



MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DIVISION OF COMMUNITY HEALTH

PRIORITY DISPATCH TASK FORCE MEETING

June 5, 2019 – 10:00 A.M.

MEMBERS PRESENT

Chief Troy Tuke, CCFD
David Slattery, MD, LVFR
Samuel Scheller, GEMS
Chief Shawn Tobler, MFR
Chief Jim Kindel, BCFD
Paul Stepaniuk, HFD
Brett Olbur, Dignity Health

Sarah McCrea, RN, LVFR
Wendy Lotman, LVFR
Devon Eisma, RN, OM
Monica Manig, HFD
Mike Barnum, MD, AMR/MW
Christopher Stachyra, CA
Tony Greenway, Valley Health System

SNHD STAFF PRESENT

John Hammond, EMSTS Manager
Laura Palmer, EMSTS Supervisor
Rae Pettie, Recording Secretary

Gerry Julian, EMSTS Field Representative
Scott Wagner, EMSTS Field Representative

PUBLIC ATTENDANCE

Michael Holtz, MD
Jim McAllister

Larry Johnson

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The Priority Dispatch Task Force convened in the Red Rock Conference Room at the Southern Nevada Health District on Wednesday, June 5, 2019. John Hammond called the meeting to order at 10:06 a.m. and stated the Affidavit of Posting was posted in accordance with the Nevada Open Meeting Law.

I. PUBLIC COMMENT

Public comment is a period devoted to comments by the general public on items listed on the Agenda. All comments are limited to five (5) minutes. Mr. Hammond asked if anyone wished to address the Board pertaining to items listed on the Agenda. Seeing no one he closed the Public Comment portion of the meeting.

II. CONSENT AGENDA

Mr. Hammond stated the Consent Agenda consisted of matters to be considered by the Task Force that can be enacted by one motion. Any item may be discussed separately per Committee member request. Any exceptions to the Consent Agenda must be stated prior to approval.

Approve Minutes for the Priority Dispatch Task Force Meeting: June 5, 2013

Mr. Hammond asked for a motion to approve the June 5, 2013 minutes of the Priority Dispatch Task Force meeting. A motion was made by Dr. Davidson, seconded by Chief Troy Tuke and carried unanimously to approve the minutes as written.

III. REPORT/DISCUSSION/POSSIBLE ACTION

A. Vote for Chairperson

A motion was made by Dr. Slattery, seconded by Chief Kindel and carried unanimously to nominate Sarah McCrea as Chairperson.

B. Discussion of Medical Telemetry Channels and Frequency Capacity

Dr. Slattery stated there has been an increase in the number of receiving facilities, which includes the FEDs (Freestanding Emergency Departments) and Micro-hospitals. EMS crews are required to make radio telemetry contact prior to transporting to FEDs and Micro-hospitals. The FAO (Fire Alarm Office) currently has a limited number of radio channels that can be allocated. The issue was brought to the Task Force to discuss the limitations of both SNACC (Southern Nevada Area Communications Council) and the CCC (Combined Communications Center). Dr. Slattery introduced Wendy Lotman, Fire Communications Supervisor for the City of Las Vegas, to provide an in-depth explanation of the issues she has been experiencing.

Ms. Lotman informed the Task Force that in addition to her supervisory duties she also serves on SNACC's Board of Directors, as did her predecessor, who was primarily responsible for approving new radio channels to be added to the system. Historically, no screening criteria or protocol was put into place. Requests to add a new channel were taken directly to SNACC for approval, not the FAO. There are 12-16 radio channels in each slot. Currently, three channels are available in the existing bank. In anticipation of CCFD obtaining new radios, requests from other agencies for new channels, and additional requests from the FEDs and remote EDs, SNACC essentially needed to redo the entire radio template and was looking at adding an entire new bank of 16 radio channels. Ms. Lotman noted the following issues:

1. Flashing the radios to input the agency name and link it with the right receiving facility is a hands-on process. Although the installation for each radio is software, it affects the hardware of the radio. It takes 60-90 days to update every radio in the system and ensure they are all flashed with the appropriate fleet map with the proper names in the proper zones. In the meantime, they assign it a generic name such as "New Hospital 1" and "New Hospital 2." But the crews in the field don't necessarily know which hospitals are associated with those names. The process becomes a bit unmanageable when they are required to add additional facilities to the system. There are currently six facilities waiting for approval pending the outcome of the Task Force meeting.
2. Does the radio traffic justify each receiving facility to have their own channel, or could facilities within the same system share a channel? Telemetry via telephone still exists. However, the limitation from a communications perspective is that the dispatcher is required to stay on the telephone line so the call can be recorded, thereby tying up their personnel for that entire time, which is the reason the radios are preferable to the phone. The SNACC system radios are getting overburdened and unmanageable as well as the field system in their determination of who is where.

Ms. Lotman stated that she ran a SNACC report since January to get an idea of the activity level on each radio channel. Large systems such as UMC show hours of usage. However, the smaller systems show five minutes of usage for the same time frame which tells her they may not need their own channel because the equipment and resources are expensive to maintain. She attended the Task Force meeting to ask for suggestions or workable solutions for the system from their perspective.

Ms. McCrea asked about the process for a facility requesting approval for licensure as a destination center. Mr. Hammond gave an example of FEDs and Micro-hospitals who obtain a license through the Nevada Division of Public and Behavioral Health. He noted that they approach him beforehand to advise of their plan, but he has nothing to do with their licensure. Once assured they are affiliated with a hospital, he ensures that they will take all comers, regardless of the ability to pay or the payor type. In addition, they need to remain open 24/7, have a physician on staff 24/7, and meet all other ancillary requirements. They need to comply with the Alternate Destination Protocol as it relates to patients transported by EMS and to be able to receive communication either through telemetry or via telephone. The communication must be recorded at the FAO. The same is required for addiction treatment centers and behavioral health facilities. Mr. Hammond related that there has been discussion

about maintaining the recording on site, but since he doesn't have purview over receiving facilities, they could refuse to provide telemetry recordings if asked to do so.

Ms. McCrea asked about the expectations of the FEDs and micro hospitals as it relates to the healthcare community and the kind of notification they would need to obtain outside of just a telephone. Mr. Greenway remarked they are all required to participate in EMResource to notify EMS and the receiving facilities as to their color status and number available beds. He feels that in the event of an MCI, radio communication would be very helpful to the healthcare community, and they want the capability of being a resource.

Dr. Slattery remarked that with the anticipated increase in the number of FEDs and Micro-hospitals the idea of sharing radio channels is going to be an important issue. The level of usage is very important for the receiving facilities and EMS providers. If they are not using the channel to its full capacity, then they're going to need to come to a decision with regards to the allocation of those resources. He asked if there are anticipated issues with the sharing of channels. Mr. Olbur was under the impression that all the FEDs and Micro-hospitals would be on one channel. It was explained that a dedicated channel will be given for receiving facilities operating within the same system. Mr. Greenway said the challenge may be more at the provider level which would just be training on which system is associated with each FED and Micro-hospital. He asked Wendy if the radio channel issue arose because of a need for additional funding. If so, there may be a solution. Ms. Lotman stated that another bank of channels had already been created in anticipation of the increasing requests; they had to reconfigure the fleet map. The issue is related to the maintenance aspect of assigning names to those slots because it involves a hands-on update every time another facility is added to the system. A lot of time is spent updating each radio to ensure the names are accurate. There is the potential to flash remotely in the future, but currently they don't have the equipment.

Mr. Scheller stated that a possible solution would be to look at the old Med 9 architecture and infrastructure. Prior to the SNACC radio network you would get on Med 9 to request a telemetry channel and you were subsequently patched through to the appropriate hospital. He asked if they could look at doing something similar utilizing the 800 MHz radio network if it's a recording issue.

Dr. Slattery noted that it's important that they focus on the discipline of assigning channels. Regardless of the number of radio channels and capabilities, they need to be disciplined about the decision because there will be continued growth in Southern Nevada and the resources need to be allocated efficiently. It is not efficient to provide a facility with a dedicated radio channel when they only received five minutes of radio traffic in a three-month period. Dr. Slattery proposed that they initially combine all the FEDs and Micro-hospitals into a single bank. From a training perspective, EMS providers need to be mindful of where they transport their patients. It will be interesting to listen to feedback from them since there will be fewer radio channels. He feels that in the long run it will be more efficient for the crews because they will go to one radio channel instead of having to flip through six different radio channels. Mr. Hammond agreed and added that patients going to FEDs are not critical, so they have time to wait for the initial telemetry to be completed prior to beginning their own. Ms. Lotman clarified there will be no additional cost to combine the FEDs and Micro-hospitals on the same radio channel. Both SNACC and their I.T. department, who are responsible for reprogramming and organizing, are in support; it's a manpower cost, not an infrastructure cost. However, she noted they obtained a new recording system last September and there may be additional maintenance costs in the future. Chief Tuke suggested that new facilities who come on board give early notification, so they can be operational prior to opening their doors.

The Task Force discussed the dynamics of designing the radio channels either geographically or by system. Ms. Lotman noted that her vision is for every main hospital, trauma, and pediatrics to have their own channel, and for the FEDs and Micro-hospitals to have some method of sharing outside of those three. If they find that one or more of the FEDs or Micro-hospitals is very busy, they could split off from the shared radio channel and be given their own.

Dr. Slattery made a motion and Chief Kindel seconded the motion for the Priority Dispatch Task Force to make a recommendation to the Southern Nevada Area Communications Council to allocate one radio channel per system to Freestanding Emergency Departments and Micro-hospitals. The motion passed with all in favor and one opposed.

Mr. Scheller remarked that one problem with having multiple FEDs on a sealed channel is that confusion may arise if the receiving facility is not listening to that channel. Dr. Slattery stated it was a good point, and that moving forward they may need to rethink whether telemetry needs to be established on all calls, or to rely solely on EMResource. They are currently in a learning phase as it relates to whether a notification needs to be made for EMS traffic going to the FEDs because each department is a little different in terms of their capacity and capabilities. It was a safety net for the FEDs to be aware of what's coming in and have the right of refusal. Allocating one radio channel per FED system parallels the discussion of efficient use of the radio system. Can we stop or decrease the amount of radio traffic to these FEDs? That may or may not be appropriate now, but the data shows the volume is insufficient to warrant a separate radio channel for each FED. Mr. Olbur stated one of the initiatives Dignity Health is working on to relieve over-crowding is doing reverse transfers to the Micro-hospitals. This includes ambulance transfers; not necessarily telemetry, but at least the Micro-hospitals will be aware that an EMS crew is on their way because it'll show up on the EMResource display screen. It's a good way to eliminate a lot of the traffic. Mr. Greenway noted that the majority of EMS providers do not have access to EMResource; it is accessed through their dispatch center. He clarified that "majority" includes AMR, MedicWest and Community Ambulance, which represents almost 80% of EMS transports. The challenge is getting a unique username and password for each provider. Ms. McCrea stated the EMS providers at LVFR have a generic username. Mr. Greenway stated that settings and passwords can be changed unknowingly with a generic username. That is what stopped AMR and MedicWest from proceeding forward with giving it to 1500 EMS providers.

IV. INFORMATIONAL ITEMS/ DISCUSSION ONLY

Dr. Slattery asked whether there were any additional issues that need to be addressed at another meeting. Ms. Lotman replied that their solution will most likely be adequate for SNACC. Ms. McCrea agreed to report on the timeline of implementation at the MAB meeting to keep them in the loop. Mr. Greenway suggested they revisit the issue in the future to address any issues that may arise.

V. PUBLIC COMMENT

None.

ADJOURNMENT

There being no further business to come before the Task Force, the meeting was adjourned at 9:58 a.m.