Emergency Medical Services Advisory Board

WASHOE COUNTY HEALTH DISTRICT
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MEETING MINUTES

Date and Time of Meeting: Thursday, August 5, 2021, 9:00 a.m.
Place of Meeting: Washoe County Health District
1001 E. Ninth Street, Building B, South Auditorium
Reno, Nevada 89512

1. *Roll Call and Determination of Quorum

Chair Krutz called the meeting to order at 9:05 a.m.

The following members and staff were present:

Members present: Neil Krutz, Chair
Kevin Dick
Eric Brown
Joe Macaluso
Dr. John Hardwick via phone
Doug Thornley

Members absent: None

Ms. Spinola verified a quorum was present.

Staff present: Mary Kandaras, Deputy District Attorney
Nancy Diao, Epidemiology and Public Health Preparedness Division Director
Andrea Esp, Preparedness and EMS Program Manager
Julie Hunter, EMS Program Coordinator
Anastasia Gunawan, EMS Statistician
Dawn Spinola, Administrative Secretary, Recording Secretary

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2. *Public Comment

Limited to three (3) minutes per person. No action may be taken.

Chair Krutz opened the public comment period. As there was no one wishing to speak, Chair Krutz closed the public comment period.

Chair Krutz announced that Items 11 and 12 would be heard immediately after Item 4.

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3. Consent Items (For Possible Action)

Matters which the Emergency Medical Services Advisory Board may consider in one motion. Any exceptions to the Consent Agenda must be stated prior to approval.

A. **Approval of Draft Minutes**
May 6, 2021

Mr. Brown moved to approve the minutes. Mr. Macaluso seconded the motion, which passed unanimously.

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4. *Prehospital Medical Advisory Committee (PMAC) Update
Dr. John Hardwick

Dr. Hardwick explained PMAC was being reorganized to better align with the protocol meetings to make sure that all of the medical directors for each department have input. They added a protocol to place pacer pads on anybody with a malignant arrythmia or ST elevation MI.

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11. *City of Reno and REMSA CAD-to-CAD Implementation Project Update
Cody Shadle

Ms. Esp introduced herself for the record. She noted there would not be a presentation on CAD to CAD (C2C) as the intended presenter was unable to attend due to a family emergency. Kathleen Nickel had provided the update requested by the Board. Ms. Esp pointed out the Board had received hard copies and would be provided a copy in electronic format. Additionally hard copies were available to attendees. The information included the updated scope of work for C2C, a summary of features, and a user guide.

Mr. Dick mentioned that when the Strategic Plan update came to the District Board of Health (DBOH) and the C2C project was looked at, one of the Board members, a Councilman from Sparks, expressed his displeasure with the lack of progress that has occurred with the C2C initiative. This was one of the items that was really significant, one of the priority items, that came out of all of the work that happened in 2013 and 2014 with the establishment of the regional oversight and the franchise renegotiations. Mr. Dick opined this project would benefit from more transparency, it seemed rather opaque from the outside to understand what was happening. They were seeing things about liability issues, and confidential information, but there are not any details provided or explanation. We have had this kind of reporting now it seems, for years. He stated he would like to get a lot more information and understand what is going on, why this project is unable to move forward and where the impediments lie to it.

Chair Krutz stated he concurred with what Mr. Dick had to say and hoped that at the next meeting they would see a rigorous, thorough, complete update.

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12. Discussion and possible approval of moving the November 4, 2021 meeting to November 5, 2021 (For Possible Action)
Andrea Esp

Ms. Esp explained the Oversight Program was requesting to move the November 4th meeting to November 5th, a Thursday to a Friday, to accommodate the Health District retreat that will be taking place.

Mr. Dick pointed out that he had requested the Board's involvement in rescheduling the meeting, as it conflicted with the DBOH Strategic Planning retreat already scheduled for that day.

The Board members indicated they were comfortable with the move.

Mr. Brown moved to approve. Mr. Dick seconded the motion, which was approved unanimously.

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4. *EMS Oversight Program and Performance Data Updates
Andrea Esp

Ms. Esp noted she would like to highlight a few accomplishments of the team. Over the last three months the EMS partners, REMSA, the fire agencies, and EMS oversight staff have been working on the strategic plan. Even though progress maybe not as quick as we would have hoped, there has been a lot of progress made, and a lot of great discussion has taken place, especially around identifying different determinants, of which maybe Fire or REMSA only should respond, not both. There was also great discussion on how to a better job of calling off or cancelling one of the other agencies, so we are better able to provide resources across the community when resources are limited. They have been meeting bi-weekly and discussing that issue and anticipate having something in place come January 1, 2022.

In addition, the team continues to work on updating plans, including the Mutual Aid Evacuation Agreement (MAEA) and Mass Casualty Incident Plan (MCIP). Along with data performance updates, we receive regular requests from our partners to provide data reports for them, so we continue to work provide those in a timely fashion. We are working on a new protocol to make sure that we set expectations of how those requests are made to us. To also help with that we are cross-training in our team to make sure that even though someone is on leave or there is a vacancy that we can still provide that information, and timely.

The team is working on revising the REMSA franchise map for FY19-20 and FY21. We will be presenting on that in November once census data has been released so we can finish that review here internally. There has been a record number of exemptions lately, which will be discussed further later in the meeting.

Additionally, the program receives requests from the Community Services Department (CSD) on different special events and other items to review, resulting in duplication between our program, our EMS partners. Julie Hunter has worked collaboratively with EMS partners to streamline that process so we are not all reviewing the same things, and is one collective report that is being provided back to CSD.

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5. Presentation, discussion, possible approval, and recommendation to present the revised REMSA Exemption Guidelines Letter to the District Board of Health (For Possible Action)
Julie Hunter

Julie Hunter introduced herself for the record. The REMSA exemption guidelines had been revised to better define criteria used by the District Health Officer (DHO) to approve late call exemptions requested by REMSA Health. The original guidelines were written and approved in 2016, and many things have changed since then. The highlights of the recommended revisions include language to account for impacts due to multiple construction projects, which lead to traffic congestion and road closures. Language to better define exemption criteria for local, state, and federal declared emergencies was also revised. Consistency regarding deadlines for submittal and approval for both the Oversight Program and REMSA has been established, as has the activation of the MAEA which had not been included before. These revisions were presented to the DBOH on July 22, and the Board requested that the revisions go to the Emergency Medical Services Advisory Board (EMSAB) for discussion and recommendation to approve, and

then be returned to the DBOH for final approval.

Mr. Thornley asked if, in the space between 2016 when the exemptions were last revisited and now, how many incidents would be falling into these categories. Ms. Hunter indicated she did not have the information but could look into it. She noted that lately there has been quite an extensive increase in system overload and Status 99 exemption requests, 148 in June and 68 in July. Mr. Thornley asked what that meant for service level in the community. Ms. Hunter replied there have been long hospital wait lines for ambulances waiting to get patients into the hospital. Road construction has also been a problem. If the roads are closed then the lateral streets are congested, and some of the engines have had to shut down because they are not able to go anywhere. As a result, the multiple construction projects in the area are causing lots of problems with response times. Also, new major developments are adding to congestion in places like Cold Springs and Spanish Springs. Mr. Thornley asked how these exemptions helped with the mission to provide high quality EMS service to the region. Ms. Hunter stated she would defer to someone else for that response.

Aaron Abbott, Executive Director of REMSA, introduced himself for the record. Nothing about the Status 99, which are hospital delays, as well as system overload, have been changed in these exemption letter revisions. The revisions that are being suggested in the exception guidelines impact street closures, multiple construction projects, things of that nature. What REMSA has seen, as this community continues to grow, streets are widened, major arteries are shut down, is that we have an increased number of system shutdowns. As an ambulance is responding, they are trying to route around certain construction projects, but because there is a freeway construction project and then a major artery construction project, all the detours are essentially shut down or congested. They have not seen this number of situations in any recent times where units are having to shut their lights and sirens off, there is just not anywhere for them to go. 2016 was a much different era for this community and we're trying to account for some of those changes that are beginning to rear their heads.

No matter how many ambulances you have on the street, if you cannot drive around the streets, you are not going to get anywhere anytime soon. And so that is one of the major requests added in this revision proposal. The addition of MAEA, so logically the hospital has to be evacuated, I don't know how many resources it would take to have to evacuate one of our major hospitals in the community that logically would fit into a mass casualty incident criteria, requesting a lot of resources from outside mutual aid to come in and help us.

The original language for the local, state, and Federal declared emergency revision requests does not meet a definition of what happened here during a local disaster. It says local disaster, but it also says in which there was a formal emergency management process, and then local resources were requested. What we found out during the pandemic is that everybody, every community across this nation is experiencing local- and federal- and state-level declared disaster. Under the current definition, if you look at the situation with COVID, we are under a federal, state, and local declared disaster. We have been for some time, that has not been lifted. The language in the 2016 letter does not lend to what happens when, for example, somewhere within our response area there is a major earthquake and we have major building collapses. There is no emergency management process set up. There is incident command, and there is an initial response to that, and all resources will be involved or dedicated to something that large. The 2016 language does not lend itself to what happens when we have our own emergency here and suddenly all our resources are consumed. It is not reasonable to expect an 8:59 Priority 1 response time standard to apply in that situation. So we are just simply trying to take what we have learned from 2016 until now and apply it and better refine what those exemption criteria

would be.

Mr. Abbott continued, stating those were the major pieces of the revision, and offered to speak to the questions regarding system overload. System overload is a statistically relevant measurement, a 3-times standard deviation of average response numbers over a 20-week period. It has nothing to do with staffing or anything else going on in the system. What it tells us is when we hit system overload we are in a significant and unprecedented period of time of call volume, which only used to happen a couple times a year. REMSA rarely applied for exemptions, even when it did occur. It is happening daily now, so what we are seeing in this community is changing in the amount of utilization of 911. We are significantly impacted by 911 call volume, and the statistics are calculated using every hour of every day of every week along a timeline for the past 20 weeks, one of which just ended, showing a period of volume not seen in past 20-week periods. So as the 20 weeks rolls along that average line continues to creep up and up, so that is an adjustment period. Due to that, we know we have got to continue to add more resources into the 911 system. As that increase occurs, the opportunity for system overload should decrease, except in a situation where the call volume continues to outpace the average 911 responses for the past 20-week period. What REMSA is seeing, and the reason why there have been so many overload exemptions being requested, is because our 911 call volume is drastically outpacing our previous call volume, at a pace that we have not seen before. Literally almost every other day we are in a system overload period. The reason that that overload exemption criteria exists is because no agency on the face of this planet can add resources in a 20-week time period and continue to add them at the required pace.

That is compounded by hospital delays, and we are also seeing an unprecedented number of hospital delays. That tells us that not only are our resources stressed, but the hospital system resources are stressed at the same level. They are unable to offload our patients from the hallways. That's also causing an increase in mutual aid utilization, so the City of Reno, TMFPD, and our other mutual aid partners including Storey County and Carson City are all being impacted because when we are in a system overload with five ambulances sitting on the wall at the hospital unable to be offloaded, we are requesting mutual aid. And that is the only right and appropriate thing to do in that situation. However, it is causing a strain on everybody down the line. There's no change in the Status 99 exemption criteria, which is the hospital offload criteria, except for trying to standardize the timeline in which we submit those. Some of them throughout this letter in the past have been three business days, some have been five business days, some of them have been five business days after the end of the month, so we are trying to standardize when those business days or when that due date is due, for those exemptions. They did change the system overload time criteria from three to five because we are standardizing across the board.

Mr. Thornley asked what is the difference between receiving the exemption and not receiving the exemption operationally speaking for REMSA?

Mr. Abbott replied that, operationally speaking, it doesn't change what we do from an action item perspective. When we are in system overload, we know that is because the 911 volume has outpaced our available resources, otherwise we wouldn't apply for those exemptions. We would still be making those calls regardless of the amount of 911 calls in the system. All it changes is in the response time compliance calculation; those calls would no longer count for us or against us. They are removed from the data set and set aside so that the numerator and the denominator both decrease by the same amount.

Mr. Thornley stated he did not think he was able to support the requests without better

understanding what the impact on the data collection and the ramifications for the administration of the agreement are. He needed more information before he could say yes to this.

Mr. Dick noted that, under the franchise agreement, either the DHO or the DBOH can grant exemptions for these special circumstances for REMSA. An exemption means that when they do not achieve the 8:59 second response time, that it is not counted against them and their compliance under the agreement. I did update the exemptions in 2016, because I felt that the changes then were primarily administrative and clarifying items. When these came to me, I felt like these were significant changes in the exemptions, and I think it is appropriate to consider that we have an emergency, a declared emergency, etc., and there is an exemption that applies. But then there is a recovery period, perhaps after the emergency is no longer declared, when things are still disruptive. We have seen a huge impact to our healthcare system out of this type of emergency that I think will have a longer-term consequence than if we had a fire or an earthquake or a flood. I think the construction exemption is maybe a little bit more straightforward, but it is still a change.

Mr. Dick went on to say I had decided that I wanted this to go to the DBOH for them to make the decision on these exemptions. And they then decided they like to hear what the EMSAB's opinion is on this. I think it is appropriate to have these exemptions. I think it is a little loose the way it is put as far as how the decision is made on when to grant exemptions if there is no longer a declared emergency or make a decision that it is a recovery period. Frankly I do not think that that should just fall to me to make that decision, there should be some more transparency in the way that decision is made. So I would suggest that that decision should be something that goes to the DBOH level, and it may be something that the EMSAB wants to get appropriately involved in regarding a recommendation to the DBOH.

Mr. Thornley stated so to be clear, I am not a hard no on this, I am a no today. And the reason I am a no today is I hear everybody saying that we have impacts to the hospital system, to REMSA, to the respective fire departments, and I just don't feel like I have enough information on the net effect of what these exemptions are against the franchise agreement, or an understanding of what we are doing to make adjustments in our delivery system as a region to get ourselves back on track. I am a little startled to hear that we have gone from two or three times a year in an overload situation to every other day. The anecdotal data is not enough for me to feel like I am making a good decision. I feel like we need a broader conversation on this before it goes back to the Board of Health. Mr. Dick stated I don't disagree with you on that. I do think that the agencies and the EMSAB should be engaged and in agreement on the path forward.

Mr. Macaluso asked if there was an analog, another EMS agency, in a similar situation across the country? And if so, how do these requests and exemptions align with that system? Are we on track to mirror what would be expected?

Mr. Abbott explained I just got back from a national conference in Las Vegas, and my colleagues across the nation are facing all the same problems. They have unexpected variations in their call volume, some are high, some are low. The low presents a whole other host of problems when it comes to revenue and keeping staffing and paying your people and staying alive as an organization, as we all know. Some of them are extremely high, situations, emergency status. So there is a lot of parity in the national scene right now as to what is happening with health care in general and a lot of it is a trickle down. And remember, pre-hospital health care is still health care. And coming out of post-pandemic, we are going to have impacts with COVID in a way that probably nobody foresaw in a long-term situation. I have

been involved in other disasters, large fires, earthquakes, and when your employees lose homes, when the economy starts to shut down and other bad things start happening, there is an impact to the safety net systems. And so even in other types of disasters you are going to see this period, post the actual response, response sometimes is a clearer path to deal with the situation than recovery is. And we will see those impacts for some time. But I think more direct with your question, I have strong belief, and if you Google ambulance service right now, you will probably come across article after article of EMS agencies shutting down, or EMS agencies across the country dealing with significant challenges when it comes to the 911 call volume. I hope that answered what you were getting at.

Mr. Thornley answered, in part, I guess I am looking at the exemption requests. Like the third bullet, for example, to me seems like a workflow issue, moving from three to five, an ambiguous time frame to a solid five-day time frame, by which those exemptions will be submitted. How does that compare, specifically, that one for example, how does that compare? That to me is less controversial than some of these other issues around are we just going to increase the need to submit exemptions versus fundamentally change the way we provide a service. Bullet three, to me, is a little more like housekeeping, and does that align, as an example, with other systems around the country?

Mr. Abbott responded I have worked in a management capacity in two other systems, ambulance services, and I can tell you that when you have seen one ambulance service you have seen one ambulance service in one community. And really from a housekeeping perspective, we changed it to five, and I think Ms. Esp and Ms. Hunter can attest to this, that we just could not keep it straight, because one was three and one was five and we were all having troubles with the number of exemptions that we were submitting, what our time frames were and we would forget, and plus, they are dealing with vaccination PODs and we are dealing with vaccination PODs and all kinds of other things in our careers that we had not dealt with before. It was just difficult to keep it straight.

On the other items, specific to MCI and disaster declarations, every EMS system that I am familiar with has a disaster declaration exemption criteria and MCI criteria, typically a mutual aid or for provide mutual aid. That is typically an exemption criteria, because we are sending resources out of our system down to somebody else's. These are not unprecedented or unusual.

Dr. Hardwick noted I think I agree with everybody else; it just appears too nebulous to give this a green light right now. And another thing, from the ED standpoint, we are seeing a mild increase in COVID cases here, but the ambulance traffic we are seeing is considerably just kind run of the mill emergencies and urgent care complaints that appear more consistent with, I think, two things. And again, this is anecdotal, one is just a growing population of Reno, we all know that Reno's population exploded during the pandemic because a lot of people from larger cities moved to our area. And two, we are getting a lot of ambulance traffic from the new CARES facility, as I think they are going through growing pains figuring out who they need to actually call 911 for.

I think we are seeing probably social ills that resulted from COVID. But I think a lot of what we are seeing is an explosion in our population. I did question whether or not is this was truly secondary to the state of emergency, and COVID, or is this just the result of a growing city. And maybe social ills are going to be with us for quite some time. But we have to get a little bit more creative about addressing and working with our partners at the CARES facility, and the cities of Reno and Sparks, coming up with creative ways to possibly divert these ambulance calls, or come up with other ways to address these problems, which I know REMSA is already involved

with, but, right now, we are kind of saying we'll just come up with a nebulous time for how long of an exemption period. This seems fraught with a potential for abuse of that.

Dean Dow, President and CEO of REMSA Health and Care Flight, introduced himself for the record. 47 years in health care, a flight paramedic hospital administrator. Multi-faceted career in health care. To Aaron's point, Dr. Hardwick's point, we provide health care. We are part of the public health system. Yesterday in our community between all three hospitals, not including the VA, there were 57 positive and/or suspected COVID patients admitted, 13 in ICUs and three on ventilators. That number this morning 70 positive or suspected, 15 in ICUs and four on ventilators. We are part of the health care ecosystem. And when that ecosystem starts to be stressed, and starts to crumble, we are affected in ways that sometimes we can control and sometimes we cannot control.

As noted by the EMS oversight group, Mr. Dick, and Aaron Abbott, we have significant wall times every day. Those wall times are averaging 45 minutes. We as an organization, have had ambulances sitting in emergency rooms waiting to unload patients for up to four to four and a half hours. We have had our fire partners sitting on the walls at hospitals for the same period of time, three and a half, four, four and a half hours. Some may present that nothing is being done about this. Some may present that there is a state statute, which there is, that says after 30 minutes an EMS organization can notify that hospital that they are leaving the patient and going back into service. But it is obvious there are no beds and not enough staff at the hospital to assist, so the responder(s) stay with the patient until the hospital staff catches up and can take over their care.

The system is stressed, we have to go into overload exemptions and that impacts our ability to be compliant to the franchise relative to response zones and performance. California is down 44,500 nurses. Nationally, 50% of all nurses right now are the age of 50 years old and older. Retirement rates and rates of nurses, nurse practitioners, PAs, janitors, hospital staff in general, are leaving by the hundreds and hundreds. In this community alone, between the three hospitals, Northern Nevada, St. Mary's and Renown, we are down hundreds of nurses.

So part of this is staff. Part of this is my organization is short staffed just like Renown, St. Mary's, Northern Nevada. People will tell you that my organization does not pay enough. People will tell you my organization is not trying to recruit good people. Those are two falsehoods. We pay above national average, we just increased our overall pay for everybody in our organization by 3.15 percent, we have an employee sharing program, we're recruiting nationally, but to Mr. Abbott's point, I am on the phone almost every other day with CEOs of large systems whether they are fire-based, hospital-based, independently based like ours, or community-based like ours, and we are all shorthanded.

Countless communities across this country are shorthanded when it comes to prehospital care. This is not just a problem for Reno, Washoe County, Sparks, and REMSA Health, it is a national problem. Our responding partners and our organization, along with EMS oversight, are working diligently at looking at how delivery systems can change. It is a recognized fact that on low priority calls we do not need to be sending out fire trucks, numerous paramedics, and an ambulance. In some cases, we can safely move those patients over to Nurse Health Line. We are looking at and understanding how to manage hospital transfers better. This week and into next week, we are implementing units that are specifically dedicated to doing nothing but inter-hospital facility transfers. We are looking at systems across this country and looking at single-resource responses. We continue to look at different ways to do patient guidance. We are involved with Renown Health and their RTOC system that went into effect this week helping

manage patient movements better. There is no one silver bullet to this problem, it is a multi-faceted problem, and it is a national problem.

In the last three months, we have responded to the CARES campus over 550 times. As also noted by Mr. Abbott, those increases in 911 volume are not Priority1s, they are not Priority 2s, they are Priority 3s and even lower acuity patient concerns. A lot of this drives from COVID and from a heightened awareness of healthcare in general, but it also drives from the Affordable Care Act, it also drives from opening up Medicaid programs across this country, because people then start having better access to health care. But the problem is, is that gaining that access is very difficult. They cannot get in to see their private care physician or the clinics, so they turn to the 911 system and emergency departments. We have people working diligently every day to try and modify and enhance every component that we can. We are working with the hospitals, on these problems, but again, they have significant staffing issues themselves, and we would be more than happy at any point in time to provide more information and bring it back in front of you with updates on where we are improving situations and where we continue to be challenged.

Mr. Thornley stated I want to be clear; I do not think that the exemptions that you are asking for do not make sense. They make sense, I just want to understand the information that we are basing them on. And I want to have a broader discussion with the fire partners and the hospitals and you, of course, in terms of what are we doing to improve this situation here in our region. I do not think it is lost on anyone in the room that it is a national problem, and that it is not REMSA-specific. So to the extent that you took my earlier questioning to mean that I thought it was REMSA-specific, I apologize for that, that was not my intent. I just do not feel like we have enough information, I do not have enough information, to make an informed decision today on how these exemptions fit in the broader paradigm with how we are attacking the problem.

Mr. Dow stated that he totally, totally understood. And I don't think I took your statement directly towards REMSA Health, but I did take it in a sense that it was directed towards the system. And since we are a very large part of that system, and we are the component of that system that is monitored, very closely, and that we understandably have contractual obligations under that franchise, I think it is prudent for me to articulate publicly what the additional problems of the ecosystem are and that it is an ecosystem. And I know several of you understand that, but it does need to be said. We have been asking for meetings because we have got to work this problem. Because I, for one, firmly believe, it is not going to get any better. Due to that, we are going to have to drastically modify how we respond and how we do things, obviously being patient-centric and being patient-safe moving forward. That is always the number one goal. But none of us can continue to do business the way we have been doing it. We have built this system over forty-something years across this country, and to realize that we've got to stop now and retool that, is a tough road to go down. I appreciate your patience and your attention.

Mr. Brown recommended that we refer this matter for broader discussion to resolve the issues before we take action on the actual exemptions?

Mr. Krutz pointed out that was not a motion, but an opportunity to discuss.

Mr. Dick stated I would recommend that we go ahead and advise the DBOH to make the changes of just the time frames that are in here, so it is consistent with that five-day period so that at least we can get that in place officially and that we continue and have an item come back to the EMSAB and maybe even have a special meeting if something gets resolved sooner as far as how to handle this issue of recovery, post-emergency and whether an exemption is provided for that period and the multiple construction projects.

Mr. Brown seconded. Mr. Dick said it was not a motion, but I will make it a motion. Chair Krutz aske the Board if everyone was comfortable, we all have a motion we all understand. Mr. Brown stated yes. Chair Krutz asked Ms. Kandaras if she was comfortable with what we are doing, and she stated she was unclear on the motion.

Mr. Dick stated I would propose a motion that we recommend that the DBOH adopt the revisions to Exemption 1, MCI, MAEA, the exemption for Miscellaneous #1, which is a business day issue, the weather exemption revisions, the system overload revisions on the time periods involved and the Status 99 revisions. Also that we have the Regional Oversight Program work with the regional EMS agencies on Item 3, the local state and federal declared emergency and #5, construction, to come back with their recommendations for the advisory board to consider as far as changes to be advised to the DBOH.

Mr. Thornley asked could you make it clear for me what the overload situation is in your motion?

Mr. Dick replied so the overload exemption would remain as it is, but we would clarify that the documentation required for the exemption is that 5-day period.

Mr. Brown seconded the motion which passed unanimously.

[Mr. Dick left the meeting at 10:00 a.m.]

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6. *REMSA Quarterly EMS Advisory Report
Adam Heinz

Good morning, for the record, Adam Heinz, Executive Director of Integrated Health Care for REMSA Health. There has recently been a felt increase in the number of responses to the CARES campus. Every day we respond about 5.5 times. We obviously would expect that as we consolidate services, we know that there's going to be an increase in the number of responses. But many of those responses really have no medical complaint, so many times it is really to the individual's activities of daily living. We are changing people, moving people, helping them with catheter issues. That prompted us last week to have a meeting with the Volunteers of America, as well as the City of Reno staff so we had Mr. Hod, Miss Cochran, as well as Mr. Cashell sitting with us. The only person not at the table that should have been there is our City of Reno fire service partners. I asked that we begin to have those meetings on a regular basis so we can talk about different strategies. And there were immediate things that we are going to do, REMSA Health is committing to put our community health paramedic and put some sort of frequency in which we are going to respond and do some proactive management of some of the minor complaints. That is obviously not a long-term solution, it could be part of the long-term solution but there were some immediate things and obviously there are long term items. I just want to let you know that we are actively engaged in that. Three percent of the community's call volume is to the CARES campus. Every day. So it definitely is a consumption of resources.

The other is the bed delays, as we heard. Last month 349 times EMS units in our community were unable to offload. And that is defined. Typically that is up to 30 minutes, or if there are multiple units that do not have the ability. And so we know that the health care system downstream is in a position where they are not able to accept those patients readily, with one of our units being at least four hours. Yesterday we had a joint advisory committee with our fire service co-response partners. They are feeling it as well. I appreciate Manager Thornley's interest, as well as the offer to actively participate in different strategies to move that forward,

because as Mr. Dow indicated, it is likely not anything that is foreseeably going to change, and we are going to need to work on what's best for patients, and what supports the EMS system in our primary mission.

We have the pleasure of hosting the International Academy of Emergency Dispatch President, Jerry Overton, and all of you on this board should have received an invitation. The purpose of his business is to celebrate our ACE-Accredited clinical communications center. But in addition, dispatch is a topic in this community, there are a lot of things that are going on nationally that I think we could benefit from. That symposium will be an opportunity, not only for him to share the state of emergency dispatch as he knows it as the industry leader and president, but also the ability for us to have a Q and A type session for our leaders. Our community influencers and leaders, as well as our fire response partners and our dispatch leaders are kindly invited and we hope you can attend that.

And then finally, as Dean indicated, and as we know, unfortunately COVID is on the rise and we are starting to see some of our unvaccinated employees suffering. Our medically trained dispatchers are continuing to do influenza-like illness screening or COVID-like illness screening, and providing that to co-response partners to ensure that we are taking the proper precautions to reduce any type of risk that we are putting our people in during any response.

Mr. Macaluso asked do you have any idea of what percentage of your employees, especially those in the field, are vaccinated?

Mr. Heinz responded it is very high, almost 90 percent of the team members that are in my division. As an organization we are around 84 percent total, which includes those individuals out in the field. We did adopt measures that include those who are unvaccinated are required to wear masks and of course with patients we are going to continue to wear masks as well. We continue to work to try and convert the unvaccinated and provide education so that the opportunity exists for them to get vaccinated. We would like to see 100 percent.

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7. *City of Sparks Fire Department EMSAB Report
Chief Jim Reid

Good morning, Chair, members of the Board, for the record Jim Keinz, Division Chief Operations, Sparks Fire department. In front of you is our quarterly report and I am here to answer any questions.

The Board had none.

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8. *Truckee Meadows Fire Protection District (TMFPD) Advisory Board Update
Chief Joe Kammann

Good morning, everybody, for the record Joe Kammann, Division Chief, Truckee Meadows Fire. You should have my report in front of you. If you have any questions, I am here to answer anything you have.

The Board had none.

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9. *Reno Fire Department EMS Advisory Board Update
Reno Fire Department Staff Representative

Good morning, Chief Dennis Nolan, you have my report in front of you, and if you have any questions, I will be glad to answer them.

The Board had none.

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13. *Board Comment

Limited to announcements or issues for future agendas. No action may be taken.

The Board had none.

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14. *Public Comment

Limited to three (3) minutes per person. No action may be taken.

Chair Krutz opened the public comment period. As there was no one wishing to speak, Chair Krutz closed the public comment period.

Adjournment

Chair Krutz adjourned the meeting at 10:07 a.m.