



Sheraton Park Hotel
1855 South Harbor Blvd
Anaheim, CA 92802

Scope of Practice Committee Meeting

- 1) Local Optional Scope Requests (call to order 0900)
 - a) iGel: SSV, Kern, Coastal Valley
 - i) Dr. Rudnick: Motion to accept applications as a block
 - (1) Clarification: SAD should not include King .. this should be listed separately
 - (2) Confirmed Adult only
 - (3) Question if wave form capnography should be required. Date for requirement not yet set.
 - (4) Limit pediatric SGA use to paramedics
 - (5) Definition of ped patient is within Length Based Tape
 - (6) Dr. Miller sent papers from Anesthesia regarding use of these airways
 - (7) Q about intubating through some SGAs. Some allow, others don't. Dr. Duncan says that they try to avoid this due to low success.
 - ii) Motion passed
 - b) Hydroxycobalamin application
 - i) Dr. Brown...should be rarely used .. could there be mission creep?
 - ii) ICEMA has for 2 years, no use so far
 - iii) Dr. Shepherd indicated that motivation for application was use on rescuers
 - iv) Dr. Bosson: should protocol be clearer about giving O2 even if normal O2 sat? New protocol clarifies this.
 - v) Dr. Backer asked about literature, some studies support.
 - vi) Dr. Malmud states that empiric therapy is standard practice in the ED
 - c) IV Acetaminophen: San Diego Local Optional Scope Application
 - i) Dr. Koenig: safe and effective option as alternative to opioids. Many opioids are in shortage.
 - ii) Question: is this to eliminate opioids? No, just another option.



- iii) Dr. Brown cautions about too many pain options (see ketamine below)
- iv) Dr. Miller questions efficacy. Others say this is established in literature, hospital post op.
- v) Dr. Goldman...IV Tylenol is rapidly replacing opioids in 26 NorCal EDs.
- vi) OTCs are allowed orally... not a scope of practice issue
- vii) Dr. Backer: does scope believe this is evidence of efficacy and safety.
 - (1) Dr. Gausche-Hill: evidence is there
 - (2) Dr. Malmud: 1 study looking at trauma shows efficacy
- viii) Dr. Rudnick motions to accept LOSOP, seconded by Dr. Freeman
 - (1) Motions passes, no nays
- d) tPA for IFTs: Orange County Local Optional Scope Application
 - i) Dr. Stratton wishes to allow ALS transport of stroke patients while Activase is infusing. This allows more rapid transfer between spoke and hub hospitals for thrombectomy. He notes that drip and ship is standard practice in transferring stroke centers. Current protocols create unreasonable delays in transfer. Inter-facility paramedics are much faster than CCT RN. OC has special medics trained in use of transport pumps. Rates set by sending facility.
 - ii) EMSA: Local Optional Scope allows. This proposal asks for exception to full CCTP training program requirements
 - iii) Questions about managing BP control: application forthcoming for request labetalol for this and cardiac patients. Currently no mechanism for BP control. Nitro not considered acceptable. Dr. Goldman states KP is looking at over 400 transfers...none of these needed BP control, especially for short transfers, however this is for patients that did not need labetalol in the ED. Unstable BP patients do not qualify for this program. Comment about potential for unintended hypotension in the setting of AIS.
 - iv) Dr. Backer states group needs to be careful about moving CCTP scope into LOSOP. EMSA came to conclusion that they are uncomfortable with patients with "multiple drips". States that if critical care is needed, we need to find another solution to this problem. Suggested that TNK may be substitute?
 - v) Question about transport times in OC. Similar to trauma IFT .. max is 22 minutes, ave is 18 minutes.

- vi) Question about pumps...4 IFT providers, the rest already have transport pumps.
Special group of medics trained directly by OC LEMSAs. Currently they perform about 12K patients/yr, many on drips.
 - vii) Question about training certification: no known classes or certifications in California.
CCTP training is 200 hours in state regs.
 - viii) Motion made and seconded to recommend approval to EMSA.
- 2) Trial Studies
- a) TXA report/recommendations: ICEMA, Alameda, Riverside
 - i) Request to approve for LOSOP
 - ii) Report by Dr. Neeki
 - (1) Largest civilian North American trial
 - (2) Summary
 - (a) About 400 patients from 3 LEMSAs
 - (b) 228 penetrating trauma
 - (c) 8 pediatric
 - (d) Outcomes: Lower 28-day mortality in TXA group .. primarily in the penetrating group.
 - (e) 2 DVTs in each group
 - (f) 1 dose vs 2 dose sub group analysis: no statsig difference.
 - (g) Blood transfusion sub group analysis: lower transfusion in TXA group
 - (h) Lower hospital LOS in TXA group.
 - (i) NNT = 22
 - (j) Mean administration = 33 minutes
 - (3) Dr. Bosson: Questions about statistics
 - (a) Discussion about confidence intervals and power of study. Confidence intervals cross 1 in the 24 and 48 hour groups. Power is about 20%. $p < 0.05$ in the penetrating 28-day group
 - (b) Odds ratios are unadjusted. Adjusted numbers will be sent out.
 - (c) Data only shows safety...not enough power for efficacy.
 - iii) Dr. Miller: Should we consider limiting TXA to penetrating? Dr. Bosson: need adjusted ORs. Drs. Duncan and Luoto .. other studies show safety in all groups. This study not powered for the blunt group due to low n.



- iv) Is there a “mandate” to give this? Trend suggests yes
- v) Very inexpensive
- vi) Can hospitals do this? Yes, but better if done early, especially in rural areas. And could be dropped or delayed in the hospital.
- vii) Dr. Freeman, Motion to move to LOSOP, seconded
 - (1) Motion passed, no nays
- b) AirQ report/recommendations: Ventura
 - i) Dr. Shepherd
 - (1) 274 patients .. 80% success rate
 - (2) Recommend inclusion in LOSOP
 - ii) Motion to accept recommendation
 - (1) Motion passes, no nays
- c) Ketamine: San Diego
 - i) Dr. Backer: Question to group about adding SD to currently active trial studies vs Ketamine as opposed to LOSOP. Is it time to stop 3 current trail studies?
 - (1) Mixed opinions from the group. IRB not needed? Probably except in SD due to local politics
 - (2) Easier to move to LOSOP but trial studies are still valuable. New counties coming on board may provide more numbers of patients.
 - (3) Not possible to be LOSOP AND trial study at same time.
 - (4) Dr. Koenig says that need is immediate due to med shortages and trial study would delay. IRB issues in San Diego make trial study there impractical. Dr. Farah states that safety is already abundantly demonstrated in the literature. SD prefers LOSOP for this reason.
 - (5) Dr. Backer opposes having LOSOP and Trial Study at the same time. Asking for recommendation from committee.
 - (6) Dr. Miller favors continue trial studies.
 - (7) Many comments about severe opioid shortages and safety tradeoffs of delaying ketamine rollout.
 - (8) Many comments about safety of ketamine. Widely accepted across US.



- ii) Dr. Mackey reports 12 administrations with one dosing error. 1 patient got double dose without adverse effects due to wrong dosing card used. Very helpful with extricating a hip fracture patient.
- iii) Question to Dr. Koenig: Single formulation of ketamine? Currently shortage makes single concentration difficult. This could be a source of error especially with IV. Military has done this safely. IN options are also being investigated
- iv) Safety concern...various ketamine shortages, only large dose vials available. Possibility of massive overdose.
- v) Any conversion to LOSOP would have to be approved by the Commission, no earlier than June due to Brown act.
- vi) Dr. Miller: Question to committee: Are we ready to recommend converting Ketamine from Trial studies to LOSOP?
 - (1) Dr. Brown moves to recommend LOSOP with conditions, following structure, data collection of current trial studies.
 - (2) Motion seconded and passes

BREAK 1030-1045

EMDAC General Meeting

Meeting start 1120

- 1) Introductions / Announcements
- 2) Approval of December Minutes
- 3) EMSA (Dr. Howard Backer)
 - a) National Collaborative for Bio-Preparedness (<http://www.ncmbc.us/docs/16MBB/Runge.pdf>)
 - i) Sentinel surveillance
 - ii) Want to add EMS
 - iii) Wish to provide dash board data (APOT etc) in exchange
 - iv) Provide elegant mapping. More to come
 - v) Advantage over First Watch? ... Free
 - b) Core Measures
 - i) Questions if LEMSAs are using the core measures to improve local processes?
 - ii) Dr. Sporer states that some LEMSAs are acting on the numbers.



- iii) Dr. Garzon states that data quality is first step
- iv) Dr. Backer recommends that improvement projects are included in the QI section of the EMS plan
- c) Email coming today that NEMSIS is reporting a “data breach”. NEMSIS 2.2 data, immediately recognized and mitigated. Zip Code level data only.
- 4) Vote and approval of 2018 Scope of Practice Committee and Legislative Committee
 - a) Vacancy on Scope Committee
 - i) Dr. Attila Uner recommended to fill vacancy
 - ii) EMDAC approves by vote
 - b) Leg committee
 - i) No Changes
 - ii) EMDAC approved by vote
- 5) Treasurer’s Report (Attached to Agenda)
 - a) Dues are due for some. Please check with Karl
 - b) Costs have gone up for each meeting: +\$1100 each this year.
 - c) Karl reports that dues may increase.
 - d) Treasurers position .. looking for replacement in about 2 years. New Secretary next year will assume dues of meeting planning.
- 6) EMS Commission (Dr. Eric Rudnick)
 - a) Tomorrow AirQ to be discussed
 - b) Core Measures for 2017 expected May 31
- 7) Legislative Update (Dr. Sam Stratton): CP, APOT, Vet med
 - a) AB 1776: Allows EMS to transport police dogs.
 - b) [AB 1973](#) (hyperlinked to state website)
 - i) Defines EMT or Paramedic as a “Health Practitioner” therefore required to report domestic violence. Previously only hospital personnel, including hospital based paramedics, were required to report. EMDAC has no position. EMSAAC supports.
 - c) [AB 1795 \(Gibson\)](#):
 - i) Proposes to allow EMS to transport directly to a community care facility, as opposed to an acute care facility. Includes psychiatric and sobering centers.



- ii) EMDAC and EMSAAC both support. CNA and CalACEP are opposed...paramedics are having scope creep. CalACEP proposes that sobering center has RN. Dr. Luoto has spent time in sobering centers and states this is too expensive.
- iii) ACEP may "limit" their opposition but recommend minimum 32 hours of training to be able to triage. Dr. Backer notes that 160 hrs refers to community paramedicine. Dr. Stratton says LEMSA would designate and approve local facilities and included in EMS plan. This month's issue of AEM has paper on intoxicated patient, 1% needed medical care and those who do had readily recognizable conditions by paramedic.
- iv) ACEP may remove opposition if sobering center had some level of local certification for minimal standards. Dr. Backer states that there is no licensing structure for sobering centers and those run under governmental auspices are exempt from licensing, even if license were otherwise required.
- d) [AB 2293 \(Reyes\)](#):
 - i) Allows for EMTs from California Conservation Camp (troubled juvenile or young adults) program. Their < 7-year felony background would often disqualify for LEMSA certification. This bill proposes to relax these standards.
- e) [AB 2102 \(Rodriguez\)](#)
 - i) Allows for out of state paramedics, during declared emergency, to temporarily licensed or certified to function as paramedics
 - ii) Excludes privately employed paramedics
 - iii) Recommend that EMDAC oppose
 - iv) State regs currently allow out of state paramedics to function under local scope. Is this bill necessary?
- f) [AB 2961](#)
- 8) CHP use of Oxygen and Airway Adjuncts (Dr. Tamkin)
 - a) Background: 7500 CHP officers complete 21-hour Public Safety first aid course. Optional skills can be added. EMR level of training is now additional 27 hours more and all officers have this. O2 and airway adjuncts are carried on every vehicle. There is no EMR level of "certification". 12 hour mandated refresher every 2 hours.
 - b) Dr. Tamkin asks that EMDAC recognize CHP officers as EMR trained and therefore allow the use of these optional skills.
 - c) Dr. Brown wanted to verify that BVM training is performed.



- d) Dr. Duncan: public safety first aid for CalFIRE.
 - e) Dr. Backer states there is a difference between training standards and scope of practice. Problem with EMR is we've always have training standards but never had a certification standard for EMR. Regs say OK if trained and tested and authorized by local medical director.
 - f) Dr. Vaezazi questions training approach to O2 administration training and indications. Dr. Tamkin states that this is addressed in the training.
- 9) Sidewalk CPR (Dr. Marianne Gausche-Hill)
- a) EMDAC, CalACEP, AHA
 - b) Toolkit being mailed out
 - c) Statewide push for sidewalk CPR on June 7
 - d) June 5th LALive
 - e) Every LEMSA can participate
 - i) If LEMSA does activity then please submit data via toolkit

LUNCH 12:30 – 1:00

- 10) Special presentation AND Discussion (1305 hours)
- a) Stroke: Jeff Klingman, MD, Kaiser Permanente
 - i) DAWN and DIFFUSE trials
 - (1) Two studies looking at the extended windows for stroke thrombectomy. Previous studies limited to 6 hours.
 - (2) Some people are slow "progressors" ... and may therefore have a longer time window.
 - (3) DAWN: First study. Very selective group (proof of concept)
 - (a) 6-24 hours, 200 patients
 - (b) Rankin < 2
 - (c) Big stroke (NIHSS 10 or above)
 - (d) LVA M1 or anterior cerebral artery (excludes M2 and basilar)
 - (e) < 70 ml ischemic core. MRU diffusion is best. CTP is more practical.
 - (4) DIFFUSE 3
 - (a) 6-16 hours, 182
 - (b) Rankin < 3

- (c) NIHSS > 5
- (d) LVO in M1 or ACA
- (e) CTP or MRI diffusion
- (5) To Find these people
 - (a) Independent people
 - (b) Big strokes
 - (c) Need CT Angiogram
 - (d) Need CT perfusion or MRI scan
- (6) EXPRESS (Expediting the Process of Evaluating and Stopping Stroke) Kaiser .. using MRCLEAN protocol
 - (a) What is the best scale for paramedics? STROKE 2017; 48: 290-297
 - (b) Based on 2016 Numbers, 17.4 acute strokes were evaluated to find 1 patient eligible for EST. (Kaiser data) n = 2546. Within 6 hours
 - (i) Only 1241 qualify...due to misidentification (times last known well 1/3, sepsis, etc.)
 - (ii) 638 with NIHSS > 7 .. candidates for endovascular therapy
 - (iii) 141 had LVO and treated
 - (c) 80% of large strokes not helped by bypass, IV therapy still works and is time sensitive
 - (d) Current AHA guidelines
 - (i) Go to closest source of IV tPA
 - (ii) Bypass benefit is uncertain
 - (iii) AHA talked to authors of DIFFUSE 3 and DAWN and then published new guidelines almost immediately.
 - (iv) CTP using RAPID software. \$17,000 for spoke hospital. Can be done right after CTA.
 - (v) In 2013 3 studies didn't show benefit (MR Rescue, IMS III, SYNTHESIS) likely due to patient selection and older devices.
 - (vi) EXTEND IA is only study that reported denominator 70/549 (13%)
 - (e) Dr. Stratton points out that most patients were treated at 16 hours .. few at 24.

- (f) Dr. Gausche-Hill. Patients taken to primary then secondarily transferred did more poorly. Refers to Rhode Island study. Dr. Klingman says that those studies.
- (g) University of Calgary engineering students are working on designing algorithm on destination decisions.
- (h) Dr. Klingman states that oversaturating the comprehensive centers is not good for the system
- (i) 50% of strokes walk in but 80% of LVOs are brought by EMS.
- (j) Stroke algorithm are potentially too complicated for EMS
- (k) Dr. Salvucci states that stroke differs from STEMI and Trauma because many patients require drips (tPA, cardene etc..) Dr. Klingman states that few need BP treatment enroute. TNK could be very helpful here.

BREAK 2:30 – 2:45

11) EMS-C Report (Dr. Donofrio)

- a) Educational forum (great success) Nov 9 Fairfield
- b) Pediatric readiness survey 2019
- c) Discussion regarding Pediatric CE requirement for paramedics
 - i) Currently 40 hours CE required. But doesn't specify how those hours are allocated.
 - ii) EMSA has considered this before...they have been approached by geriatric groups EMC groups. Logistically difficult.
 - iii) National Registry has a competency requirement but California does require NREMT registration but doesn't require ongoing maintenance of registration.
 - (1) Downsides of requiring this are costs passed onto paramedics
 - (2) 22,000 paramedics in CA. Unknown how many are NREMT registered.
 - (3) EMSA maintains a database with a CE log, verified by EMSA staff.
 - iv) Comments were made that we emulate a system that is already done nationally
 - v) Additional comment regarding training burdens and on integration of pediatric education into existing topics.
- d) EMS 2050: Much discussion about high level training requirements.

12) Assess and Refer Group (Dr. Sporer)



- a) Discussion about scope of the group to come up with standard way of managing Assess and Refer. Request by Dr. Baker due to bad cases that come to his attention. This is also prompted by Blue Cross/Blue Shield decision to reimburse for alternate transport or no transport. Dr. Baker felt that consistent statewide guidelines or general policy would be essential.
 - i) Define patient
 - ii) Define assessment (vital signs)
 - iii) Documentation
 - b) Significant discussion about how paramedics are not trained to do this. Some feel this is done all the time, relatively safely.
 - c) Attachment in the meeting agenda packet
 - d) Discussion to continue in June meeting.
- 13) Epi Safety Kit (Brian Hartley and Dr. Eric Rudnick)
- a) [Epi safe kits](#)
 - b) Dr. Rudnick prefers this due to just two markings on the syringe.
 - i) This is used in New York State, and also Kern County
 - ii) Cost is much much lower than epi-pens
- 14) Drug shortages (Dr. Backer)
- i) Interested in hearing from LEMSAs that have had success managing supply
 - ii) Brian Hartley: Shortages due to pharmaceutical company consolidation. Carpujects are now gone. EMS is down on supply priority. Hospitals get drugs first, then EMS.
 - iii) General discussion that expired meds are not dangerous, just possibly slightly less effective. Threshold for “expired” = 94% effectiveness. The only regulations about the use of expired meds apply to pharmacies that sell expired meds. There are no regulations that prohibit EMS from using expired drugs.
 - iv) Dr. Mackey will formulate a letter from EMDAC that supports the safety and efficacy of using expired pharmaceuticals in the setting of drug shortages.
- 15) Air medical SOP and Criteria for Pediatric Intubation (Drs. Duncan and Gauche-Hill)
- a) Task Force has come up with guidance regarding pediatric intubation
 - b) CAMTS accreditation
 - c) Training standards
 - i) for flight paramedics



- ii) Ground medics would require CCT training
 - d) Crew configuration, especially for RSI, should be Nurse/Paramedic configuration.
- 16) NAEMSP Chapter (Dr. Brown and Dr. Kahn)
- a) Should EMDAC consider becoming a State Chapter of NAEMSP?
 - b) What are the advantages? Disadvantages?
 - i) Advantages: Provides opportunity for non-LEMSA medical director to participate in a another forum.
 - ii) Disadvantages: Concern that Chapter and EMDAC may move in different directions or even cross purposes.
- 17) Ballot Initiative (Dr. Hern)
- a) AMR has sponsored a ballot initiative that privately employed paramedics fall under the rules that allow them to be unavailable if on a break

Upcoming Events

June 7 CPR Flash Mob (co-sponsored with CalACEP) Drs. Gauche Hill and Rose

June 19, 2018 (Sacramento)
Sacramento DoubleTree Suites
11260 Point East Drive
Rancho Cordova, California, 95742

RA in Riverside: June 27-28

September 11, 2018 (San Diego)
Holiday Inn Bayside Hotel
4875 North Harbor Drive
San Diego, CA 92106

September 28/29: State of the Future of Resuscitation: Take Heart America (Alameda)

RA in Sacramento (Oct 24-25) with CodeSTAT training on Oct 26th



December 4, 2018 (San Francisco)
Marines Memorial Club and Hotel
609 Sutter Street
San Francisco, CA 94102

Draft