September 15, 2020

Scope of Practice

Call to order by Ken Miller

1. Monterey - TXA LOSOP Application and Hemorrhage Policy
    a. Group Discussion
        i. Ken Miller noted that, per prior discussions and agreement at EMDAC, indication for TXA must include systolic BP ≤90mmHg and that estimating blood volume loss is problematic
        ii. John Beuerle explained concern that BP could be late sign, that patients with hypertension may be in shock at a higher BP and, on the other hand, some patients live with a systolic BP less than 90
        iii. Dave Duncan provided some historical perspective as to why this threshold was chosen, including the factor that was in Crash2 and incorporated into trauma triage algorithms, and this was how trauma surgeons were able to support TXA in the field
        iv. Several comments in the chat supported including tachycardia
        v. John Brown commented in chat re removing EBL
        vi. Mark Luoto commented that the group had moved towards uniformity in TXA protocols and that their system had removed tachycardia under that
        vii. Atilla inquired about packing wounds, would there be a concern for paramedics packing depressed skull fracture or penetrating abdominal wounds.
            1. John Beuerle responded that they would look at that to clarify in the policy.
    b. Scope Recommendation
        i. Ken Miller requested motion to approve with amendments: removal of HR and EBL as criteria, requiring SBP <90mmHg as indication for administration. – Atilla Uner / Kim Freeman
2. Napa - Hydroxycobolamin
    a. No discussion
    b. Scope Recommendation
        i. Move to approve as is – Kim Freeman / Nichole Bosson
3. San Joaquin - Heparin/Nitro Renewal
    a. Discussion
        i. Katherine Shafer reported no changes to the protocols, there were no prior adverse events with 100% case review.
        ii. John Brown asked how frequently stroke patients are being transferred with heparin.

iii. Katherine Shafer did not have specific number, but in her experience, it was more frequently cardiac patients.
iv. Kim Freeman recommended adding contraindication for PGE inhibitors.
v. Katherine Shafer clarified that the paramedics are not initiating it and that the patient must be stable on the drip prior to transport; paramedics are aware of that contraindication from SL nitro in the protocols.

b. Scope Recommendation
    i. Move to approve as is – John Brown / Atilla Uner

4. EMS Commission Subcommittee on SOP Deletions – Atilla Uner
    a. Group met on July 27th, 9 commissioners, 4 EMS authority staff
    b. Discussed development of a systematic approach to evaluating effects of deletions of paramedic practice/procedures, with a threshold as to which need evaluation, and clarification of who to report data to.
    c. Limited to statewide deletions.
    d. Highlighted examples: Removal of RSI in San Diego after study with worse outcomes, but no study after as to effect; Removal of surgical crics from state scope without follow-up.
    e. EMDAC requires data collection and reporting for addition of items, similar recs could be made for deletion.
    f. For any protocol/procedure deletion that is decided upon by the state EMS commission, the state commission would not entertain the proposal without plan to have some analysis of the potential effect of removal.
    g. John Brown ask to clarify – one of the reasons removed things in SF is because it was just not being used, saves money on stocking and training. How would follow-up be relevant?
        i. Atilla clarified this is only for statewide deletions, not to individual LEMSAs.
    h. Kris Lyon – One of the examples was RSI in San Diego, believed this was in the context of a trial not removal from state scope?
        i. Atilla clarified that that was a comment from Jim Dunford, deferred to him to clarify further.
    i. Marianne Gausche-Hill agreed that not every removal should require study for removal, if there is data showing possible harm etc. If new devices/interventions available, may make sense to revisit.
    j. Nichole Bosson asked to clarify if these evaluations are meant to be prospective in advance of deletion, or a plan to evaluate after removal.
    k. Atilla clarified that the motion is that there must be a plan to evaluate after removal, do not need the data prior.

5. Vaccination by Paramedics/EMTs
    a. Dave Duncan commented on plan for template regarding administration of flu and COVID vaccines.
    b. Brian Hartley stated that they will have prefilled influenza vaccine syringes this year.

c. Ken Miller commented that the challenges of COVID vaccination will be a steep climb given the cold storage and a 2-shot series. Half of the vaccinated persons become febrile. So engaging personnel for the first time with influenza will be helpful.
d. Dave Duncan queried whether EMTs should be included.
e. Brett Rosen commented that EMTs can do IM Epi, so it would be similar for EMTs to do influenza vaccine.
f. Marianne stated it would be reasonable in collaboration with Public Health. There is also a volume limitation for children into the deltoid. For LA Counties application, everything for the public is in collaboration with Public Health. Otherwise, EMS can provide vaccination to their own personnel.
g. Brett Rosen concurred in chat.
h. Chris Kahn: "We did this in San Diego for hepatitis A vaccination (paramedics, not EMT-Bs). We didn't see any adverse effects or other concerns"
i. Group discussed age threshold for vaccination and pediatric volume.
j. Dave Duncan suggests leaving pediatrics out of the template for now, risking complications of split dosing. Protocol is meant to be implemented by LEMSAs in collaboration with local DPH. Within each application, individual LEMSAs can integrate peds.
k. Marianne concurred, since we do not know the volume for COVID vaccine right now. For influenza LA chose to go with IM only (there is an IN) and exclude children.
l. Dave Duncan: For those who want to include EMT-Bs, maybe limit to prefilled syringe. The protocol is also limited to IM.
m. Atilla Uner brought up for consideration that this may be splitting peds and adults, but that could still offload adult clinics.
n. Marianne Gausche-Hill suggested that peds have a lot of access to influenza vaccine, may add peds later.

JOINT EMDAC/EMSAAC

Called to order by Dave Ghilarducci at 10:05
Moment of silence for Dr. Steve Tharratt and Dr. Bruce Haynes

1. EMSA Report - Dave Duncan
    a. Reflection on COVID response, current trends and next steps
    b. Vaccinations for COVID
        i. There will be a template LOSOP for vaccination.
            1. Limited to COVID pandemic time
            2. Limited to IM injections in adults
            3. Must be implemented by the LEMSA in conjunction with the local public health department or officer
        ii. There are 3 vaccination trials ongoing.
            1. AstraZenica is restarted after a 1 week pause due to significant

adverse event, details unclear.

2. All have different recommendations for storage, including cold storage, for one below typical freezers so that may be challenging.

iii. In selecting vaccines, must consider safety and efficacy first but also consider feasibility.

c. Chapter 13
   i. Reviewed history of Chapter 13, given the overwhelming comments, decided to take back to a workgroup level.
   ii. Involves similar group from prior workgroup with EMSA oversight.
   iii. Goal is to have a product at 6 months, which will work its way through the stakeholder groups.
   iv. Marianne asked how one can assist.
   v. Dave Duncan clarified that if people can agree that there is a need to clarify medical oversight then the ultimate goal is to get it into a state that prioritizes patients, takes into consideration all stakeholders needs, and gets into regulation.
   vi. Larry – Can you separate out the EOA component?
   vii. Dave Duncan responded that they had considered that, but the Ch 13 regs are all encompassing, including so much including QI and specialty systems, include so much that we need to work our way through all components, and all stakeholders need to be involved.

d. Trauma Regulations – Dave Duncan stated that revision will be resumed soon, that is a priority for EMSA.

2. Other Discussion
   a. Kristin Weivoda stated that EMSAAC conference is planned for June 2 and 3rd at Lowes, will use the 2020 agenda. Travis is working with Carol. Confirmed plan is to move forward with the conference in some format.
   b. Gary Tamkin suggested that we continue to leverage this teleconference technology for meetings in the future.
      i. Larry concurred and feels it increases work efficiency, though some in-person meeting is good.
      ii. Dave Ghilarducci suggested we might continue in-person meetings, but less frequently, and working out technology so that we can offer remote option for all meetings, money we are saving not meeting in person could be used to invest in the necessary technology ('Owl'?).
   c. Kathy inquired about Community Paramedicine Bill 1544, possibly convening a group to develop plans if it passes.
      i. Dave Ghilarducci suggested to wait until closer to that time.
      ii. Cathy Chidester noted that we must continue to move forward with the current programs, regardless of passing, it will take a while for the regs to be implemented.
      iii. Dave Duncan agreed that we should work together around these issues.

d. David Magnino brought up several bills pending governor signature that may affect new EMTs that have convictions: one they can get it expunged, one that they may not have to register as a 290, which could affect our ability to deny and/or take more time for our investigators to approve/deny an application. This is more towards the EMTs.
    i. Dave Duncan said there is still work to be done on this topic.
    ii. Sean Trask confirmed they are still exploring this and how it would fit into the regs, to determine if a change is needed, confirmed concerns are understood.
e. Dave Magnino informed the group that typically would be doing the EMS memorial bike ride at this time, now moving virtual, have 300 registrants.

EMDAC

Called to order by Dave Ghilarducci
Minutes from June approved - ?/ Carl Schultz

Treasurer's Report – Dan Shepherd

1. Reviewed dues status, there are a few members that have not paid
2. He and Hernando Garzon are working on the EMDAC list serve, if you have been left off, please let them know.
3. Dave Ghilarducci recapped that we had all agreed to continue dues this year, running a surplus, then will review plan again at the December meeting; expects costs will be lower moving forward as we may continue more remote meetings.
4. Marianne Gausche-Hill brought up for discussion the idea of two virtual and two in-person conferences.
    a. General comments in chat concurred with that plan.
    b. Dave Ghilarducci brought up the question of EMS Commission meetings.
    c. Dave Duncan stated first meeting will likely be virtual, others not decided.
    d. Atilla Uner brought up in chat importance of still meeting in person.
5. Motion to approve Treasurer's report – John Brown/Eric Rudnick

Cal-ACEP – Vivian Reyes, Vic Gulati

1. Vivian Reyes recognized EMS and thanked EMS from CalACEP and noted the benefit of collaboration between CalACEP and EMDAC.
2. Introduced Dr. Vic Gulati, incoming president.
3. Vic Gulati explained the new board will meet in the next month to determine legislative response, emphasized that he is available for calls and communication.
4. Active ACEP members are welcome to join the virtual board meeting.
5. Kathy Staats brought up discussion regarding patient transfers during MCIs.
    a. There was some confusion around COVID transfers, and there is a workgroup

convened to develop a more uniform process.

b. Vivian Reyes noted that there is opportunity for improvement in patient movement in disasters, regulation not written with COVID in mind, so there were things identified that need to change – suggests one determine short-term and long-term goals for positive change. CalACEP would like to collaborate with EMDAC on this.

6. Update on Assess and Refer Task Force – Kathy Stats
    a. Focused on COVID.
    b. Evaluating LEMSA policies and a letter from Howard Backer.
    c. Adjustments include specific inclusion/exclusion, QI requirements, trigger points and stakeholder involvement/buy-in.
    d. Awaiting for feedback from the taskforce.
    e. Goal is working policy moving forward.
    f. Marianne informed the group that LA also has its own Assess/Refer Task Force and will continue to share with this group.
    g. Kevin Mackey queried whether ground work is being laid for moving beyond COVID in the future.
    h. Kathy clarified that the first step is COVID and then will look at the broader patient group.
    i. Dave Ghilarducci noted that the initial policies were in the context of anticipated overwhelmed EMS systems.
    j. Kathy confirmed that is what the current policy is focused on.
    k. Clayton Kazan commented that the system we had before COVID, with ambulances on the wall for 3-5 hours, was not sustainable, and emphasized that the focus needs to be on the future.
    l. Dave Ghilarducci concurred that the focus needs to be beyond COVID.
    m. Kathy Staats explained that pre-COVID there was a lack of knowledge of these policies or the issues around APOT delays in the past, now increased communication and collaboration will help.
    n. Hernando Garzon noted that these current policies are under pandemic conditions with considerations for allocating scare resources - at the early levels of surge where we have to start to make modifications in EMS response, we want to provide equivalent care to refer patients to their care plan, but as the resources become more scarce, you may pull back on responses to lower acuity calls so that you can respond faster to the critical emergencies; these issues are different than routine care with treat and refer policies.
7. Clayton Kazan brought up national ACEP collaborating with ASA on use of ketamine instead of with NAEMSP, suggests ACEP collaborate with the correct organization on issues related to EMS in the future.
    a. Vivian Reyes stated that she will bring this to back ACEP.
8. Kevin Mackey brought up that Aurora CO passed legislation to ban Ketamine in the prehospital setting and requested ACEP become involved when legislators start to legislate medicine.
9. Kristi Koenig suggested in the chat: “Perhaps a partnership with CAL/ACEP on management

of behavioral health patients including options to mitigate prolonged ED boarding."
10. Vivian Reyes summarized that Treat and Refer and Patient Movement during MCIs are their two big issues this year.

Legislative Report – Kathy Staats

1. Two important bills on the governor's desk. If the governor signs or does not sign within the allotted time, it becomes a law; If he vetoes, the legislature has the opportunity to counter.
2. AB890 – Reached governor on September 14th
    a. Addresses NP scope of practice.
    b. EMDACs opinion is that NPs are important in EMS and oversight is important.
    c. Encouraging members to contact the governor and oppose the bill.
    d. Vic Gulati explained that the issue of NPs has come up many times, this year's environment limited effect of lobbyists and this year legislature was more fixed on the issue, but will continue to fight on this issue.
    e. Brett Rosen concurred on the challenges of reaching the legislators. There was strong lobbying on the other side. Overall this is a national effort by the big NP organizations. Multiple states allow independent practice by NPs.
3. AB1544 – Also on governor's desk
    a. Addresses community paramedicine and triage to alternate destination.
    b. There are mixed support in the EMDAC group.
    c. Likely that this will pass.

Scope of Practice – Ken Miller

1. Reviewed scope recommendations as above.
2. Reviewed discussion on vaccinations as above.
3. Mentioned EMS Commission subcommittee on evaluation of statewide scope removals, deferred to Atilla Uner for any further discussion.
4. Buprenorphine trial study approved.
5. Pilots on community paramedicine have been extended by OSHPD through Nov 2021.
6. Impact and response to potential changes to EMT conviction reporting still TBD.
7. Kevin Mackey suggested that there might be an automated process to move LOSOP to Standard SOP, if there is enough adoption throughout the state. Gave example of TXA, there is enough adoption, we are creating processes that are more difficult. Does it need to go through the regulatory process? Queries if there is a way instead to be more nimble.
    a. Dave Duncan confirmed it does need to go through the process, just need to pay close attention to what we want to pull into standard scope.
    b. Suggested it be a group discussion/decision rather than a timeframe and/or use threshold.

COVID Update – Dave Duncan

1. Regarding COVID, moving in the right direction, opening economies, surge data cases peaked on July 10th and then hospital admissions after that, now we are back down below initial levels, attributes this to good adoption of NPIs.

2. Number of health officers that have left positions (estimates 10) signals the pressure everyone is under.
3. Will have a template LOSOP available for administration of influenza vaccine and COVID vaccine once available.
4. Vivian Reyes reiterated that CalACEP would like to collaborate on approach to COVID and future surges, to improve the alignment of the regulations with the solutions.
5. Dave Duncan acknowledged that much of the response has needed to be 'just in time' given the speed of COVID, feels we are in a better place now in regards to coordinating moving forward, looks forward to looking back and learning.
6. Eric Rudnick queried when the vaccination template would be complete and what it means to 'collaborate' with the local health department.
7. Dave Duncan stated the template will be available at the latest tomorrow; it is complete but will review with the current discussions in mind.
8. Group discussed standardization but flexibility at the local level is good.

Discussion on Wall Times

1. Hernando brought up increasing wall times, already at winter levels, concerned that this will continue to rise; need real-time wall time data across the state. Queried whether LEMSAs could share wall times on a weekly basis with EMSA, in order to monitor on a week-to-week basis this choke point in the system?
2. Ken Miller concurred this would be helpful and noted that ambulance to ambulance offload times can vary significantly and it will not show up in a monthly report; volunteered to assist in the effort.
3. Hernando Garzon is reporting excess wall time past 20 minutes by provider and by hospital so that it can be quantified and allows EMS to put dollar figures to the numbers.
4. Ken Miller will send Hernando a sample output.
5. Dave Ghilarducci suggested a common set of metrics.
6. Karl Sporer noted that he has struggled to get movement at the hospitals even with data.
7. Clayton Kazan remarked that the typical approach by the hospitals is to attack the data. LA has also had issues with ambulances waiting outside. Suggests hospitals can pay EMTs if needed.
8. Jay Goldman has seen improvements, at least short term, with direct communication between the EMS Agency and the CEOs.
9. Katherine Shafer has tried that approach but has had resistance still.
10. Karl Sporer and Carl Schultz both report some reasonable success with that approach.
11. Jenny Farah: "Base Hospital Medical Directors can be a good liaison for these issues too… focusing the narrative to say.. limited EMS runs means less revenue for the hospital system helps"
    a. Discussion in chat over CEO level issue and concerns that Base MD contracts may limit their power, however, they can help translate the issues and are valuable allies
12. Kris Lyon suggested that keeping the patient outside in the ambulance is a clear EMTALA violation; this could be an opportunity for collaboration with CalACEP.

13. Vivian Reyes asked if this group has a voice on the CHA committee? Concurred this is a hospital problem that affects the ED and prehospital.
14. Karl Sporer stated he does not believe we have a rep on that committee.
15. Marianne Gausche-Hill brought up the issue of physicians evaluating patients in the ambulance and then sending them home, also keeping them outside for up to 6 hours in 1 case. LA EMS reached out to hospitals to notify them that its an EMTALA violation and licensing issue. Also having discussion about the legality of charging hospitals a fee for wall time. Thought was via policy but may need to go a different route with contracts.

Bylaws Committee – Marianne Gausche-Hill, MD

1. Subcommittee developed a draft pre-COVID and then the committee has not met since; draft was reviewed.
2. Suggested that we possibly engage an outside law firm to review the changes to the bylaws to ensure they are legally sound.
3. Summary of involvement of associate members:
    a. Including two associate members as voting members on exec board of directors.
    b. In SOP – 4 active members and 2 associate members.
    c. Legislative committee – limited to LEMSA Medical Directors.
    d. Medical Advisory Committee – expanded, includes both active and associate members with chair voted on by committee members.
4. Consideration to have different types of membership, potential different costs.
5. Clarification that all members are physician members.
6. Clarification that President, Vice President, Treasurer, Secretary would be limited to active members – Kevin Mackey suggested making that clearer in the draft.
7. Discussion of plan for moving it forward:
    a. Committee has more work to do before releasing the draft, target December meeting.
    b. After subcommittee agrees on working draft, they will review with EMDAC board and then distribute to members for feedback.
    c. Clayton Kazan asked for feedback in advance to help guide the subcommittee work.

Unified Scope of Practice Update – Atilla Uner

1. Shared summary data.
2. Noted that most intubated in one attempt 85%, outliers reviewed and have explanation.
3. 2/3rds of SGA use is rescue use.
4. Full RSI is most common, 84%
    a. Katherine Shafer raised concern that patients receiving only paralytic without sedation, Kris Lyon concurred.
    b. Gary McCalla clarified that this approach per protocol is for hypotensive patients, and only for the RSI procedure, after which they immediately sedate.
    c. The group agreed on the hypotension but there was debate on ALOC alone as a contraindication to sedation.
    d. Ability to use ketamine now will reduce concern regarding hypotension.

    e. Atilla Uner clarified the 16% is when both drugs are not given, not clear which drug missing.
    f. Multiple comments that ketamine alone is also a problem – issues of vomiting, rigidity, laryngospasm.
    g. Atilla plans to review the cases to further clarify when this occurs.
5. First attempt success was higher with full RSI compared to modified RSI (not both drugs).
6. 2/3 of ETIs are VL without bougie, 1/3 are VL with bougie, 2 had DL (policy is all VL so this is for equipment failure or other unusual circumstances).
7. Most ETIs are on scene, 93%
8. Complications occur in 15% of cases
    a. 10% peri-intubation hypoxia
    b. 4% hypotension
    c. 1% regurgitation
    d. 1% dislodgement
    e. 3% bradycardia
    f. 9% CA pre intubation
    g. 11% CA post intubation

Opioid Pilot Update, Contra Costa – Gene Hern

1. The pilot involves 4 components: Leave behind Narcan, Warm handoff to DPH, Opioid receiving center, Buprenorphine pilot project.
2. Buprenorphine pilot is now live, reviewed inclusion/exclusion for protocol.
3. Willing to share the materials with other agencies, and LEMSAs are welcome to use the components they like.
4. Currently involves a group of paramedics as part of the pilot but plan to expand to whole county.

COVID and Fire Camps – Brett Rosen

1. No documented cases of COVID at any of the camps from camp exposures, no transmission (there were a few who tested positive on arrival).
2. Seeing cases of poison ivy and poison oak that are not responding well to steroids.
3. If you would like to visit a Base Camp, please contact Brett.
4. In future, will coordinate testing in camps coordinated with EMSA; Issue is going home for testing causes delay.
5. Jeff Kepple queried about validation of no transmission in camps.
    a. Brett clarified that they are using what presents to the medical tent. They are not testing everyone.
6. Karl Sporer noted that they are cohorting people and things are well organized so that they can quarantine and test people when a positive COVID is identified. Minimizes mixing of people, especially around meals.
7. Marc Gautreau states they tested a lot of people and the efforts at the camps have been successful at preventing spread.
8. Dustin Ballard stated that they had a team in Marin, sent DPH team to do surveillance

testing, and a large number declined testing, queried if this is a broader issue?

a. Brett Rosen states this hasn't been an issue to his knowledge though the federal folks have their own rules.

Note on draw-up epinephrine

9. Brett will be distributing packet on draw-up epinephrine by EMTs, would like standardized training throughout the state and carry on all units, trying to go LEMSA by LEMSA, most are OK, a few have given a hard 'no', notes that regulations are silent on use of draw-up epinephrine in one LEMSA after approval in another.
    a. Dave Ghilarducci asked if there was a common thread among LEMSA refusals.
    b. Brett Rosen clarified most concerned about med errors, some just felt did not need another solution.
    c. Kristi Koenig voiced that SD is one of the opposers and the reason is concern for med error.

Round-table

Alameda – Karl Sporer

- Less 5150 and using alternate methods to divert from EDs

Marin County – Dustin Ballard

- Seen move to more King use and overall less airways in the COVID era. Also looking at iGel. Interested in hearing about experiences with peds and with BLS from other LEMSAs.
- Alternate care site may move again. No patients thus far. Interested in discussion about making alternate care sites more useful for patient offload.

San Mateo County – Greg Gilbert

- Looking at revamping paramedic accreditation
- Will expand MSU to cover whole county

LA County – Marianne Gausche-Hill

- Hired new PTI Medical Director, Dipesh Patel.
- The Commission approved PHAST-TSC Stroke Trial on the novel neuroprotectant Transsodium Crocetinate – this has been discontinued by the funder Diffusion Medical Inc. with resources shifted to COVID research, there were 4 patients enrolled, no adverse outcomes
- Reviewed COVID cases in LA, have 31 cases of children MISC
- Rolling out Ketorolac now
- Denise Whitfield chairs the Innovations Technology and Advancements Committee, the committee reviews may be useful to this group

Kaiser - Jay Goldman

- COVID numbers improving
- Moving toward TNK as primary thrombolytic

San Diego - Kristi Koenig
- May be moving into the purple zone, R effective is just above 1, still have a lot of hospital capacity, a lot may be attributed to the San Diego State outbreak, these count as County numbers (though the state prison does not)
- Final stages of operationalizing the flu vaccination program with paramedics, starting with vaccinations on each other and then moving to the SNFs
- Recently had a case of wound botulism due to black tar heroin so on the lookout for bad batches of heroin

Sacramento - Kevin Mackey
- DPH is collaborating again on testing, now there is funding, stood up testing sites yesterday, 7-days/week, have 6 COVID response units

Orange County – Carl Schultz
- Considering alternate destination process for psych patients, but may be too little too late, not sure if can get it up and running before Jan 1st

San Joaquin County – Katherine Shafer
- Big education campaign on oxygen use
- New position in their office, second in command on the admin side, that just started this week
- Looking to do a TBI protocol based on Arizona's protocol in the next round of updates in mid-2021
- ICUs were taxed above capacity but now numbers are improving

Imperial – Kathy Staats
- Big push for flu vaccinations among providers and at hospitals
- Rolling out protocol updates
- Initiatives in collaboration with the state handing out masks at border crossing to encourage NPIs

Riverside/ICEMA – Reza V
- Noticed early on the EMS volumes declined but DOAs increased despite decline in volume, continuing to track and continue to see a higher than historical average of DOAs – includes non-transports after failed resuscitation
- Common theme of symptomatic patients for days not going to hospital, there are PSAs to attempt to address this, but our data still shows ED volumes are at 80% of usual
- Nichole Bosson explained that LA County is seeing similar trends and looking into this further with the data

Meeting adjourned at 14:15