
Richard Henderson, M.D.
Steve Hanson
Steve Peterson
Todd Jaynes

MEMBERS ABSENT

CCHD STAFF PRESENT

Jane Shunney
Jennifer Carter – Recording Secretary
Joe Heck, D.O.
Karl Munninger
Kelly Quinn
LaRue Scull
Mary Ellen Britt

PUBLIC ATTENDANCE

Bob Andrews, CC Emergency
Alice Conroy, Sunrise Hosp.
Bede Parry, AMR
Brian Rogers, SW
Cody Baldwin, CCSN
Connie Clemmons-Brown, UMC
Derek Cox - AMR
Don Hales, AMR
Ed Wetzel, AMR
Jackie Taylor, UMC
John Wilson - SW
Jon Kingma, BCFD
Kathy Sneed, St. Rose Hosp.
Lynda Courtney, CC Franchise Srvcs.
Margaret Williams, Mt. View Hosp.
Matt Netski, AMR
Mike Griffiths, Mercy Air
Missy Greenlee - Mercy Air
Pam Turner, Valley Hosp.
Patti Glavan - Boulder City Hospital
Paul Fischer, Sunrise Hosp.
Randy Howell, HFD
Rebecca Harrison, CCSN
Ross Berkerey, St. Rose Hosp.
Sandy Young, LVF & R
Scott Rolfe, UMC
Sharon Henry, SW
Sue Hoppler, Desert Springs Hosp.

I. Consent Agenda

A motion for Board approval of the following items on the Consent Agenda was made, seconded and passed unanimously.

- **A. Minutes Medical Advisory Board Meeting December 5, 2001**
- **B. Phenergan Protocol to Drug Committee for Review**
- **C. District Procedure for EMT Paramedic Training to Education Committee for Review**
- **D. Referral of Pediatric Closure Issue to Procedure/Protocol Committee for Review**
- **E. Referral of Intravenous Therapy Protocol to Procedure/Protocol Committee for Review**

II. Report/Discussion/Possible Action

Dr. Davidson introduced Blaine Claypool, Chief Operations Officer of Valley Hospital & Medical Center the newly appointed representative to the MAB from the FAB. He also welcomed, Assistant Fire Chief David Kalani who has replaced Chief Ken Riddle from Las Vegas Fire & Rescue on the Board.

III. Informational Items/Discussion Only

A. Emergency Medical Services Regulations

Dr. Heck referred to the draft of the proposed EMS Regulations provided in the MAB packets. The proposed revisions are necessary because of changes in the Nevada Revised Statutes and Nevada Administrative code. Likewise, changes have been made in District protocols and procedures in an effort to remove any conflict in the Regulations. The next workshop is scheduled for February 21 here in the Clemens Room at 08:30. All those who are interested are invited to attend.

C. Committee Chairmen

Dr. Davidson indicated he has spoken with the committee chairmen over the last couple of weeks. The 3 committees (Drug and Device, Procedure and Protocol, Education) will be structured so that the actual working body of each committee will be nine members. The selection of those nine will be done by the committee chairmen. Dr. Marino will be the head of the Drug and Device committee. Dr. Lauuwe will be continuing as chairman of the Education committee. Dr. Nicolas Han will head the Protocol/Procedure committee. The committee chairmen will appoint the nine members to each of their committees based on the new structure.

B. Divert Presentation

Dr. Davidson presented portions of a lecture he did at a national symposium.

He explained it is important to identify and establish a community wide diversion protocol that will ensure safe, timely, effective treatment of patients through the EMS system into the EDs. The emergency rooms of the 1970's have become high-tech emergency departments that can provide care to everyone.

1. To provide a very good EMS system
2. To provide a system that works in a timely, efficient way for the community
3. To have strong emergency departments to receive these patients
4. To provide good medical oversight

They established the following guidelines for diversion:

1. Diversion has to be temporary
2. During system overload, all hospitals in an area must open
3. Diversion must be defined prospectively, in advance

Everyone should recognize that different hospitals have different capabilities.
In addition, he discussed the reasons for divert:

1. Increased ED visits

   In the mid to late 90's ED visits went up from 89 million a year to 102 million a year. That represents a 14% increase, or roughly an increase of 35,000 visits per day in the US.

2. HMO Demands

   Specifically there are more HMO contracts and a decrease in HMO private medical doctor availability.

Other factors that are working against us are emergency departments closing and the medical personnel shortage.

He displayed a chart that showed the changes in the population in Las Vegas. He also discussed both urban and rural growth. The population in Clark County grew from 867,000 to over 1.5 million in the year 2000. The population for the rural areas is even more significant. Mesquite has experienced a 27% increase in growth in the year 2000. North Las Vegas has grown by 15%, Henderson has seen a 13% increase. It is amazing growth not really seen too many places in the country. Incredibly rapid growth both in our urban and rural populations is complicating our diversion problem.

The use of EDs for non-urgent conditions has greatly increased and there is definitely a decline in physicians that are willing to provide any type of specialty service to us in the EDs. It is felt that both of these issues are definitely documented as resulting from EMTALA.

3. 911 System

   The volume has increased and this system is over used and is often misused.

Dr. Davidson displayed a graph that depicted the average "drop times" or the time it takes EMS personnel to transfer care to the ED staff after arrival at the hospital. Between 1996 and 2001 the

drop times have increased significantly. In 1996, there was an average of 35 minutes to drop patients off and transfer care. In 2001, there was an average of 56 – 58 minutes. This data does not reflect the most recent peak times where drop off times have been as long as 5 – 6 hours. Dr. Davidson stated AMR was the source of the data. A question was raised about the data being inconsistent with data collected at the hospitals which does not show the drop times being as long as reported, by AMR. In fact one facility reported drop times that averaged under 10 minutes in December 2001 and January 2002.

Another graph showed the divert status of the hospitals during 1998 – 2001. Beginning in January 1998 the hospital EDs were open. Then the patient volume increased and the graph shows that in 1999-2000 slowly conditions deteriorated to where the EDs were hardly open any more. This trend continued into 2001 and resulted in a change to the divert policy in this community on April 25, 2001. The effect of that change is that the EDs are nearly back to the open status experienced 5 years ago. What the data shows is we did open things up.

The national standard is actually 23 minutes and they feel 30 minutes is reasonable. This mission statement of the transport agencies "Bed transfer of a patient completed over into the facility within 30 minutes" represents a radical change and although some data shows that some facilities may be able to get a crew out in 10 minutes, that is probably not occurring in general throughout the community.

1. One of the most important recommendations was a real triage system for the EMS person that come in that is just as effective, timely and efficient as the triage that occurs for walk-in patients.
2. A second suggestion would be to adjust closure times from 60 minutes to 75 minutes or 90 minutes.
3. A third suggestion was to create holding areas within hospitals. Holding areas could be staffed by whomever the facility designates to run that holding area, but it probably will not be staffed by the transporting agencies.

These are positive things that could be done to move forward to improve drop off times. He stated all sides of the issues would be heard, including the facilities, EMS agencies, ED physicians, directors and nurses.

Joe Calise commented one issue that has been discussed previously is communication from the field to advise the EDs patients are being transported to their facility. If he was made aware a patient was coming he could try to find a bed and be prepared to receive the patient. He stated the agencies had committed to look at that issue and to communicate with the hospitals, but it is not happening at his facility or at the facilities of his counterparts. In addition, he and at least 3 other nurse managers find fault with the drop off numbers from the agencies and the nurse managers have done their own studies and there are times when ambulances wait an hour, the managers are concerned about how the drop times were determined and they feel the numbers need to be checked out.

Dr. Davidson commented drop off times aren't always the fault of the facility and drop off times are not bad all the time. The drop off times are very good most of the time. But, there is definitely a trend that at peak times of the day, on certain days drop off times have reached very high numbers up into the 4, 5, 6 hour range. For the most part, drop off times are acceptable, except during the identified peak times. We are trying to determine what we can do during these peak times because we know they are going to continue to occur and we need to plan what we are going to do.

A meeting occurred between the agencies, Dr. Kwalick; Steve Minagil, CCHD Legal Counsel; and Roma Haynes, County Franchise Services Coordinator and the issue of drop off times and paramedic activities in the hospital were discussed.

Dr. Kwalick commented that in order to put things into perspective, legal counsel advises "that pursuant to Nevada law the obligation of an EMS permittee in transporting patients is to deliver the patient to an emergency medical facility and provide reports as required by the Clark County District Board of Health Emergency Medical Services Regulations. "Acceptance" of a patient transported to an emergency medical facility by that facility is not a pre-requisite for a permittee's responsibility to end. It's unlawful for a hospital or a physician working in a hospital emergency room to refuse to accept or treat a patient in need of emergency services and care. "Emergency services and care" means medical screening, examination and evaluation to determine if an emergency medical condition or active labor exists". This is in state law. The authority of an attendant of an ambulance or an air ambulance or a fireman employed by or serving as a volunteer with a firefighting agency to provide an emergency medical care is limited to pre-hospital settings, i.e., before delivery is made to an emergency medical facility. Such attendants or firemen are prohibited from performing procedures or tasks in furtherance of a patient's care within an emergency medical facility. This has been going on for decades we have to find ways to reach consensus and to ease into this transition period.

In effect what the law says is when the EMS transport providers arrive inside the ED doors they no longer have the legal authority to continue any care at all. Paramedics don't have legal authority to continue to monitor patients, SVNs, administer or to give any type of medication. What has transpired over the years is that we've become very comfortable letting the paramedics continue the care that they've provided enroute. Because the EDs are so busy and the EMS providers are so capable, those two things have come together in a form that, we have them continue to perform the care after they arrive in the ED. The true legal stance is that they are not allowed to do that and we have to understand that the agencies are calling on everyone involved to try and decide how we are going to work with them to provide continuity and good care to patients and allow them to get back out into the field to respond to 911 system calls.

Some physicians feel there has to be some type of overlap of responsibility, so that when a person is in the emergency room on a stretcher and M.D.s are able to get them to within the 20 minutes timeframe that has been proposed, then there has to be an expectation that the EMS service will also be ready to continue to monitor for that transition period. If the transition period becomes extended or extenuating circumstances arise then obviously there has to be accommodations made. However, to assume that as soon a person crosses the threshold of the hospital property that the EMS providers are no longer required nor allowed to do any type of monitoring this is an odd interpretation at best. A second problem is that by EMS protocols IV's are started in the field, which makes it difficult to triage that patient to the waiting room. (JCAHO) The Joint Commission on Accreditation of Hospital Organization

requires that everybody who arrives at the ER, regardless of what door they enter or mode of transportation are triaged and treated in order of severity. That is something that is lost sometimes with our EMS services because from their perspective they are on a tight schedule, which is appreciated. But, if the EDs have patients with chest pain out in the waiting room, they are also under the same pressure and we have to give the triage nurse or the charge nurse an opportunity to mesh the two patient groups into one triage system. Unfortunately, there has been difficulty getting that done at times.

No one has ever said that continuity of care would end the moment a patient walks in the door. What the transport agencies have asked for is that, within 30 minutes their mission is to be able to turn over complete care of the patient, transfer the patient to an ED bed and leave.

Dr. Homansky added a comment on what JCAHO says. They actually address this and say that the transition in care has to be within a reasonable period of time and they don't define that. What you have in a hospital where you have paramedics coming in and watching monitors and taking care of patients that have never been through either allied health or delineation of privileges (DOPs) of the Board of Governors or the executive committee is like someone coming in off the street to practice. They may be very qualified and able to do that, but unless they are approved by the hospital's allied health committee or have DOPs in that hospital they're not able to take care of patients and that's what we're having them do for extended periods of time.

One of the many participants felt this is the whole city's problem and Dr. Kwalick's guidance is going to be crucial in helping get through it. It's not just a matter of what the law reads; because the law also reads the hospitals can close. The group doesn't want to do that, we want to be open 90% instead of closed 90%. We were 60% closed a couple of years ago, now we're 95% open.

The FAB is scheduled to meet on February 8 and it is hoped that the MAB can endorse guidelines to continue to improve upon the current system and also to suggest how to attack prolonged drop off times.

Dr. Lauuwe asked if consideration had been given to increasing the closure time. She questioned if it would help to extend the closure time in a hospital that is really overloaded so no ambulances would go there.

Blain Claypool responded the members of the FAB discussed that option sometime in September or October. One of the things needed to be recognized when looking at the data Dr. Davidson has presented, is what the Blue Ribbon team has been able to accomplish with regard to closure over the last year. If you look at our current system we are not even a year into it. That was the position of the FAB that we look at it for a year, letting it roll out and work on the problems as they came up. Because there are problems that have come up and we have some suggestions that the FAB can discuss and can work on. We did talk about extending the time and thought that that may be disruptive to the system. By increasing the 60-minute window it will also increase the waiting time for those hospitals waiting in line to close. The repercussions down the line are what we are considering and we thought that it may increase too much, and that the 60-minute window was appropriate.

It was noted that over the last 10 days in the afternoon to evening periods times are extended to as much as over 5 hours drop time. SWA, AMR and LVFD met with some of the hospitals, and with UMC yesterday and came up with a plan that was pretty workable for the time being. All realize that

paramedics cannot do any treatment in the hospital. That was the legal impression. There are huge liabilities for the hospitals and the providers, if medics do something in an ER and they do it wrong, they're not covered, hospitals aren't covered. What was decided in some discussion with the transport agencies and the Health District and a couple of physicians was that medics would wait 30 minutes. At the end of 30 minutes medics will call administration and say they are leaving and the patient will be left on the gurney. At 30 minutes they can no longer even monitor that patient.

Sandy Young spoke on behalf of Las Vegas Fire & Rescue (LVF&R) and stated all of the steps that the hospitals have made to improve drop times are appreciated. We know through the nurse managers that it is not purely an ER problem. The legal opinion from the Health District's attorney is similar to the interpretations of the city attorney for LVF&R. Medics have no right to be practicing in hospitals. She spoke with the medical executive office, the medical staff office of every hospital and learned that the interpretation of their hospital by-laws is the same. LFV& R would like to do anything to help facilitate and improve drop times, not just back away and move on. Everyone really wants to work with hospitals to accomplish a 30-minute transfer time. The goal is to facilitate the best care for patients and follow the directions given by people who sign our tickets and give the authority to practice. All want to work with the hospitals but everyone will also have to agree on a reasonable time to back away from patients on advice of our legal counsel.

Steve Peterson said he thinks a lot of the issues that he's been dealing with in the last two – three weeks have been covered fairly succinctly by Dr. Kwalick and the legal opinion that he presented. In letters to the hospitals' CEO's several weeks ago was intended to emphasize with the CEO's that there are a number of issues involved with the extended stand-bys that we're doing in the hospital ER's. There are financial implications, there are medical legal implications and all of those have been discussed tonight. The fact of the matter is, in the month of December, his crews spent an excess of five hundred hours over 30 minutes in the various hospital EDs around town. From a practical standpoint he simply can't afford to continue to do that. He understands there are patient care issues here that we're talking about. But we just cannot continue to provide that kind of a subsidy. It doesn't work for us as a business. When they're involved in stand-bys in hospital EDs the crews are out of service, can't respond to calls that come in. Or they respond and they're late to calls that come in. I don't think that's benefiting anyone. His comments were reserved and restricted to just reemphasizing what Dr. Kwalick said in the terms of the legal opinion. I think it's pretty straightforward. How you interpret that and get to a reasonable transition period is really the issue here. They will go with 30 minutes if the national or regional standard is 23. AMR is a big company. They have data from around the country. There are systems that are much larger than Clark County see many more patients and more transfers than Clark County and the 23 minutes standard is not unrealistic. Certainly 30 minutes is something to shoot for. They are happy to do that. He said they were happy to talk to various hospitals and UMC has been very forthcoming and working with everyone on trying to come up with some form of relief for the various crews for us to provide or concentrate staffing in one area within the hospital ER so that we're able to relieve some of crews and get them back out on the street. Serious problem. It's not something that is really related. The divert issue is a resource allocation issue, it's a management issue within each of the hospitals. They can only do so much; everyone understands that. But we need to talk about opening up some other doors. Perhaps alternative transport destinations. Looking at protocols and refining the way that triage and transfer patients is handled. There are probably multiple answers here but the point of it is, we've got a clear legal definition and he thinks it needs to be dealt with, sooner rather than later.

According to Dr. Riesch Desert Springs Hospital took 23% more patients between the years 2000 – 2001, 23% more than they did the year before. EMTALA and COBRA laws do not allow hospitals to take patients if they don't' have the capacity to treat them.

In general it is agreed that the transfer agencies are not necessarily unhappy with the present closure. Their focus is drop-off times. The drop-off times are not a 24/7 problem; it is a selected part of certain days. Identify what times of the day drop-off times are very high and unacceptably high. Some of the solutions that were put forward could be acceptable solutions that the MAB could endorse to send forward to FAB. They are:

- Address holding areas within the hospitals
- Address EMS triage personnel
- Address Changing closure times

Our present model is not broken. The use of internal disaster has also been brought up. That obviously doesn't benefit the patient. No one wants to see six of nine facilities go on internal disaster at once. That doesn't benefit anyone. The focus should be on the weakness of the system. One weakness is communicating from the field to the hospitals that a rig is coming with a patient – it isn't happening, it could help.

Paul Fischer said he understood Mr. Peterson's concern regarding the response times and the penalties are stiff, however the current suggested situation of walking away from a patient at 30 minutes would constitute internal disaster by definition if the person has an IV or any type of access. From a hospital legal standpoint a patient with an IV needs monitoring and if you do not have the ability to follow them because the hospital is maxed out that would constitute internal disaster and at that point you have to call an internal disaster because you can't have patients without supervision. He thinks we need to try and avoid that at all costs.

An appropriate use of ambulances was also discussed with the example of when an ambulance comes in with a patient that has a sore throat, they don't need to go in a bed. That person who can walk should get off that stretcher and if they are not urgent go through regular triage. Triage is a continuous process; they can go to the waiting room and wait their turn behind the other people that have been waiting. Most hospitals don't want you to take those ambulance patients and put them out in triage. There are some appropriate for the waiting room and some are not. There is a lot of misuse of the 911 system.

Some discussion of developing an improved triage system of EMS transports just like ambulatory walk-ins triage are triaged ensued. Maybe that same system should be applied.

Another part of the problem is patients arriving with an IV. There are a lot of times where the IV just isn't necessary. If the patient didn't have an IV they could go out to the waiting room.

Also if an IV isn't needed, discontinue it and triage the patient to the waiting room.

Dr. Slattery asked Blaine Claypool to discuss what the hospitals are doing, what are their best practices, what's going on at a hospital level. It would be interesting to know what's going on in the city and what efforts are being made to help solve the problem.

Blain Claypool responded that he co-chairs the hospital committee and they meet approximately every month to address hospital flow issues. A very brief report will be coming to the FAB on Friday. There's a lot of discussion about the things that all the hospitals have done from a centralized operations center to electronic control of beds to bed tracking systems to putting together the response teams to circumvent backlogs. You can go hospital to hospital and find some very common threads and we've learned from each other and picked up ideas and are now incorporating them. We've studied and researched what causes delays inside the hospital itself. We looked at what was causing delays of discharges and the timeliness of discharges in the hospitals. It's interesting that the system as a whole is working very well until the middle part of the day and starts backing up and Jeff keeps referring to the spikes and the waiting times in the middle part of the day. The average discharge in Las Vegas is in excess of 7pm. It's almost 8:00pm and you can go hospital to hospital and the average admission is around noon. Now this is data that we have and when you pull out the information that we presented to the FAB last time, almost 85% of those delays and discharge of patients are, "outside the direct control of the hospital", such as waiting on test results to come back or we haven't processed the paper work timely or we haven't got a ride arranged for them. Then you get the issue of rounding and the culture of rounding in Las Vegas. He said Suzie Cram, his counterpart at Sunrise intend to meet with the other hospitals, sit down with the MEC's, present this data and share that it's causing a real backlog for us. If we can work on the physician rounding culture and get these hospitals to stand together as we stood together to solve part of the divert problem then maybe we can change some of that culture and that alone can help really break the backlog of patients. Our backlog occurs right through the middle part of the day and that's between the average time of admission around noon and the average discharge at 8pm. There's a lot that's been going on and we're going to go through some of that on Friday. We meet monthly and you're welcome to attend.

Discussion ensued about employing paramedics as hospital employees in the EDs and have them function as individuals that could go about and take blood pressures and admit patients and draw blood and assist with setting up suture trays. This could relieve some lack of nursing staff which Dr. Kwalick agreed could be an asset if medics were employed by hospitals, not as paramedics but as ER technicians.

UMC looked at this possiblity a few years ago and The State Board of Nursing states paramedics are doing activities that are only assigned to the nurse in the nurse practice act and using medics in this manner is not acceptable.

In the interim, ambulance companies are making staff available to assist with monitoring patients until a transfer can be made.

Dr. Davidson said no one wants to see anyone of our facilities become overburdened to the point that they can not open up in an appropriate time frame which is 60 minutes that is what we chose for closure, it can be changed. The idea of the 60-minute rotation was not to play games. It was to let facilities unload and let the continuation of 911 system calls continue to flow into an area. That was the idea behind rotating closures to give people time in a set standard to reorganize and regroup their EDs. One hour is not enough sometimes. The transfer agencies are asking to work with ED doctors and ED

hospital facilities as a hospital to transfer the patients from their care to our facility so they can go back into the 911 system.

Paul Fischer stated we need to recognize there is perhaps an inverse proportion to drop-off time and divert. Divert/closure was fixed by creating longer drop times. To equilibrate the system throughout the valley someone having 10-minute turn around drop times and someone having over an hour needs to be stopped. The fact that someone's over 30 minutes now and someone's at 10 minutes means the system is not working as well as it could be. One way of getting there is extending the time to 90 minutes thereby enabling the rigs to utilize the whole valley's resources to try and overcome the problem. There's an administrative code and Nevada statute for all occasions and while some have been quoted, there are others that say a service, (service being an EMS service) may render emergency care to the sick and injured while in an emergency department of a hospital until responsibility of care is assumed by regular staff of the hospital. His advice is that before any facility or any EMS facility transport system adopt unilaterally any rules or regulations by themselves on another establishment that all this is taken into cognizance through FAB and then through the appropriate channels and come back to MAB with a recommendation that can be accepted by all.

It was agreed that this has to be a transition that brings both parties to a common working point one that works both for EMS and for the ED. Some feel expanding closure time from 60 to 90 minutes would allow for that trickle of patients that were committed to the ED to arrive.

Tim Gardner said he hasn't been in the field for 2 ½ years. He has been behind a desk. But he has learned some things in dispatch, which he recently came to adopt that, may be helpful in this situation. Most of the calls that come through 911 aren't usually life threatening. There are low percentages that are. That is determined from the beginning of the 911 calls because the dispatchers are giving some sort of care over the phone. Whether it is lay the patient down, or pre-arrival with CPR. The rest of the patients are accessing 911 because they don't know whom else to call. So they call 911 because they know an ambulance will come. If ALS providers get on scene of a patient that is not critical, that truly is not an ALS patient. The majority of these patients that are going to these hospitals are clogging up ERs because they are non-ALS, is it appropriate for ALS providers in the field to triage these patients elsewhere? There has always been a thought that every time a patient is transported they must go to the ER. It has evolved now that the ERs can't handle this patient volume and maybe these patients can go to urgent care centers. Why are they going to the hospital with a sore throat? Some want to go to the hospital by ambulance because they don't have any other transporting means. Get them to a point other than a hospital and maybe that will free up some time. San Francisco has done a lot of triaging. They've triaged industrial patients and they've triaged inebriate patients with tokens via the bus. That could work here under an oversight committee if patients are triaged in the field that aren't going to ER's. All those patients should be evaluated and maybe that would decrease the amount of patients going to the hospital EDs and clogging them up. The other thing is bed availability during peak times. It's really those peak times that are a problem. It's not 24/7. A lot of ambulance providers will call on the way to the hospital. That may not work, why not call from the scene during the peak times, on the phone, not on the radio because really the radio is there for med orders and the people that have critical patients won't get the orders. But via the phone on the ER talk to the nurse manager and ask if they can take the patient. If not call the next hospital prior to leaving the scene. Find a hospital that can take the patient before getting back enroute. Just food for thought, those are just possible options.

These were felt to be excellent suggestions. The Blue Ribbon Committee, MAB and FAB have proposed ideas right in line with what Tim presented. Alternative 911 programs, i.e. call education advise lines, non-emergency resources, alternative transportation (medi-coach) , alternative destinations (urgent cares or shelters).

The discussion of extending the divert times, staying closed longer sounds good, however, UMC is in the zone with three other hospitals and the only zone that has four hospitals. If UMC is forth on the list or down at the bottom to close and the time is extended, that means UMC is going to have to stay open for 90 minutes for other hospitals to stay closed, it may be six hours before UMC can close. If UMC is forced open that six hours will kill others. Right now if UMC is forced open there could be a wait time of another four hours before UMC can close and during that time 25 ambulances may arrive. And if ALS providers are already waiting in the hall chances are that's where they're going to end up. UMC met with AMR, SW, and LV Fire yesterday and discussed possibly creating four zones. There hasn't been any discussion with Valley about this but maybe considering putting UMC and Valley in a zone and Summerlin and Mountainview in a zone. If closure times were extended then maybe the two zones in the northwest could handle it better.

Dr. Davidson thought this suggestion to re-evaluate the regions could be considered by the divert task force.

It was felt that the closure policy is set basically to restrict the number of hospitals that can go on closure, it's not restricting the number of hospitals that can be transported to if everyone else is open.

Dr. Davidson explained try to understand that this is the concept that we're trying to make people in the field understand, for example, UMC's closed in region A. Desert and Sunrise are both open in region B. Those are accessible facilities via patient and EMS requests. There are multiple ways to get a patient out of a region. Regions weren't developed with block walls around them to keep people in a given area.

Blain Claypool said essentially if you look at that, one of the things we did when we talked about the concentric rings and the three regions, if you go to four regions which you've now done, it defeats the purpose of one of the things that talked about on the Blue Ribbon Committee and what you presented tonight Jeff, when everybody is full, everyone should open. We would now be creating something where four hospitals would be closed.

The EMSystem was now brought into the discussion. It was pointed out that the EMSystem was developed to accept more helpful information like "forced open" or wait times greater than 40 minutes, 60 minutes or 90 minutes? There should be so much more information passed on via this screen. It was agreed we're not giving enough information to each other on that screen.

The group moved on to talk about the need to revisit the number of regions and closure times.

Should increased closure times be to 75 or 90 minutes? Should we change regions? Should we readjust regions? Should we provide a certain region, i.e. region A two closures instead of one? The Divert Task Force is willing to review these ideas again.

Blain Claypool recalled this was discussed at the Blue Ribbon Committee and one of the things discussed at the FAB was trying it for a year. He recalled when we turned on, on April 25, saying when will this new closure system be tested. Everybody thought it was going to be tested in October, then in November, then in December and what we're seeing is that in the last ten days there have been a lot of problems and a lot of issues. We're "testing" the system right now. Maybe it's not time to totally throw the thing out. We set up some criteria that we were going to evaluate after a year. And one of that criterion was availability.

Some questions arose in the group related to increase in volume, increase of ambulance traffic, more patients, we need answers to these questions.

Desert Springs Hospital has had a 7% increase in patient volume from 2000-2001, 23% increase in volume in ambulance transport between 2000-2001. So we're seeing a marked increase in ambulance transports as opposed to just patients walking in off the street.

John Wilson said to give you an idea the January-to-January AMR and Southwest data; ambulance transports are up 7%. The number of ambulances on the road is up over 21% as a combination between our two services. So they've added a lot of resources to respond to it. The crisis is here today. It's happening now and we appreciate the hard work that a lot of people are doing. We appreciate the fact that UMC has worked with us in a very short order created a triage area for us to be able to offload patients. Desert Springs is cleaning out their old fast track area so that we can do the same. Kind of the concept that we've rolled out to facilities, some more receptive than others, was that we would have beds for ALS patients. Patients that were BLS or ILS that couldn't be triaged for what ever reason out to their waiting room would have chairs. Our problem is an issue of resources. Talking with hospital administrators they say well why don't you guys find a way to pool or whatever. The problem is that without our gurneys from the hospital our ambulance can't go respond without a gurney. We can't expect patients to lay on the floor. Without the monitor that goes with that ambulance it's a little tough to treat a cardiac patient. So what we've been asking of the hospitals, we've not hit all of the hospitals yet, is help us to get our units out in 30 minutes. The reason being is that we don't get a closure. We don't get to say "hold on 911 system we're too busy". We don't have the ability to shut down 30% of our resources because we don't have staffing. That doesn't work for us. We don't have that option. The bottom line is that there is a nursing shortage. I don't think this is an ER issue, I don't think it's an ambulance issue. It's been made our issue because hospitals don't have enough staff to take care of the open beds that are in these facilities. The bottom line is that we have to be able to respond. It's not an option. No body else is going to be standing with AMR or City Fire when we're not able to respond to that call for the dying baby. We're on our own and that's our primary mission folks. So after we deliver to the hospital we're trying to say hey listen, we're willing to stick with you for 30 minutes, work with us to help us get on out. We'll do whatever we can, but we can't staff permanently in you ER's with paramedics and EMT's to take care of these folks. So as we come around to meet with you please work with us. We don't have any options. Our back is against the wall. That's why its been made a crisis and the crisis is happening as we speak here tonight.

It was pointed out that when we first rolled out this new closure program a QA program was presented to prospectively look at certain outcome measures. From August through January 31 every agency that transports agreed to submit data on every transport to the Health District. Once all that data comes in for

January there will be valid data to look at and answer a lot of these questions. It's probably 2 – 3 weeks before the numbers are crunched but it's going to be very important information.

These data will be a priority to present next month.

D. ED Nurse Managers Report

Joe Calise reported on the Nurse Managers meeting, stating the ED's continue to have EDs occupied by people who shouldn't be there, CPI's and the mentally ill. The CPI protocol is in place but not being utilized enough. Appropriate care for the mentally ill is still a problem and the ED is holding legal 2000's on a daily basis. Many in the community are attempting to solve these issues. Metro has asked the ED's for help in dealing with GHB patients.

Dr. Davidson encouraged all the nurse directors to attend the FAB, Divert and MAB meetings because they have their finger on the pulse of what's occurring in the ED's. We need the information you can bring from the ED's.

E. QA Report

Tabled

F. ED Divert Statistics

The average for the facilities is 92% of the time they are Open.

IV. Public Information

The Pediatric Hospitalist Conference is being presented at Sunrise Children's Hospital. It's the 5th annual, here in Las Vegas, April 5th and 6th. You can get this information from Sunrise and this brochure. It's here for anyone that wants to look at it and sign up.

Dr. Fildes read a brief statement, Earlier this week the American College of Surgeons notified UMC that it has been re-verified as a Level 1 Trauma Center. UMC is Nevada's first and only Level 1 Trauma Center. Last year treating more than 11,000 patients making UMC one of the busiest trauma centers in the United States. UMC is an integral part of our community's public safety network and it provides services not only to Southern Nevada but to the neighboring states of California, Arizona, and Utah. At the heart of this effort is the long standing commitment of a select group of surgeons from Las Vegas community who possess special expertise and commitment in the care of injured patients. This week we learned that several surgeons have been forced to withdraw from practice due to the sudden and dramatic increase in medical malpractice insurance. This will make it difficult if not impossible to provide uninterrupted trauma care to the community. The staff of the UMC trauma center pledges to do all that's in its power to continue providing care for the injured patients in our community during this difficult time. Where we stand right now is that there's been a withdrawal of one of our primary trauma surgeons leaving 16% of our call schedule uncovered. We're trying to cover the final week of February; we do not have a schedule for March. Behind the primary call panel are the surgical specialists in

cardiothorasic, orthopedic and neurosurgery. We're checking now to see if they can provide call coverage for March and beyond.

Also Dr. Davidson commented the malpractice issues are at crisis proportion in this state as well as some of our neighboring states. There is a similar crisis going on with the OB/GYN community. Soon there will be a similar crisis with the emergency departments as we're all having extreme difficulty renewing and becoming insurable under new malpractice groups. He commended all trauma surgeons because they take more than their share of the trauma calls.

As there was no further business, Dr. Davidson called for a motion to adjourn. A motion was made, seconded, and carried unanimously to adjourn the meeting at 7:49PM.