# MINUTES
# EMERGENCY MEDICAL SERVICES
# MEDICAL ADVISORY BOARD MEETING
# JUNE 4, 2003 – 3:30P.M.

**MEMBERS PRESENT**

Allen Marino, M.D., St. Rose Siena Dominican Hospital
Bryan Lungo, M.D., University Medical Center
Darrin Houston, D.O., Lake Mead Hospital
David Daitch, D.O., Boulder City Hospital
David Watson, M.D., Sunrise Hospital
Donald Kwalick, M.D., Clark County Health District
Donald Reisch, M.D., Desert Springs Hospital
E. P. Homansky, M.D., Valley Hospital
Frank Pape, D.O., Summerlin Hospital
Jeff Davidson, M.D., Chairman, Valley Hospital
John J. Fildes, M.D., University Medical Center
Jon Kingma, EMT-P, Boulder City Fire Department
Philis Beilfuss, R.N., North Las Vegas Fire Department
Richard Henderson, M.D., St. Rose DeLima
Rick Resnick, Mesquite Fire & Rescue
Chief Steve Hanson, Clark County Fire Dept.
Steven Peterson, American Medical Response
Timothy Vanduzer, M.D., Mountain View Hospital
William Harrington, M.D., University Medical Center

**ALTERNATES**

Aaron Harvey, Henderson Fire Department
Brian Rogers, Southwest Ambulance
Karla Perez, FAB Representative
Tim Crowley, Las Vegas Fire & Rescue
Virginia Deleon, Nurse Manager

**MEMBERS ABSENT**

Alice Conroy, R.N., Sunrise Hospital, Nurse Manager
David A. Rosin, M.D., Mental Health & Development Srvcs.
Asst. Chief Mike Myers, Las Vegas Fire & Rescue
Pete Carlo, EMT-P, Southwest Ambulance
Division Chief Randy Howell, Henderson Fire Department

**CCHD STAFF PRESENT**

David Slattery, MD, EMS Assistant Medical Director
Jennifer Carter, Recording Secretary
Michael MacQuarrie, EMS Field Representative
Rae Pettie, Sr. Administrative Clerk
Rory Chetelat, EMS Manager

**PUBLIC ATTENDANCE**

A. Harland, Sunrise Hospital
Davette Shea, WestCare Nevada
Gregg Fusto, UMC
Jackie Mador, Summerlin Hospital
Jay G. Craddock, NLVFD
Jim Osti, WestCare Nevada
Kathy Kopka, Sunrise Hospital
Kevin Slaughter, D.O., Desert Springs Hospital
Patti Glavan, BCH
Sam Wilson, SMS
Scott Johnson, LVFR
Shawn White, HFD
Sue Hoppler, Desert Springs Hospital
Todd Rush, CTC

## CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The EMS Medical Advisory Board convened in the Clemens Room at the Ravenholt Public Health Center at 3:40 p.m. on Wednesday, June 4, 2003. The meeting was called to order by Chairman Jeff Davidson, M.D. He stated the Affidavit of Posting, Mailing of Agenda, and Public Notice of the Meeting Agenda were executed in accordance with the Nevada Open Meeting Law. Chairman Davidson noted that a quorum was present.

## I. CONSENT AGENDA:

A. Minutes Medical Advisory Board Meeting May 7, 2003

B. Referral to Procedure/Protocol Committee: Review of Draft Revision to Procedure for Chronic Public Inebriate Operations Protocol

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

## II. REPORT/DISCUSSION/POSSIBLE ACTION:

A. Divert Task Force Report

1. Discussion of Legal 2000 Divert Operations Protocol

Chairman Davidson reported Brian Rogers, SWA, provided statistics on agency transports at the Divert Task Force meeting. The statistics were a reflection of formed L2K patient transports during 1-9 rotation for the month of May 2003. According to the report, L2K patients were rotated to local facilities, during this time frame, as follows:

| | |
|---|---|
| 15 ------ Desert | 12 ----- Sunrise |
| 14 ------ Summerlin | 11 ----- St. Rose Siena |
| 13 ------ UMC | 10 ----- Mountain View |
| 13 ------ Valley | 10 ----- St. Rose DeLima |
| 12 ------ Lake Mead | |

Chairman Davidson explained the hospitals are receiving formed L2K patients from the transport agencies on a 1-9 rotation. The rotation is not based on the highs and lows that every facility is experiencing. For example, if one facility has ten formed L2K patients and all the other facilities have five, the facility with ten L2K patients would remain in the 1-9 rotation. After all facilities are in receipt of five formed L2K patients, the 1-9 rotation begins.

Nurse managers voiced concerns that the 45-minute transfer of patient care time limit for L2K patients, set forth by the Legal 2000 (L2K) Divert Operations Protocol, could be difficult to maintain at times, Chairman Davidson continued. However, reportedly, to date, there has not been a problem upholding the 45-minute transfer of patient care time limit. Transport agency representatives indicated they were willing to wait beyond the 45-minute time limit, provided the system has adequate resources to respond to the needs of the community.

The Divert Task Force discussed the prospect of considering alternatives to the current L2K patient level-loading plan, of five patients per hospital, due to the concerns raised by smaller facilities, that holding five L2K patients has placed an overwhelming burden on the smaller facilities, Chairman Davidson reported. The task force suggested referring the issue to the Facilities Advisory Board (FAB) for consideration of L2K patient level-loading alternatives. However the task force strongly recommends that the overall average for the L2K population be maintained at 50 beds or higher, in an effort to accommodate the L2K population growth in the community.

After brief discussion the MAB agreed to refer the matter to the FAB, for consideration of alternative plans to the current L2K patient level-loading plan.

2. Discussion of A, B & C Regions with the Addition of Spring Valley Hospital

Chairman Davidson reported the Divert Task Force suggested incorporating Spring Valley Hospital, when it opens October 1, 2003, into region A. Region A would then consist of five facilities for which two facilities may close simultaneously. Another suggestion was to wait until Southern Hills Hospital opens, February or March 2004, and create an additional region. Chairman Davidson suggested incorporating Spring Valley Hospital into zone A temporarily, until Southern Hills Hospital opens. He reminded everyone that the zones were created for closure rotation, not for boundaries of patient destination.

A motion was made to incorporate Spring Valley Hospital into region A, allowing two facilities to close simultaneously in region A, until Southern Hills Hospital opens, at which time a new plan for structuring the regions will be considered. The motion was seconded and passed with 19 yes votes and 1 no vote.

B. Discussion of July and August MAB meetings

A motion was made to postpone the July 2, 2003 MAB meeting. The motion was seconded and passed unanimously.

The MAB agreed to meet August 6, 2003 as regularly scheduled.

## III. INFORMATIONAL ITEMS/DISCUSSION ONLY

A. Presentation on Epidemiologic Syndromic Surveillance in the Hospitals

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 a 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 two 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).

B. Update on Trial Protocols
Legal 2000 Divert Protocol

Rory Chetelat reported there is no new data to assess on the Legal 2000 Divert Protocol. However, he mentioned he has gathered information that was requested of the EMS office regarding EMS practitioners releasing patients in the field. It is not feasible for Emergency Medical Technicians (EMTs) to diagnose patients and refuse to transport. He said the question has been asked on several occasions "why are patients who do not necessarily need to be transported receiving EMS transport"? Studies across the country have shown, that field triage and refusing transport systems do not work. Therefore, he continued, data was compiled for the years 2002 and 2003 on total EMS calls, and total non-transports. Rory distributed the reported totals to the committee. The data reflected 30% of total system-wide EMS calls were non-transports (patients who are not being transported to EDs). He explained 30% of patients who call 911 are being released from EMS transport by signing an Against Medical Advice (AMA) form.

A question was raised regarding how the agency report totals compare to national averages and whether the reported 30% of non-transports should be considered too high, and/or an indication that resources are under utilized.

Rory replied based on related articles and magazines, the system-wide total percentage of non-transports is comparable to other systems across the country. He stressed that the reason for presenting the system-wide total percentages of non-transports, is to address concerns that EMS is needlessly transporting patients to EDs, and to emphasize that 30% of 911 calls are not being transported to EDs by ambulance.

Clarification of AMAs was requested.

Rory explained AMA is used as a blanket term in the EMS community. While there are patients who truly choose not to be transported AMA, agency providers have informed low acuity patients of the ED circumstances when wait times are extensive, and providers have suggested alternatives to being transported by ambulance, i.e., traveling by personal vehicle would be less costly, and quick care centers may be utilized rather than EDs. If the patient chooses to employ suggested alternatives, the patient is required to sign an AMA form.

C. Update for Community Triage Center (CTC)

Jim Osti, Senior Director, CTC, reported the CTC is continuing an increased service to the community. Admissions to the CTC are up to 522 for the month of May. There has been an increase in the number of Chronic Public Inebriate (CPI) transfers from transport agencies, 54 CPI patients in the month of May. The definition of Civil Protective Custody, changed and became more restrictive which reduced the number of transports by law enforcement to 73 admissions in the month of May down from 155 in the month of April. Hospital transfers were up 152 admissions in May from 99 admissions in April. Nearly one third of the CTC admissions for the month of May resulted from hospital transfers. CTC is continuing to track the number of callbacks, which are individuals that go back to the hospital or to another facility. In April there was a 3% call back and in May there was a 4% call back.

Mr. Osti encouraged participation in the Technical Advisory Committee meeting which meets in the Clemens room after the MAB.

Acknowledgements from the board were expressed on the great job that is being done by the CTC and the positive impact the CTC has had on the EMS community.

D. ED Nurse Managers Report

Virginia Deleon reported the nurse managers met at Summerlin and reviewed the revised protocol on triaging ambulance patients. All the nurse managers supported the protocol, she mentioned, however it was unclear whether the policy should be incorporated by each hospital individually or if it should be referred to the Procedure/Protocol Committee.

Chairman Davidson pointed out that the initial plan was to have the nurse managers design a uniform triage procedure that every facility could incorporate within its own constraints, in an effort to provide uniformity throughout all facilities to EMS patients.

Virginia responded the nurse managers would then submit the draft triage protocol to the FAB. She reported there was a presentation from Metro detectives regarding GHB (illegal drug) use, which has become a major problem in Las Vegas. The nurse managers were asked to report potential GHB use to Metro, in an effort to assist with possible solutions to ceasing the problem.

Ms. DeLeon mentioned WestCare gave an update on the CTC at the nurse managers meeting.

E. QA Report

No report.

F. ED Divert Statistics

Not available.

## IV. PUBLIC APPEARANCE/CITIZEN PARTICIPATION

Dr. John Fildes, Medical Director of UMC Trauma Center, presented comments to the MAB. He read the comments to the audience and committee members, from a printed document. The printed document read, "I would like to address a misunderstanding that has developed between the UMC Trauma Center staff and the Pre-hospital Transport Services. It involves the Clark County Health District's (CCHD) Trauma Patient Destination Protocol and the UMC Trauma Center's Activation Criteria. The CCHD's Trauma Patient Destination Protocol defines criteria for pre-hospital personnel to identify injured patients who need to be transported to the trauma center. The UMC Trauma Center Activation Criteria are used by the trauma center staff to direct an in-hospital tiered response system. These Activation Criteria were designed for internal use only.

The trauma center was CLOSED for 10 days during the liability crisis in July 2002, but it has ***never*** been on DIVERT. During normal operations, the UMC Trauma Center accepts patients with a wide variety of injury related problems. However, during peak operating periods, the trauma center can only see those patients who meet the criteria defined in the CCHD's Trauma Patient Destination Protocol. This is necessary to insure patient safety and continuous service to the community. I am working with the UMC Trauma Center staff to correct this misunderstanding. Over the next few weeks, I will be meeting with the CCHD and transport agencies to further clarify this issue. Thank you for your time and attention".

Dr. Fildes clarified that when the EMSystem screen reads "trauma center activation", it is the UMC Trauma Center's Activation Criteria, which goes into effect, which is a protocol that is utilized by trauma center staff only. He suggested consideration from the Health District of renaming the Trauma Patient Destination Protocol on the EMSystem.

Dr. David Slattery replied, to eliminate confusion, the name of the Trauma Patient Destination Protocol will be changed on the EMSystem to "Destination Criteria" instead of "Activation Criteria".

Chairman Davidson announced there was an internal disaster (ID) at Summerlin Hospital the evening of Tuesday, June 3, which lasted for a period of three hours. He reminded everyone the current policies and procedures specify, when a facility goes on ID, all other facilities are required to open. He mentioned although there was some confusion at some facilities, all facilities eventually opened during the ID.

Summerlin Hospital shall conduct a review of the ID within the next 30 days as per prior policy and agreement, Chairman Davidson continued. The review is mostly for educational purposes, to understand why the facility went on ID, what could be learned from it, and how to cope as a community to further alleviate the load when a facility goes on ID.

Dr. Frank Pape, Summerlin Hospital, gave a brief explanation of the ID. Multiple problems occurred at once, and patient volumes proceeded, he explained. Sick people were in the hallways, very sick people were on high flow oxygen, and the hospital ran short of oxygen tanks. The computer system went down throughout the entire facility. He mentioned as soon as the staff realized the oxygen tanks were running low, and only lasting 30-40 minutes with high-flow patients, a call was placed to the company that delivers oxygen tanks. The company was unable to provide oxygen tanks to the facility within a timely manner, as the delivery truck was immobile.

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Chairman Davidson stated there was a Hazmat occurrence at Valley Hospital, Tuesday, June 19. A patient with classic symptoms of significant exposure to an organic phosphate was carted through the ED causing an ED technician, three nurses and five–six patients to pass out from contact with the patient. He said he thought this incident would be a good item for review, in an educational forum, at the nurse managers meeting.

Chairman Davidson introduced Dr. Kevin Slaughter, the ED Director at Spring Valley Hospital. Dr. Slaughter will represent Spring Valley Hospital on the MAB beginning October 2003.

Rory commented on behalf of the EMS community that the EMS community is there for support in the event of a shortage of EMS casualty equipment and supplies. Facilities are encouraged to utilize EMS for related support.

## V. ADJOURNMENT

As there was no further business, Chairman Davidson called for a motion to adjourn. The motion was seconded and passed unanimously to adjourn at 4:35 P.M.