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Medical Director's Update for Base Station Physicians' Committee July, 2011

Please notify hospitals early of patients contaminated with hazmat type substances. It is important to give the hospital a chance to evaluate the potential for ED contamination that would result in a closure for evaluation and/or decontamination. The hospital staff can meet the patient just outside the ED door and determine whether the patient needs immediate treatment (always the priority), and whether they need decontamination. This may be the substance as simple as tear gas spray, pepper spray, etc.

Off load delays do occur. If they are prolonged (estimated >30 min) or involve multiple units you may notify the EMS Duty Officer. They can help determine what the cause seems to be, the efforts being undertaken to resolve the problem, and other issues.

A Burn surge plan is under development. This will develop a process for dealing with a large scale incident with many significant burns. A focus will be concentrating the most severely injured in the UCSD burn center, but use the trauma centers and 911 receiving hospitals for patients as well. It will also address the need for transfers within and outside the county in large events, and patient care education and treatment communication.

The STEMI system continues to perform well. EMS will provide some detail at today's meeting. The major challenge continues to be false positive cases and effective transmission of 12-lead EKGs.

Flu season is on the horizon, but it is time to assure vaccine. Orders and vaccination plans should be reviewed. There likely will be a small change in the indications/contraindications. Some hospitals around the country report improved patient outcomes with mandatory health care worker vaccination.

Tdap vaccination should be obtained for those who have not received it. For school children, there is a new vaccine booster requirement for entry into 7-12 grades.

Measles was reviewed in last month's Medical Director's Report. Remain on the lookout for cases so they can be isolated upon arrival at the hospital. See last month's report for details.

Pointers for glove use were forwarded by a hospital infectious disease practitioner. Gloves should not be donned to drive the vehicle to the scene, but rather when you arrive on scene. Cleansing hands before glove placement with an alcohol based agent is recommended.

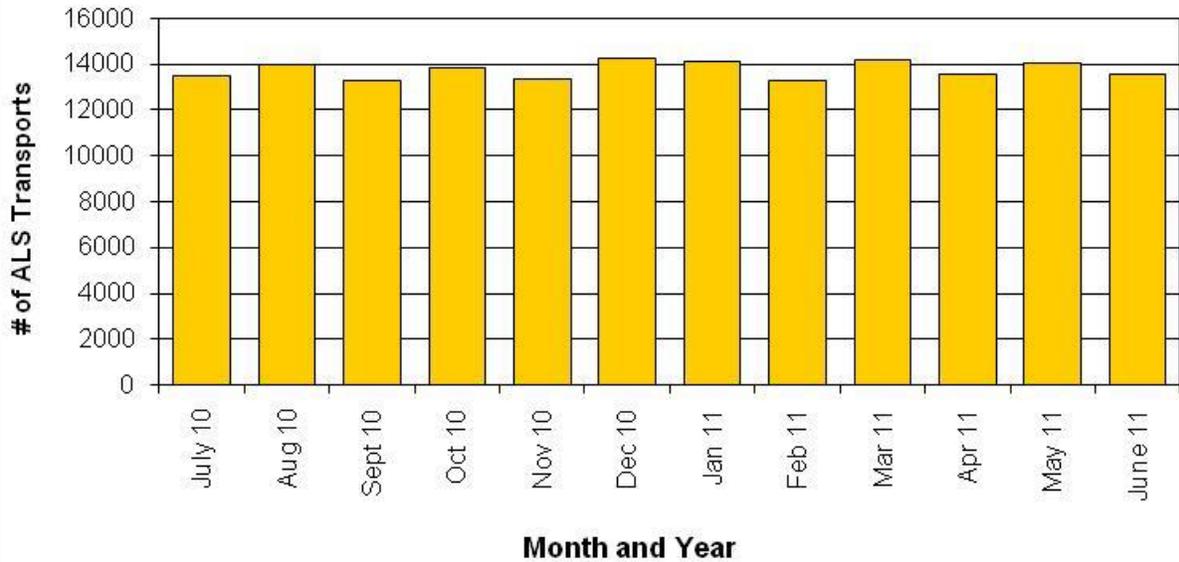
If gloves become contaminated by blood or body fluids, hands should be cleaned and gloves should be changed before transport once the patient is stabilized. Once care of the patient is transferred at the hospital, gloves should be removed and hands cleaned, either washing (if visibly soiled) or with cleanser. Gurney rails can be cleaned if necessary before leaving ED.

EMS personnel have been observed continuing to wear gloves placed in the field "throughout" the hospital on their way out. Hand hygiene is a requirement after patient contact. Not performing appropriate hand hygiene and using gloves inappropriately may spread organisms throughout the hospital, impeding infection control efforts. Efforts to prevent healthcare associated infections are a major thrust of improvement in the health care system.

The Emergency Nurses Association released standard metrics to evaluate emergency department crowding. Signed by nine health care organizations including the American College of Emergency Physicians, the metrics will allow collection of standard data on the patient's visit to the ED. The document is available at <http://www.ena.org/media/PressReleases/Pages/ReduceEDCrowding.aspx>.

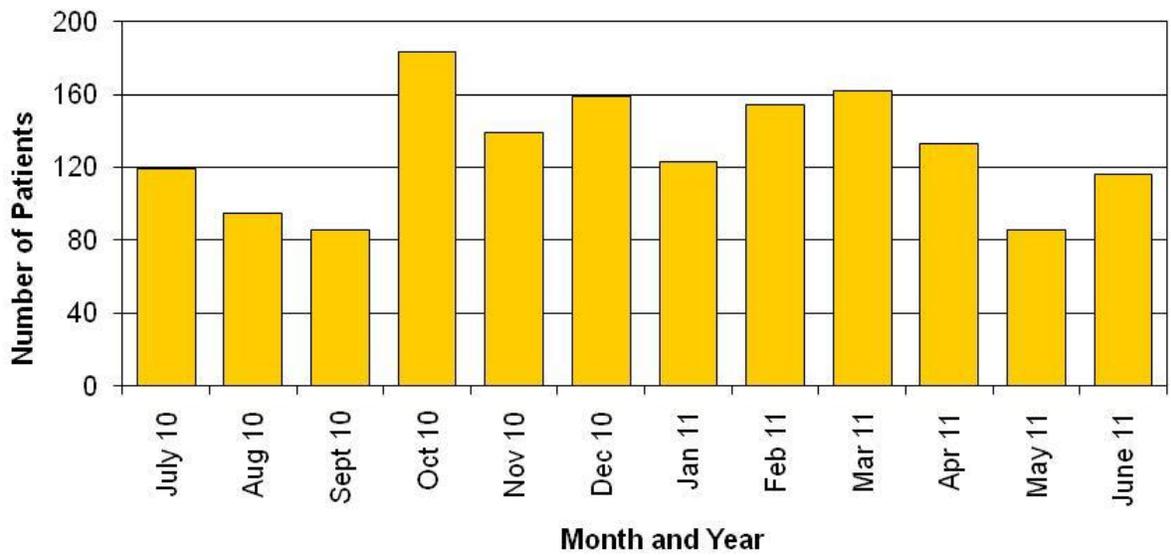
The March letter to BLS providers was reviewed in the April Medical Director's Report. Just as a reminder, BLS providers should be aware of rules and notifications governing code 3 response. Agencies must leave a patient care record with the patient in the hospital. The identity of patients being transported should be established before transport. Finally, each BLS agency must have a contact person and telephone number for quality improvement inquiries from the Base Hospitals.

Number of ALS Transports, County of San Diego, July 2010 - June 2011

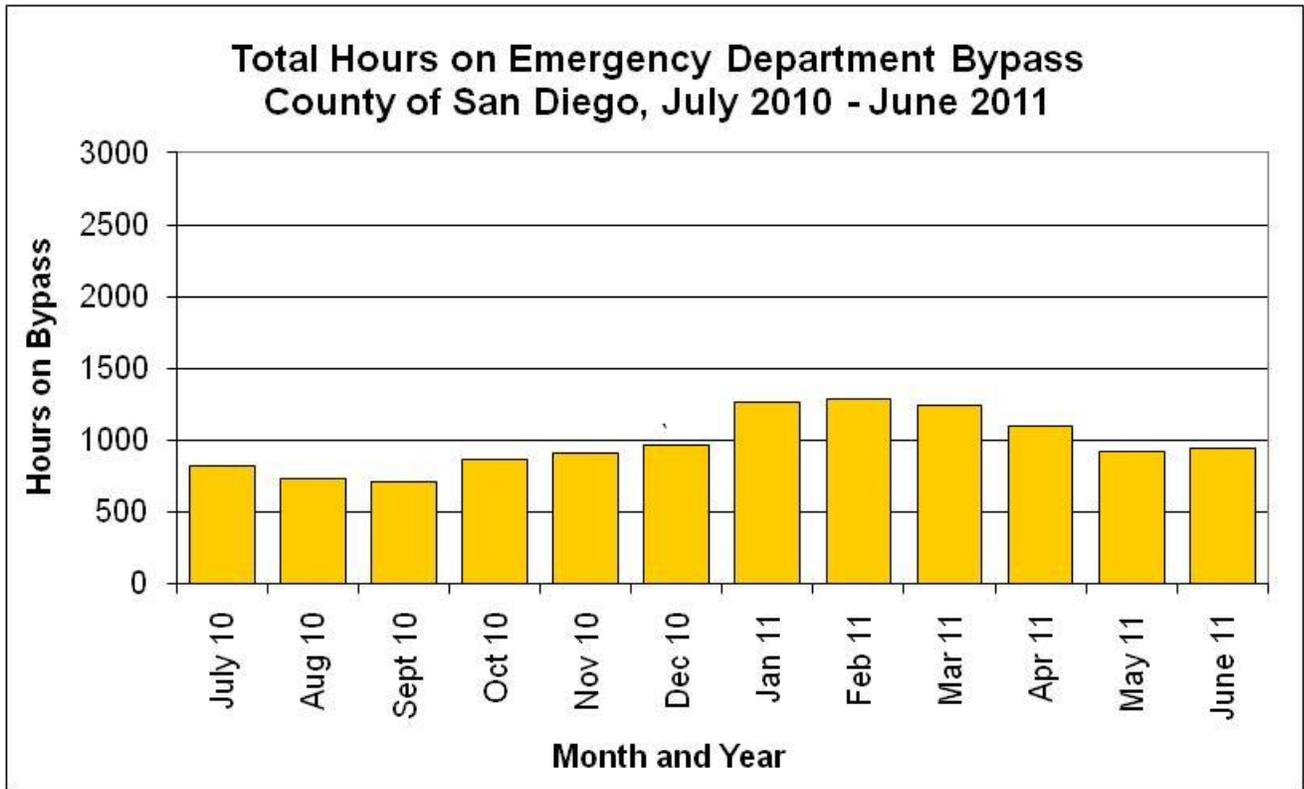


Source: County of San Diego, Health and Human Services Agency, Emergency Medical Services, MICN Records, July 2010 – June 2011 Note: Numbers based on Run Outcomes of Transport by Unit and Transport by Other

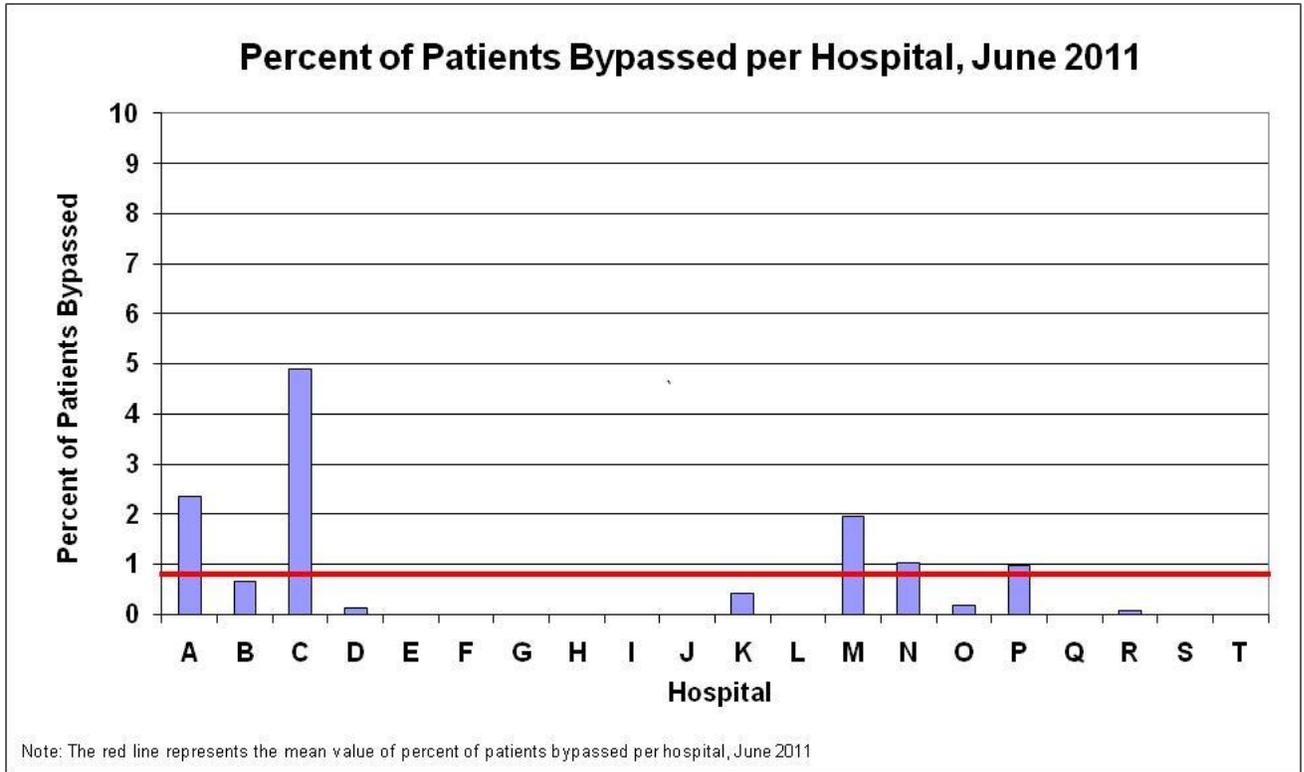
Number of Patients who Bypassed the Requested Hospital, County of San Diego, July 2010 - June 2011



Source: County of San Diego, Health and Human Services Agency, Emergency Medical Services, MICN Records, July 2010 – June 2011 Note: Numbers based on Run Outcomes of Transport by Unit and Transport by Other

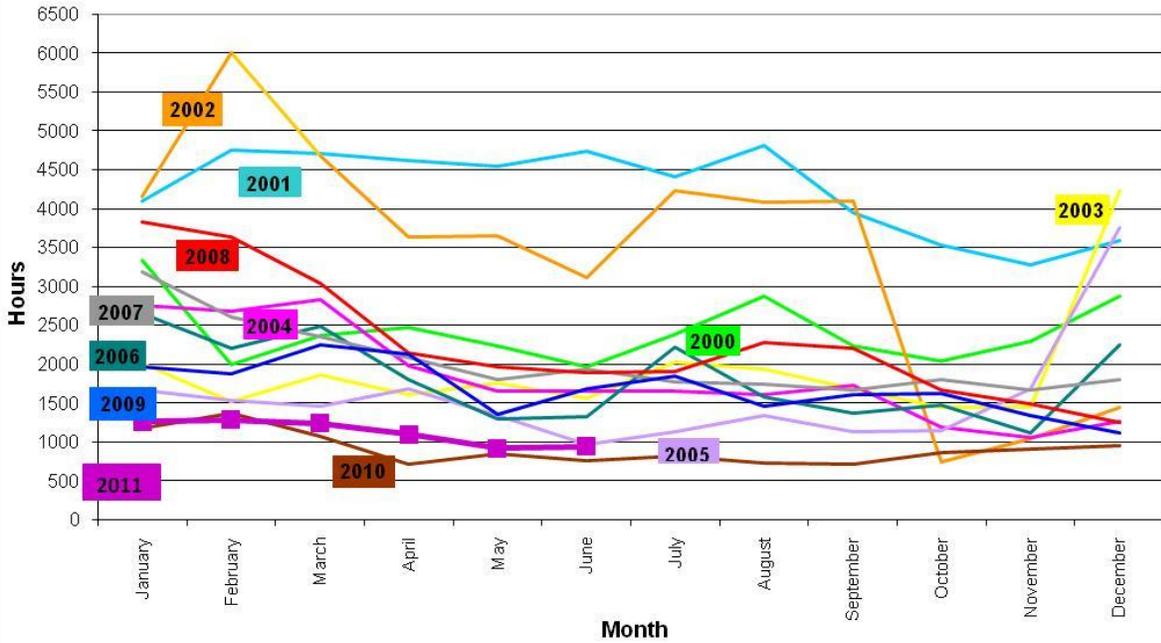


Source: County of San Diego, Health and Human Services Agency, Emergency Medical Services, MICN Records, July 2010 – June 2011



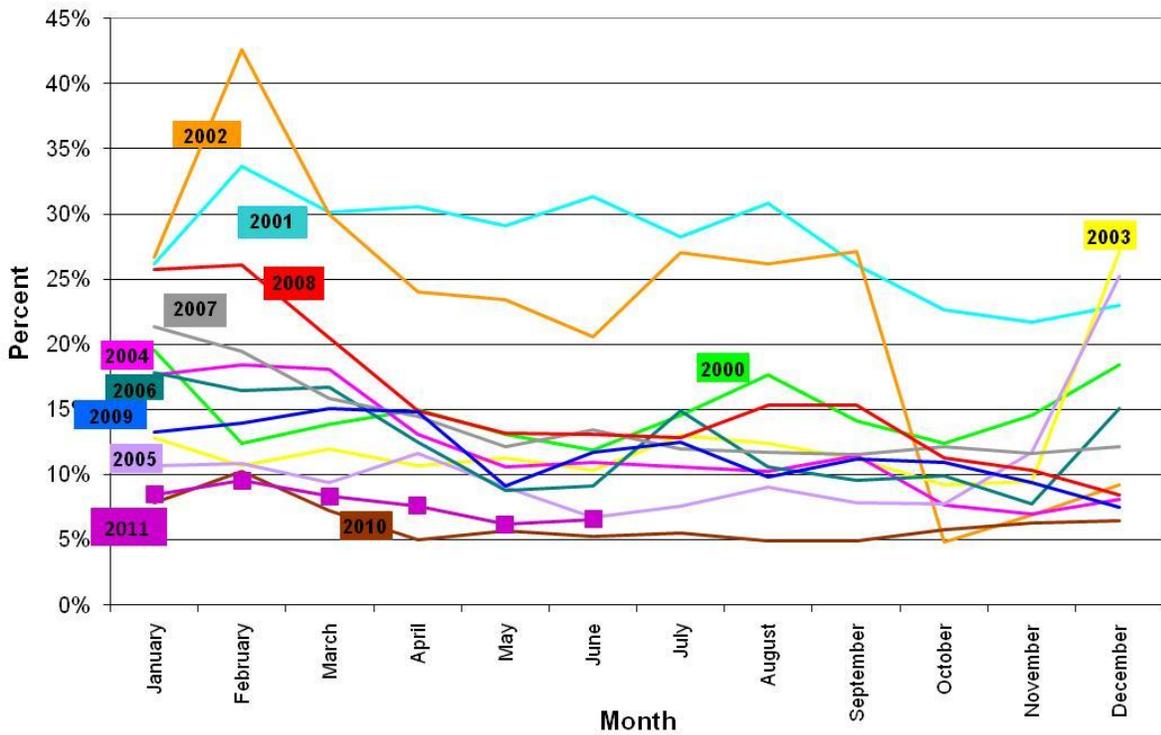
Source: County of San Diego, Health and Human Services Agency, Emergency Medical Services, MICN Records, June 2011
 Note: Numbers based on Run Outcomes of Transport by Unit and Transport by Other

Total Hours on ED Saturation by Month and Year, San Diego County, Jan 2000 - June 2011



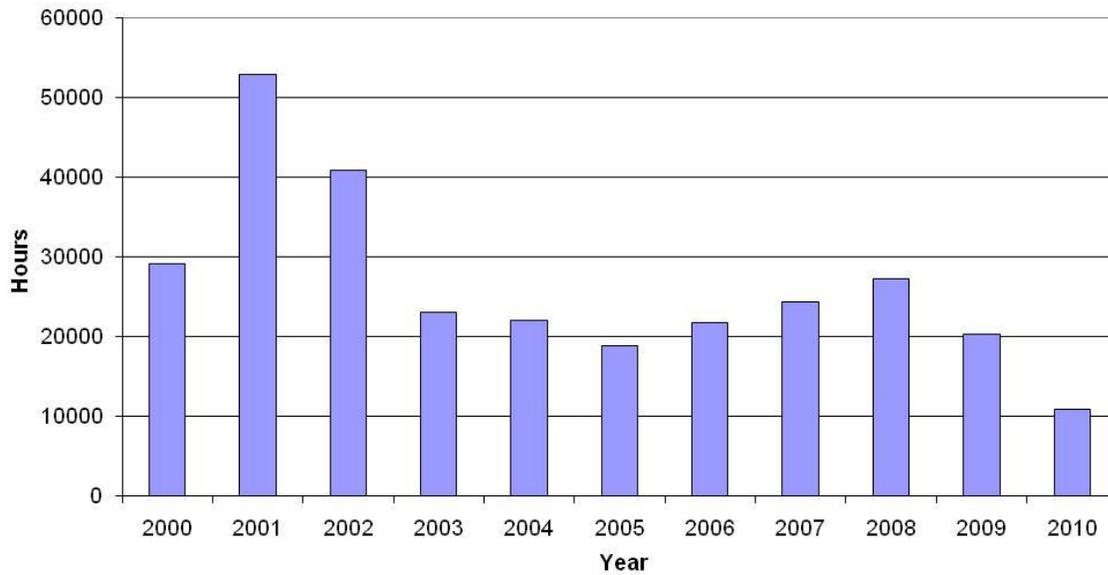
Source: County of San Diego, Health and Human Services Agency, Emergency Medical Services, MICN Records, Jan 2000 – June 2011

Overall Percent Hours on ED Sat Per Month San Diego County, Jan 2000 - June 2011



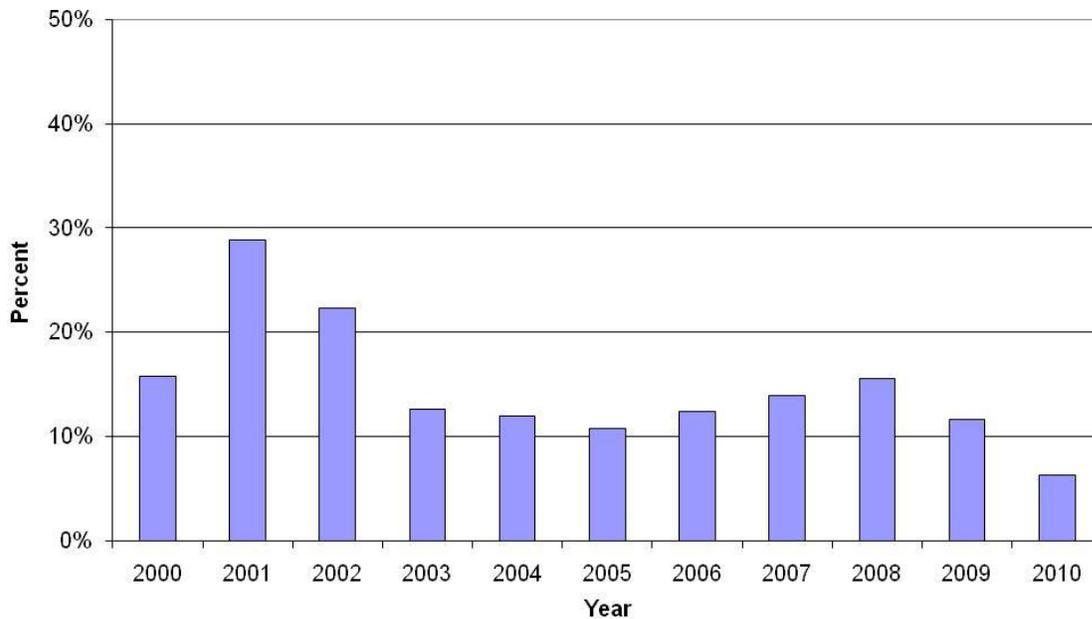
Source: County of San Diego, Health and Human Services Agency, Emergency Medical Services, MICN Records, Jan 2000 – June 2011

Total Hours on ED Saturation by Year, San Diego County, 2000-2010



Source: County of San Diego, Health and Human Services Agency, Emergency Medical Services, MICN Records, 2000 – 2010

Overall Percent Hours on ED Saturation by Year, San Diego County, 2000-2010



Source: County of San Diego, Health and Human Services Agency, Emergency Medical Services, MICN Records, 2000 – 2010