CLARK COUNTY HEALTH DISTRICT

MINUTES

EMERGENCY MEDICAL SERVICES

Task Force to Reduce ED Offload Times

February 1, 2006 - 1:00 P.M.

MEMBERS PRESENT

David Slattery, M.D., Chairman
E. P. Homansky, M.D., American Medical Response
Larry Johnson, EMT-P, MedicWest Ambulance
Debra Dailey, EMT-P, MedicWest Ambulance
Brian Rogers, EMT-P, MedicWest Ambulance
Mike Myers, EMT-P, Las Vegas Fire & Rescue
Derek Cox, EMT-P, American Medical Response
Steve Cramer, American Medical Response
Brian Fladhammer, Mercy Air
Jerry Newman, Specialized Med Services
Dan Musgrove, Clark County/UMC
Erika Conner, KVBC Channel 3
Travis Jackson, CCSN Student
Brendan Lawest, CCSN Student
Richard Henderson, M.D., HFD
Allen Marino, M.D., NLVFD / MW
Trent Jenkins, EMT-P, Clark County Fire Dept.
Russ Cameron, EMT-P, Clark County Fire Dept
Philis Beilfuss, R.N., NLVFD
Tim Crowley, EMT-P, Las Vegas Fire & Rescue
Sandy Young, R.N., Las Vegas Fire & Rescue
Aaron Harvey, EMT-P, Henderson Fire Dept
Gail Yedinak, University Medical Center
Virginia DeLeon, St. Rose
John M. Myers, Las Vegas Fire & Rescue
Kevin Crammer, CCSN Student
Chad Oliver, CCSN Student

CCHD MEMBERS PRESENT

Rory Chetelat, M.A., EMT-P, EMS Manager
Joseph J. Heck, D.O., Operational Medical Director
Trish Beckwith, EMS Field Representative
Mary Ellen Britt, RN, QI Coordinator
Judy Tabat, Recording Secretary
Moana Hanawahine, Administrative Assistant

I. CONSENT AGENDA

The Task Force to Reduce ED Offload times convened in the Clemens Room of the Ravenholt Public Health Center on Wednesday, February 1, 2006. Chairman David Slattery, M.D. called the meeting to order at 1:02 p.m.

II. REPORT/DISCUSSION/POSSIBLE ACTION

Strategies to reduce ED Offload times

Dr. Slattery opened the meeting by reviewing the causes and possible solutions of 911 availability based on the inability for the ambulance to unload their patients at the Emergency Room that was discussed in last months meeting. He also stated that as Dr. Marino pointed out, we're trying to make decisions without data. Dr. Heck requested a sample of 3 days worth of data during the busiest 8 hour period of time for each agency.

Dr. Heck reported that the goal was to try and get some data to support or disprove some of the ideas that were thrown around on the impact that certain strategies may have on hospital offload times. He stated the first thing was what impact does EMS have on hospital volume so data was collected from the National Hospital Association on the number of ED visits reported per hospital for first quarter calendar year 05 and compared that to the number of EMS transports by AMR and MedicWest. EMS accounts for anywhere from 17% to 42% for the ED volume which is on

average 25% of the ED volume rate. A second issue was the acuity level of the patients that are being seen and how ED patients are sicker and occupying more time, but most hospitals run about 25% admit rate from their ED's as well. Dr. Homansky commented that the national average is about 14% and up in Reno it is about 15%. Dr. Heck agreed and stated it is definitely higher down here because of the general lack of inpatient beds per hospital whereas if we had the average number of hospital beds per capita they would be spread out at more facilities and then we would be down to somewhere lower then 20%. He then explained another thing we wanted to look at was what things we are doing and are they making a difference. He stated the one thing that came up is the use of the 20 minute rule and how many patients does it impact. He had requested charts submitted for the same 8 hour period on the 12th, 14th and 16th of January from both AMR and MedicWest and subtracted out any charts that were interfacility transfers and came out to 280 charts total for that time frame. He reviewed every chart and compared them against the 20 minute rule and found that 22% of the patients objectively fit the criteria. Dr. Heck stated that if you look at the total volume reported for AMR and MedicWest for calendar year 05 to all facilities it was 126,862 patients. The third option was alternative destinations and treat and release programs but the concern was putting EMS in a liable situation so looking at the same 280 charts based on his subjective determination he could classify only 5.7% as not requiring ambulance transport which would only impact 600 patients per year out of 126,862 and could offer significant liability if we make a bad decision. Dr. Heck also stated that there was some discussion about c-spining too many patients so as a subset he went back through the 280 charts and of the 30 that were put on back boards over half of those he felt did not need c-spine immobilization.

Mike Myers stated that even though it's only about 5 or 6%, we would need to make the criteria tight enough to be very confident with our protocol to never allow somebody with a spinal injury to be missed.

Dr. Slattery advised this committee that Ms. Young has brought a protocol from North Carolina to review. He felt that we do need to get one and have very objective criteria that the paramedics can use and be measured on to make sure it's safe.

Dr. Heck stated that there were two other areas that he was going to look at which are not complete because he hasn't been able to get the full data from some of the other state agencies.

1. What portion of legal 2000 generated at a receiving facility is brought to them by EMS?
2. What is the number of legal 2000's that are initiated by Metro?

Dr. Slattery asked if there is any tracking of these patients that EMS has invoked the 20 minute rule on. Brian Rogers stated that MedicWest is working on a 2-ply paper that will list out the criteria. Dr. Heck stated that we came up with this criteria based loosely on the CPI protocol so we need to figure out a way to track those that are put in the waiting room and get some kind of outcome data to make sure the criteria we're using is valid and we are not harming anybody.

Virginia DeLeon stated that the nurse managers are tracking every incident that has a negative outcome and they did meet last Friday and will continue to meet on a monthly basis and will have combined meetings with EMS on a quarterly basis. Dr. Heck requested that this data be supplied to the EMS office. Ms. Beilfuss asked that data be collected on all patients that meet the 20 minute criteria not just the negative outcomes.

Dr. Slattery stated that he will take this back to the QA Committee to put on the agenda that we will develop a plan to validate that decision making tool. He also stated that in terms of mental health the one thing that we can impact is encouraging all our providers to invoke the CPI protocol.

Mr. Myers stated that we should be putting most of our efforts into the mental health reform and stand right beside the hospitals and get our city leaders to step up with us and help voice the problem.

Mr. Chetelat stated the problem is overcrowding in the hospital whether the mental health comes by ambulance or walk in, we are not fixing the problem we are just shifting the burden. Dr. Slattery agreed stating there is a powerful force of physicians, nurses, fire fighters, EMS agencies, Hospital Associations and all of us are saying the same thing.

Dr. Slattery commented that the last thing on the list of potential solutions was expanding the quick care facilities but that is still a work in progress.

He stated we need to come up with some sort of objective measurement of the offload times using the First Watch software or if somebody has anything else we can use.

Mr. Rogers suggested using the number of late responses. Mr. Chetelat added that the franchise agreements monitor the two transport agencies extremely close and that compliance is the percentage of their calls that has been measured and tracked for a long period of time.

Russ Cameron brought up using the Roam IT software stating that if this group comes up with some criteria that we need to measure that is not currently incorporated into the EPCR, it can be put there without any problems.

Dan Musgrove suggested that they try to figure out a way to combine all of these different sources of data so that when there are states of emergency in EMS you can look at how many mental health were in that day, what the drop times were because as we develop our case to go to the legislature we need to pull all these sources into one concise picture of a day. He added that we're getting all these bits and pieces but the key is going back and putting it together into a narrative story that the legislature can understand.

Dr. Slattery asked if there were any other measurements we can track and asked about requests for help from mutual aid and if that number was easily tracked. Mr. Cameron stated we can provide data for when ambulances are unable to respond since that is something we are tracking now.

Mr. Myers asked who would be taking that snap shot of the day and coordinate getting that data. Mr. Chetelat stated he wouldn't mind being the data gathering source for that if we pick some days and wanted to go out and do some research.

Ms. DeLeon also added that inpatient capacity is another interesting indicator since inpatients flow over into the ER as inpatient holds. Mr. Chetelat added that this is a big part of the whole overlap where ICU holds and mental holds clog up the emergency room.

Dr. Homansky added that in most facilities they normally do not put patients in the areas where psych holds are placed. This room is separate from the ED and ED nurses are not taking care of them.

Mr. Chetelat stated that they still take up resources and money which could be used somewhere else. It's not a problem that belongs to the hospitals or EMS; it belongs to the State mental health system.

Dr. Slattery recapped by stating the biggest impact we can probably make is our political grass roots action. Improving the 20 minute rule which will be sent to the QA committee to look at the validity and safety of that process, and send out the message to your providers to use the CPI

protocol right now and start tracking these 20 minute drops and make some sort of notification in your PCR that you invoked that protocol.

III. INFORMATIONAL ITEMS/DISCUSSION ONLY

None

IV. PUBLIC APPEARANCE/CITIZEN PARTICIPATION

None

V. ADJOURNMENT

As there was no further business, Dr. Slattery called for an adjournment at 1:45 p.m.