June 16, 2020

Call to order 9:02 by Ken Miller

Scope of Practice

1. Unified Scope of Practice HEMS – LA County, Merced, El Dorado
    a. Discussion of Unified Scope of Practice Data Collection Tool, Atilla Uner
    b. LEMSAs adopting the Unified Scope of Practice do so without modifications, all data collection also the same
    c. Type of SGA can differ
2. TXA for Coastal Valley – Trauma and PPH
    a. Discussed requirement for hypotension in hemorrhagic shock as indication. This is clear in Trauma Protocol 7802, but TXA Protocol 7907 would allow administration in a patient who is not hypotensive, but tachycardic with blood loss.
    b. Group discussed that hypotension should not be a requirement for PPH.
    c. Coastal Valley will edit to make clear the requirement for hypotension for trauma patients; no requirement for hypotension for PPH.
    d. Discussion of contraindication of 'Isolated Head Injury' – group agreed this is not the target population but would be rare to be hypotensive, and no indication of harm, not required to include
    e. No objections to approval with clarification of hypotension for trauma.

EMDAC

Continued to discussion of Trial Study led by Ken Miller

1. Buprenorphine Trial Study – Dave Goldstein, Gene Hern
    a. Dave provided background:
        - Partnered with DPH who has more than 500 patients in the program and any one time, any patient that comes to the County hospital who is a candidate is offered, they are enrolled in a County program if they do not have private insurance. If private insurance, they gain access through their provider. Made the County Hospital an opioid overdose destination since they have the resources to serve the population.
        - Utilize First Watch to make internal referral for every patient with OD that EMS sees even if do not go to County Hospital because they refuse transport or destination is elsewhere. So their information goes to the navigators in the DPH. As of the last month that system is in place. Within 24 hours someone reaches out.

- Train paramedics to administer Buprenorphine, have X-waiver MDs on call 24/7 as an alternate Base. Will be collecting data.

b. Gene spoke to data collection
   - Proposed trial will be subset of California Bridge, will be rolled into that IRB, which went through Cal OSHA IRB. Based on the Bridge program funding through the State, needed to go through at the state level. When proposed adding EMS, felt it should go through the same process. Also this way the scope of the IRB extends statewide if anyone else wants to participate. Gene will find out more about contact.
   - Combination of Cal Bridge forms with a separate EMS component with a number of data points.
   - Reviewed Opioid Withdrawal flow diagram. COWS> 7 is the threshold, which is higher than other programs, more conservative. If patient meets criteria, EMS will contact X-waivered physician. If approved by MD, they will administer 16mg of Buprenorphine SL and reassess after 10 minutes, max dose 24 mg. The patient will be contacted within 72 hours.
   - Post-narcan Buprenorphine is a new concept. Gave 400-500 doses of narcan last year, do not expect a lot of patients but can be a proof of concept.
   - Risk of withdrawal if patient is taking methadone. People are pretty honest about what they have been taking. In other data available, of all the cases EMS has given after narcan, none have had withdrawal. Post-narcan buprenorphine has such a high affinity for the receptor, theory is that buprenorphine displaces the narcan and improves symptoms.

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c. Discussion
   - Marianne Gausche-Hill suggested that they may not be recognizing or documenting withdrawal - Gene: possible.
   - Marianne – how much is it? - Gene: not that expensive, have some funding for the drug, not sure exactly how much it costs.
   - John Rose – is this only research? EFIC? Consent required? Or is this a QI project to assist patients that will ultimately be published? - Gene: Bridge program is implemented as research, with consent, followed for outcomes, UCLA statisticians are involved. This is a portion of that IRB as a research study. Initially questioned whether this should be a Scope changes like Zyprexa BUT since already part of the IRB process and there was a enough question as to whether this is an appropriate EMS intervention, felt should go through trial study. If later SOP feels this could be part of EMS SOP, that could be considered. This is part of a study and the patients are being consented.
   - Marianne Gausche-Hill ask for comment on the metrics/ outcomes – Gene: Metrics are - Do they engage in treatment? Do they show up in

clinic? This has been associated with reduced mortality. In MA, data on nonfatal OD: 20% will die in a year, and of those who die, 5% will die in 48 hours.

- Dave Goldstein- built the First Watch connection with DPH to ensure contact information so that the patient can receive follow-up.
- Gene Hern working on a manuscript for PEC to describe an overdose receiving facility, until buprenorphine is available in all EDs and they have access to clinics, this could be a start.
- Dave Ghilarducci – would that receiving center need to be prepared to receive other ODs? - Gene: Debated calling opioid receiving facility vs OD receiving facility, will need to have some awareness of other ODs.
- Dave Duncan – Consideration of how to expand this statewide. The DEA requires specific expertise for prescribing buprenorphine. May not be enough physicians for oversight – do we need more x-waiver docs? Should EMS physicians take this on? Poison Control has some expertise, could they provide medical oversight? Concurs with Trial Study approach.
- Power points have been shared with the group.
- Kris Lyon suggests getting Rais Vohra involved as the Health Officer for …

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10:05 reconvened for meeting – Dave Ghilarducci

1. Introductions
2. Announcements
    a. Meeting schedule will be the same, planning a September meeting remotely, it is possible that December will be remote as well. Likely will need to await a widely available and effective vaccine to resume in-person meetings.
3. Minutes from March approved (Rudnick, Rosen)
4. Legislative report – Daniel Shepherd
    a. Potential additional revenue $6400 due to outstanding dues
    b. Very few expenditures for second quarter
    c. Current balance up to $34k all due to lack of meeting costs, saving roughly $20k
    d. Given anticipate no in-person meetings this year, if we collect no dues for a year, would be able to handle it
    e. Discussion:
        - Erick Rudnick: should bank for rainy day. This way can put off raising dues rather than suspending dues.
        - Jay Goldman, Marianne Gausche-Hill: Lets collect from everyone this year and reduce dues next year.
        - David Ghilarducci: Reviewed 3 options
        - Kris Lyon: There are tax implications if we go over $50k of revenue/ year. The balance is not important.

- Daniel Shepherd: Meeting costs are going up.
- Multiple people voiced desire to continue collecting dues for 2020 and revisit for next year, maintaining reserve was suggested by multiple in the chat.
- Proposed motion: bank money for this year, continue collecting for next year.
- Marianne Gausche-Hill – can we revisit next year? Just focus on this year now.

f. Group decided no change right now, will defer conversation to December. No vote.

5. EMS Commission – Ken Miller
    a. Agenda for tomorrow does not appear to be challenging
    b. Chapter 13 is coming up, will work with group on a position for EMDAC
6. Legislative Report – Kathy Staats

1) Chapter 13 updates reviewed (See also PowerPoint)

a. Per Ch 13 Standards: Developed to guide LEMSAs on EMS oversight. In 2012 a committee was formed to update standards, suspended in 2015 due to lawsuit but resumed in 2016. In 2019, 3 petitions were filed with Office of Administrative Law potential to undermine Ch 13 authority. A number of lawsuits followed, resulting in a lack of specificity. Goal is to provide clarity and specificity, assist EMS systems providing clear and enforceable standards. Also eliminate the lack of specificity in 201 and 224 rights.

b. Fire Chiefs position: Ch 13 unlawfully changes the fire service role, eliminates 201 rights, may cause loss of >4000 firefighter positions, eliminates subcontracting, partnerships and hybrid models, likely to cause privatization of EMS in California.

c. Request for explanation of position from Fire
    - Kim Roderick: Fire position is concerned that they have a duty to respond, and cannot refuse. Some LEMSAs have decided not to send Fire to certain calls, whereas they feel that it is their duty to respond.
    - Clayton Kazan: They feel it could shift power to the LEMSA. When say 'unlawfully changes the role', they are referring to changes via EMSA rather than legislative route.
    - Kim Roderick: Initial laws existed prior to EMS role and when EMS came in the Medical Oversight seemed in conflict with the history, for example some LEMSAs not wanting to send engine to medical response and this has not been clarified. It's about who has rights on emergency responses.
    - Jay Goldman: Do the Police have similar objections?
    - Clayton Kazan: 1797.201 is specific to a Fire District, if providing EMS prior to June 1, 1980, have right to continue to provide the service. What they are saying that these changes would shift power over to the LEMSA without requiring that written contract between the Fire Agency

and the Govt Agency.

- Marianne Gausche-Hill: Language states that until agreement reached, EMS should be maintained at the current level and the providers should be retained. Level can be reduced pursuant to a public hearing determines that level should be reduced.
- Kim Roderick: This document is taking away 201 rights. They would like to make sure that the 201 and 224 is included in the discussion and that it does not over-reach into the Fire response and preserves the right of Fire to go on medical calls as they see fit. Since property and lives is part of the Fire Service creed, not clear why there is such a rub on allowing all parties to participate as they can.
- Marianne- Gausche Hill: Where does it do that in the document? - Kim states she will see if Scott is available to address some of these questions.
- Kathy Staats shared letter from Fire Chiefs link in chat.
- Kim Roderick in chat "Per Cal Chiefs, EMSA, for one thing, didn't do a proper financial impact study which could cost the departments billions of dollars.
  Many of the issues go against current statutory laws on emergency responses."

b. Dave Ghilarducci points out that goals are 100% aligned, comes down to a few issues that Fire feels constrained by and on our side we are concerned about erosion of medical control. Fire has verbally said to him that they would like to more strictly define 'medical control' though we might not agree with their definition. We may want to discuss as a group what we feel the scope of medical control is.
c. Ken Miller points out the challenge of defining medical oversight is when there are policies that go to operations whose performance impacts patient outcomes. Key is to define which operational policies do or do not impact patient outcome, when they do, we can assess our level of engagement on these issues.
d. Dave Ghilarducci brought up issue of financial sustainability.
e. Reza Vaezazizi states this can offer an opportunity to establish clarity. There are different views on what relates to 201. We may be hung up on outdated regulation and the concern is generic push-back on any process that seeks to update.
f. Marianne Gausche-Hill: is there an opportunity to modify the language to ensure that those that are currently operating have some protection?
g. Reza Vaezazizi points out that we will need to compromise and work as a group to reach agreement.
h. Kim Roderick feels that there is a lot more collaboration now and understanding of LEMSA oversight, we are in a position now to have a conversation. There is no question on who is responsible for policies and protocols on patient care. But there are some factions that do not want to come to the table. It's about

operations and it will be a big fight if EMSA gets these regulations through and include dispatch piece or impact fire response. Suggests we must get in a room and discuss. It is very one-sided currently.

i. Kathy Staats: clarifying question, there is a lot of good definitions in the beginning – are their concerns regarding that aspect or mainly dispatch and operating areas?
j. Kim Roderick: Dispatch is a big one because its revenue generating, concern that this will cost fire service billions of dollars if they give up all of their control. The RFPs may say 'you will follow all policies in the County', but it's too easy to change policies, what if it says 'Engine will stay on scene until patient dispositioned' and they are stuck for an hour and a half…
k. Dave Ghilarducci proposed a way to move forward, the group can provide their input on what defines medical oversight.
l. Reza Vaezazizi questioned how difficult that might be given the diversity of the group. Risk to taking a position. Rejects Medical Control as a term because it's really about Medical Collaboration. Looking under the context of EMDAC, worked hard to get where we are and we should stay on that target, position should acknowledge EMDAC as a diverse multidisciplinary group that stays out of the control aspect.
m. Dave Ghilarducci emphasizes reviewing Chapter 13 and providing comments individually. Group discussion complete.

7. EMSA Report – Dave Duncan
    a. EMSA will likely meet via Zoom for the next two meetings, will not commit to hotel use through December. Will probably not have an Award Banquet this year either. Updates to follow.
    b. COVID perspective:
        - Continuing weekly calls.
        - Acknowledged the remarkable demonstration of EMS during this period, utilizing every aspect of EMS and mutual aid, requiring creativity and collaboration to continue to meet standards of care; in particular the collaboration with DPH. Currently is in unique place, passed the initial response, now in Phase 2 reopening, the 'new normal' – this requires us to move forward and be ready to recognize warning signs. Big priority is how we get back to our normal. This will be a challenge. Need to be prepared to react as needed.
        - Suggests continued monitoring of daily COVID counts, COVID hospitalizations are a good indicator.
        - The goal is to maintain our ability to deliver healthcare without surpassing capacity.
        - Focus on congregate care environments. SNFs likely to be an issue through the end of the year but getting a better handle on it. Seeing prisons and state hospitals escalating – implementing testing. Have testing requirements with SNFs. Anticipate less evacuations with ability

to respond earlier and shore up resources within SNFs.

- Imperial County – may be unique in the state given its relatively large population finding care at two small hospitals – both within Imperial County and south in Mexicali, and there is a large exposure burden given control measures in Mexico. Both hospitals have been at peak capacity. 97% of patients on vents are COVID+. Required a large amount of support: HCW teams deployed to the hospitals, 80 bed FMS with Med-Surg capability, large transfers out 3x both hospitals census transferred out. Ongoing need to transfer 7-10 patients per day, do see a current stability in census with these transfers and the capacity to deliver care is maintained. Could see pressures in other counties. Have had to reach as far as NorCal for beds because cannot always locate enough in SoCal. Feel Imperial County is supported. But there are two SNFs currently impacted, trying to support within the SNFs to avoid offload to hospitals.
    1. Kathy Staats brought up change in transfer process to be coordinated through the MHOAC.
    2. It has taken a lot of calls to identify beds for transfer patients. Currently using a hybrid model with MHOAC and transfer center, working ok. Will be important to discuss process in future. There have been challenges to using MHOAC only given the position of patients already inpatient, the hybrid approach addresses this.
- Hernando Garzon has been assisting EMSA with monitoring for CDPH.

8. Cal ACEP – Vivian Reyes
    a. A lot in common, more than differences. Goal is working together and building relationship.
    b. Cal ACEP has been struggling with COVID, goals for the year have been held and focus has been on adjusting and responding to members – PPE, patient care, supporting physicians working in different standards of care to address liability.
    c. Plan is to continue collaboration and discuss T&R, participation of Cal ACEP at EMDAC meetings.
    d. Offer to send request for aid to Imperial County to Cal ACEP membership.
    e. Discussion of collaboration to define future of EM and EMS.
9. Treat and Release Policy – Kathy Staats
    a. Discussion of T&R policies specifically for COVID
        - Possible exclusions: Normal work of breathing, no airway issues, no Cardiac/Liver/Renal issues, no immunocompromise, No DM/HTN, no high risk complaints (CP, SOB etc), not pregnant, VS parameters, not difficult to refer(e.g., homeless, psych), no communal living (including apt with >5 inhabitants), not under influence drugs/etoh, peds, altered,
        - Suggested advice to patient: isolation period, seeking care or recontacting
        - Testing also discussed

- Cal ACEP recommended 100% audit

b. TF discussed removing temperature requirement, also some of the exclusions may be difficult to identify
c. Atilla questioned how the policy assists paramedics in decision, and also how disparities in care regarding cultures fearing speaking up against authority can be addressed. How should the 100% audit occur?
d. Ken Miller discussed their process for audits, doing 100% review through implementing a run identifying process, review electronic record, focus on availability of referral. Commented that this is occurring regardless, key is that we provide good advice to our providers – it is going to happen with us or without us, so need a method to ensure patient safety – via advice to patient and ensuring healthcare access.
e. Jay Goldman recalls that Cal ACEP remained staunchly opposed to any T&R beyond the pandemic, and maintained their very strong opposition to T&R.
f. Kathy Staats believes that there is actually some room for discussion, particularly in disaster situations. However, refusing patients who still request to go to ED was a sticking point. But there was some openness and they are aware that these policies exist.
g. Kris Lyon put forth that Cal ACEP might be more amenable to continuing T&R after the pandemic if the policy is developed statewide with consistency.
h. Gene Hern mentioned that the issue is a steadily rising patient population in EDs without increased resources and a need to identify patients that do not require ED care, this process was already in place prior to COVID. Field providers can influence care regardless of whether a policy is in place so it's important to identify both the low-risk and the high-risk patients to provide framework for the providers.
i. Kathy Staats emphasized that it is all about the training, even with good policy.
j. Atilla Uner cautioned the ability to teach paramedics decision-making regarding triage of patients given medical students and residents receive many years of training.
k. Dave Ghilarducci summarized that this policy was initially based on concern that our system would be overwhelmed as other systems had been, but it is larger than that and impacts day-to-day operations. There could be utility to a set of guidelines that each LEMSA could adopt and represent best practice in the state.

10. TNK and Stroke – Jay Goldman
    a. Kaiser is looking to move from alteplase to tenecteplase for stroke
    b. Easier for transfers. Most will not require CCT. It is cheaper. It is mixed at the bedside – could save time to administer.
    c. Kim Freedman mentioned challenge in her system, blocked change and went back to tPA.
    d. Dose is 0.25mg/kg
    e. Question of whether this will be received negatively by other centers. Possible

that JC could come out in support of use of equivalent therapy.

11. CARES – Joanne Chapman
    a. 27 LEMSAs currently enrolled including 48 counties, 160 EMS transport agencies
    b. 2019 included 16k cases, expect over 20k for 2020
    c. Nationally 100k patients in 2019
    d. CA to National comparison:
        - Bystander CPR rate similar to national CA= 42%
        - Bystander CPR and public AED use similar to national
        - Sustained ROSC 26.5 vs 30.7%
        - SHA 26.1 vs 27.9%, SHD 9% vs 10.5%, Good CPC 7.5% vs 8.5%, very little missing data
        - Survival witnessed shockable rhythm 32.1 vs 33.2%
    e. 2018 to 2019 comparison:
        - Less AED applied in 2019
        - Bystander CPR a little higher in 2019, 41 vs 43%
        - Similar first arrest rhythm
        - Sustained ROSC similar
        - Survival similar
    b. Discussed barriers to other Counties joining
        - Issue of $ for Tuolumne and Santa Clara
        - Tuolumne does not have funds
        - Santa Clara has their own system which allows them to track their outcomes, feel its redundant and definitions are different so not worth the cost, though cannot benchmark against others. Timing is challenging to join.
        - Kris Lyon suggests a potential regional approach to the smaller counties which could decrease cost and discussion with Heart Rescue for starter funds.
        - David Magnino experienced similar struggles in Sacramento to identify funds but feels it's important to get everyone on board
        - Reza V and Kris Lyon pointed out the benefits of Joanne as the state coordinator to assist with data collection and reporting is very valuable
12. Draw up epi and tourniquets – Brett Rosen
    c. From prior discussion understood that there was no specific objection to implementation of draw up epi for anaphylaxis
    d. This will not apply to Fire Lines, feels drawing up epi in that environment would be challenging
    e. Query what is the best process to get it approved locally for 'BLS Local Optional Scope' – appears that this must be approved at the LEMSA level
    f. Cost estimated around $70-100 for Certa Dose. Can give two doses to same patient, will not use on different patients.
    g. This would not replace policy at the LEMSA, just a change in the manner of delivery

h. Dave Duncan : we may consider in the future how State agencies can take these issues on, for now it is at the LEMSA level.
i. Kris Lyon – could consider a standardized BLS scope
j. Brett Rosen requests examples of forms from LEMSAs and can modify and send out to group
k. Marianne Gausche-Hill suggests including the protocol, plan for QI and training – should be enough for approval
l. David Magnino asks for clarification on to whom the disciplinary action would fall
    - Not anticipating increase in EMT certification actions, responsible party would not change
    - David Rudnick raised paper from Seattle demonstrating large number of administrations with safety

13. Aeromedical – Atilla Uner
    m. Entering data now for HEMS unified scope, can present next meeting
    n. 154 transports out of Imperial County – able to provide CCT for these patients, have traveled far, are flying prone patients – new intervention, working thus far, have transported a couple of patients prone

Round-table

1. John Brown
    a. Opening up second alternate care site focused on SNF/discharge
    b. Have some SNFs that have COVID-capable units and can also accept behavioral health, but capacity is small, so the new facility will increase capacity and can scale up as needed. There are budgetary issues, since dependent on tourism. Trying to keep personnel and equipment, part of phase 2 recovery.
2. Hernando Garzon
    a. Showed case rates, we were already trending up as a state prior to reopening, and mobility data showed people had begun to move around – we are trending up in cases
    b. Trending case rates per 100k in counties, multiple metrics, this informs CDPH data report
    c. Reviewed impact of change R, a number for alarm is above 1.2, current R effective is 1.05 for the State – also have data by County and many counties are beginning to exceed 1.2 trending upward
    d. Current hospitalizations 3000, projection for 30 days is over 7000, almost every county has increasing hospitalizations. Linear climb in deaths is projected.
    e. This data will be available to health officers, may be able to provide data to those interested.
    f. There is a correlation between fall outs on variance factors and R effective
    g. Important to be able to identify areas of concern – can miss if looking across whole state or whole region
3. Dave Ghilarducci
    a. Hired EMS innovator to focus on follow-up on patients. Image Trend allows crews to flag patient for follow-up, can select reason. Full time person will do

these follow-ups. Estimates 20-30 per month for follow-ups.

4. Nichole Bosson
    a. Showed data from LA County – increase OHCA, decreased STEMI and Trauma by PIs, Initial increase in Respiratory and Febrile PIs now back to prior levels.
    b. Ken Miller mentioned similar trends in Santa Clara – OHCA up, Stroke down… resistance of patients going to the hospital. Psych and ETOH went down but now back to baseline.
5. Marianne Gausche-Hill
    a. COVID burden in LA remaining stable but bed capacity has decreased as additional patients use resources
    b. Remdesivir tracking tool developed – can be used by other LEMSAs
    c. Bylaws committee will continue work and discuss in September
6. Gene Hern
    a. Leave Behind Narcan – sent sample protocols and training, if anyone is interested in applying for the doses can reach out to Gene. Also individual agencies can apply as well.
7. Kristi Koenig
    a. Using local optional scope for Assess and Refer and Testing for COVID
    b. Anyone experiencing drug shortages? Experiencing bicarb shortage for HD patients. – comments in chat that amio and lidocaine are short.
    c. What are people doing in limiting AGPs?
        - Ken Miller moved to favoring LMA, PPE for everything, reduced use of nebs unless hypoxic, minimal changes – focused on prevention with PPE.
        - Kristi Koenig – went to MDI inhalers
        - Nichole Bosson – emphasis on King in LA over ETI, decrease use of nebs and CPAP, shared policy prior. Can share data review on NIV in COVID.
        - Dave Ghilarducci – notifying hospitals in advance to coordinate arrival. Similar in multiple LEMSAs, In Imperial intubate in the tents prn prior to ED entry
8. Kathy Staats
    a. Trying the MHOAC focused hybrid transfer model – still significant delays – looking for feedback on how it is working
    b. Border opening delayed by 1 month
    c. Potential to share state response to COVID at NAEMSP
9. Brett Rosen
    a. Went to State operation center, they are working incredibly hard, Dave and Hernando are crucial parts of operation
    b. Cal Fire is working on prevention of COVID in Base Camps

Meeting adjourned at 13:45

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