0900 Call to order SOP Chair Ken Miller

Unified SOP for NorCAL and Kern. No changes or edits suggested.

- 1st Freeman
- 2nd Bosson
- None opposed
- Motion carried.

TXA Santa Clara application for approval

- Discussed physiologic and/or anatomic to meet criteria to receive. Changed to AND instead of and/or.
- Add base contact if giving for extremity injury in 2.3.5. State Trauma Advisory Committee had advised this previously because they had made the recommendation that TXA only be given for uncontrolled truncal hemorrhage. Trauma surgeons cannot repair vascular arterial injury if TXA on board. Duncan states extremity injury is a contraindication for his flight services. Reza only has 4 utilizations total a month in a system with 15,000 runs a month. More often patients who need it are not getting it. Miller has large number of patients designated as MOI only going to trauma centers.
- Motion to approve TXA for Santa Clara County with amendments.
- 1st Brown
- 2nd Bosson
- None opposed
- Motion carried.

TXA MVEMS

- 1st Singh
- 2nd Bosson

None opposed

- Motion carried.

Sac County igel BLS and ALS

- In addition to current approved king.
    - Suggestion to include the complications on BLS tracking form.
- Amended
- 1st Freeman
- 2nd Brown
- None opposed
- Motion carried.

LAC pain mgmt with ketorolac and ketamine

- Discussion re acute vs chronic pain, possible error re ketorolac and ketamine, formulation of available ketamine and IV bag dosing and potential shortages (none current).
- Discussion re IN medications for pediatrics (both fentanyl and ketamine) with plan to monitor and educate via CQI. LAC precalculates (MCG 1309) every dose with unique app so provider error minimized. Plan to institute 2 provider verification.
- 1st Freeman
- 2nd Under
- None opposed.
- Motion carried.

1000: Main meeting called to order by David Ghilarducci.

June minutes

- 1st Gausche-Hill
- 2nd Singh
- None opposed.
- Motion carried.

1004: Joint EMDAC/EMSAAC meeting

Joelle Donofrio

EMSC regs question – implementation after regs

Yes answers:

- North Coast
- Central CA
- Alameda
- Marin
- Tuolumne
- Napa
- San Joaquin
- SSV
- Santa Cruz/San Benito

Considering

- Sacramento
- Merced
- Santa Barbara
- MVEMS
- SLO

Question to group re: Tool kit interest?

- "Yes"

Next pediatric readiness survey June 2020. Get excited!

- Last assessment 90% of CA hospitals responded
- Portal at Pedsready.org will close Dec 31
- National avg 67%. LAC hospitals 92%.
    - Shows benefit of EMSC.
    - Hospitals verified have lower ped mortality.
- Assessment tool will be slightly different than previous. Weighting will be a little different, but still can compare apples/apples. Pre-document unsure when available. Email Marianne Gausche-Hill if you would like a copy ahead of June 2020.

Dan Smiley

- 11th EMSA director Dave Duncan announced.
    - He has been sworn at, but not sworn in… should be official later this week.

Dave Duncan:

- ABC issues
    - Airway first. Bring everyone to one table as one team as California EMS. Welcomes anyone to reach out to him
    - Breathing: Moving forward with current issues. Community paramedicine as a priority to move forward.
    - Circulation: Moving forward to keep us viable and not have amazon and uber take over EMS.

Dan Smiley:

- Welcomes Dr. Duncan.
- Patient-centric EMS as continuing goal.
- Connect EMS to hospital.

- Triple-aim
- Dr. Gally has expressed to EMSA that governor and Secretary are interested in working with local jurisdictions to help vulnerable populations.
- Provide relevant and timely data to identify emerging issues and be able to answer data-driven questions.
- Build infrastructure of HIE to improve transitions and clinical decision making.
- Improve cx of EMS through education and tools.
- Controversary in paramedic regs. Recently alternate destination was removed from latest (4th) version of regs.
    - Community paramedicine focused on reducing 30 d readmissions.
    - Alternate destinations had been allowed for mental health and sobering stations. Pilot project removed clinic as alternate destination due to multiple factors.
    - Regulatory process has made it obvious that many details and a lot of discussion still needed. Getting a consensus during this reg period was not thought to be possible due to fee imbalances, licensing, education.
    - Goal with new director to continue to review data and answer the questions on the horizon.
    - Regs not an action item at tomorrow's commission. Regs on agenda in December.
    - EMSA submitted extension on pilot programs, likely to be granteded. LEMSAs have expressed that they don't believe pilot programs necessary. Further discussion encouraged offline. Standard approach encouraged.
- IF new director sees value in alternate destination, paramedic regs would need to be reopened. Sean Trask and executive team no stranger to doing this and is "happy to do that". Duncan promises to investigate a raise for Sean.
- On horizon: Difficult questions re EMS planning. STEMI, stroke, EMSC regs in effect on July 1 and need to be implemented. Challenges anticipated and answers to be standardized. How to ensure patient safety and quality across the state is prime goal.
- Improving customer service for providers and improving disaster readiness.
- Core measure data gathering.
    - NEMSIS compliance still not universal. Data variance to allow report-generating and EMS providers not NEMSIS compliant still an issue.
- Adhering to statutes and regulations
- Goal to prepare EMS systems to be tech-savvy, ready for emerging technologies, and continue to ensure patient safety/quality.

- Mackey compliments EMSA investigative staff for helping with paramedic investigation process in his own LEMSA. Encourages having EMSA co-investigate if you are in this unfortunate situation. This service is available throughout the state.
- Duncan reiterates support of Dan's comments, desire for California EMS as one unified team, and his desire to move community paramedicine forward.
- David Ghilarducci questions Dan re alternate destination future. Answer "My crystal ball is broken."

Commissioner Barrow:

- Interested in community paramedicine. Anticipates problem starting in January that political and legislative venue subpar for moving it forward. He encourages expertise of EMDAC/EMSAAC to be best to create landscape of future to persuade the legislators.

Announcements:

- 2020 EMSAAC conference in San Diego May 27 & 28. CME and research session included.
- Dave Mignew administrator Sac County EMS: Next Monday West Coast Memorial ride Reno to San Francisco. Go to website muddyangels.com.

1100: Presentation National Park Service by Michael Handrigan, Chief Medical Officer at National Park Service

michael_handrigan@nps.gov

- Presented regarding USFS plan to join NPS for EMS regulations
- FM51 (RM51) to be followed
- Plan to provide care to colleagues and contractors working in forest service land. Not slated to care for visitors beyond first aid while they call 911.
- No data on numbers of forest service providers or need for EMS program within any of the jurisdictions. If they have a need and do not have the staff or resources to start a program themselves, they will work with a local national park.
- Handrigan will function as medical director until local resource identified. Anticipate a number of forest lands will desire an EMS program.
- Forest service will be BLS. If paramedic providers are employed by FS, they will practice only basic SOP in FM 51. 98% will be EMTs. EMTs will be certified through national registry. Impractical to be state-certified with the mobility of fire personnel throughout the country. They will also get a park-service provider certification.
- Documentation by EMS Charts as official Park Service epcr.
- Presentation attached.

1140 Committee Reports.

- Treasurer not present. Summary later released to EMDAC, attached.
- Commission - Ken Miller reviewed commission packet and briefed this:
    - Paramedic regs revised to be on Dec agenda. *Requests wishes of us to be relayed so he can vote on our behalf.*
    - CA Public Health Manual. Published. New chapters on page 15. 2019 statewide exercise Nov 18-22 on page 17 to eval evac plans.
    - Patient Movement Plan released recently. Look at it to incorporate to your locale. Page 22 with link to the plan.
    - Trauma Regs on Page 26. Watch.
- Leg update:
    - Discussion of 1544 Gipson
        - shelved until 2020. Reason for shelving not truly known, but thought to be possibly due to change in leadership. Duncan does not have details on this, however.
    - CalACEP leg rep? Those who have had interaction has not been positive. It is pointed out that it is important to read the bill and not rely on others' summaries for information and to formulate opinions/arguments. Done right, leg review is difficult and time-consuming
    - CalACEP no longer gives an EMS award…. Interesting.
    - Leg advocacy discussed:
        - Kazan suggested should reach out to author of the bill and suggest changes when warranted
        - EMDAC and EMSAAC don't always agree and it is thought that EMDAC's voice is not heard.
        - Shafer disagrees that our voice is heard when people show up. EMDAC reps don't seem to be as involved.
        - Goldman: Could we reach a consensus on community paramedicine? Maybe a white paper? Letter regarding our vision? Do we have a consensus? What do we stand for
        - Broader discussion re: who are we? Who do we represent?
        - Ghilarducci in EMSAAC meetings states that perception is that unified physicians do have a voice that is respected.
- EMSC: Donofrio
    - EMSC regs

- Fed likes CA regs and encourages us to move forward.
- EMSC annual simulation day in Fairfield Nov 8, 2019.

- State Trauma: Goldman
  - Trauma Summit May 12-13, 2020.
  - Regs being worked on by small group before release for public comment.
  - Contentious issue is ACS verification of Level 1, 2, 3 trauma centers.
  - Pediatric trauma centers need ACS verification too? May be difficult for some current centers to qualify. Sentiment of CA and ACS discussed.

- TEMS Ronay
  - No active issues.
  - HHS mass casualty trauma triage document released earlier this year.
  - Ken Miller re: Gilroy incident lessons: GSWs came by private vehicle and LE and not by ambulance to a small 8-bed ED. 6 victims. Ambulances responded to the ED in case more victims arrived. Early activity turned the hospital black so that no ambulance traffic came. LE concern re gang? Their MCI plan is to send ambulance to EDs expecting POV. Fire engine and ambulances will go to impacted hospitals to triage and transport to other less impacted EDs. EMTALA question – EMTALA had not been addressed and was officially waived a few days later for disaster reason.
  - Studies show self-transports do better than ambulance transports in mass incidents. San Diego police transports their own. The difference of survival is believed to be delay of patient care due to staging ambulances for hot zone, crime scene.
    - Philadelphia and USC studies on scene times and POV survival mentioned.
      - Philadelphia threw patients in police cars including civilians and two studies show better outcomes. Police don't have to stage. They are first on scene. Survival doubled.
      - LA – police afraid of liability. They bend the rules for children, but don't know how to triage and transport those that might be triaged black in many cases. LE also doesn't know where trauma centers are.
  - Younger generation searches for closest ED on smartphone and self-transports.
    - >50% of patients usually transport POV.
  - New regs – TEMS 4 hour class required must be done by TEMS instructor.
  - Dan Smiley – Paramedic regs 4 hour – CAB and rescue task forces. National groups are heading toward SALT vs START triage due to interventions in triage time.

Ready Responders presentation

- Contact information for Ready Responders
  - https://www.readyresponders.com
  - Jared Oscarson
  - joscarson@readyresponders.com
- based in New Orleans
- EMTs, Paramedics, and nurses employed.
- Respond as a single person to a call that their own. They have an open mike and no incidents of foul play as of yet in 20K plus patient encounters.
- They carry bag of life-saving equipment – AED, istat (cbc, chem panel), Narcan, basic airway adjuncts, epipens, tourniquets, bandaging. They do vitals, lung sounds, PEx and determine if traditional safety of caring for them on scene. If safe, they get physician on a device to do virtual visit via telehealth. Vitals, PEx, available labs relayed to physician. Equivalent of MD visit and billed as such. Operate as a physicians group reimbursed at physician rate.
- Take all payers. Does not screen for insurance.
- They work with homeless shelters (10% volume)
- 97% patient satisfaction score.
- Partner with hospitals for patients at risk of readmit or are superusers. They meet with them once a week and have reduced ED utilization by 50%.
- Most of volume patient driven or payer driven.
- They are considering partnering with EMS.
- In a way, functions as an alternative destination – clinic on site (home visit).
- No incidents of undertriage. Every file audited. They are monitoring compliance in real time.
- HIE real time integrated with hospitals – epic and cerner.
- Custom reports can be sent to PCP.
- Moving into CA next year.
- They do not respond code 3.
- No transports at all. Refer to EMS if appropriate.
- Patient volume 3000/mo in New Orleans, launched in June 2018. New Orleans EMSs 60K. Pop 375K. 50 responders in New Orleans.
  - Volume of 911 calls has decreased, but no official study of cause/effect yet.
- 1000/calls mo in Las Vegas launched in June 2019. 18 responders in Vegas. EMS sometimes calls Ready Responders for low acuity calls. ET3 being watched to guide this partnership.
- No integration with EMS dispatch yet, but on horizon in Las Vegas for low acuity calls.

- Ped, IM, ED, and psych physicians.
- Patients referred 20-25% are called by pt directly. 40% transferred from hospital. Set up post-discharge scheduled visits.
- Nurse organizations engaged in states of operation and were advised it is a great opportunity and no push back yet.
- Other models
    - nurse advice to self-present to PCP or urgent care – 70% end up in ED anyway.
    - Ethan project in Houston – uses fire medic speaking to physician in call center.
    - Payers focused on reducing costs and improved outcomes, and have supported this business model.

HIE – Goldman in Kaiser

- Kaiser not enthusiastic about participating re privacy/security.
- Considerable risk in privacy.
- Concerns are decreased with some of the newer programs.
- EMDAC and EMS political issue needs to be solved if can resolve privacy issue.
- San Diego Health Connect – program works as this: when transmitted to Epic, sent as NEMSIS compliant document that is 28 pages long. Aware that physician will not read it. Useless to patient care and risk for legal problems. Kaiser will not proceed under these parameters.
- Dr. Farah. UCSD states the visible pcr is only a couple pages. UCSD Jim had advised Jay of the 28 page outcome. Plan to return to UCSD to discuss.
- Dan Chavez of SD. SD Health Connect folks may be best to lead a work group to resolve the issues.

Physician on scene-- Dr. Farah

- LAC protocol discussed. Physicians authorized have statutory authority (agency medical directors, base physicians on scene, etc). Without this policy, an EMS physician on scene could not direct care – only base physician (likely less qualified).
- Reza working on a policy because residents are on scene at times
- Laws likely drafted before EM and EMS authority
- This is supposed to address physicians who are systematically assisting EMS rather than the accidental. The “card” more states “go away” and does require interface with base.
- physician ride-along policy may solve this. “Direct medical direction”.

Alternate meeting locations

- Background of high cost of meeting venue

- Downside of
    - co-meeting (commission), travel, parking
    - EMSAAC partnership
- Proposed to have off-site June meeting in Sacramento since it is not associated with co-meetings.
    - Voted to be approved
    - None opposed.
    - Motion carried.

EMDAC member relations

- Ghilarducci: Value of collaboration with medical directors of all different EMS practice types and experiences. Power of advocacy. The diversity also potentially a source of weakness given that we don't always agree. Recent hx and legislation shows that there are some competing interests over who has control/power. Question: Who do we represent and who are we speaking for? Then opened to floor.
- Duncan: Speaking for patients of CA.
- Kazan: represents 4.1 million pts, 1000 calls/day. He is an at-large associate member and has no vote.
- "Mission of EMDAC…..
- Why don't the provider agencies get a vote if that is the mission of who we are?
- Bylaws then state that the only voting members are LEMSA medical directors.
- EMDAC LEMSA medical directors tend to agree with LEMSA coordinators.
- White paper uniting our voice reiterated. We should be united as agency and LEMSA medical directors.
- Garzon: LEMSA specific issues should still be able to be separated. Group has evolved to include many beyond LEMSA directors.
- Kazan: Operations is a whole different branch
- Singh: Reiterates that we work for the patients. Agencies have a business interest that LEMSA don't have.
- Gausche-Hill: Diversity is good. Regulatory issues and operations issues are all pieces of different director roles. There are specific things that LEMSA directors are savvy with. Could there be a separation between the two yet also a cohesive group?
- Schultz: Common interest needs to be the base that every member shares. We have divergent interests. LEMSA directors are essentially apolitical and not representative of an agency with a vested interest. Many in the LEMSA have to defend against the agency directors with competing interests.
- Shafer: Point of LEMSA director to be balanced voice that is neutral and best for patient care.

- Dunford: Agency medical directors are representing patients from a different point of view than LEMSA directors confined by regulatory POV. LEMSA directors do represent county government.
- Ghilarducci: Legislative positions of EMS more broad than LEMSAs.
- Kazan: Echoes that he is a public servant. LEMSA medical directors are also potentially biased. Preamble should be changed if LEMSA directors only.
- Schultz: Preamble was written decades ago. LEMSA directors were more unified then before some of the political pushes of recent. We are an entity that represents LEMSA
- Vaezazizi: There were no agency medical directors when the preamble was written. We are more united than the small percentage of things that could be separated.
- Konik: Provider and LEMSA medical director. Both have their agenda. Legislation is what divides us.
- Kazan: EMDAC isn't trying to do a study to decide where to stand. Cal Chiefs haven't been invited to meetings. EMDAC stamp was put on a letter. President name was on a letter re a meeting he didn't attend.
- Shafer: EMDAC and EMSAAC meeting with LEMSA medical directors met, was not supposed to be devious.
- Mackey: His name should never be on correspondence without approval.
- Ghilarducci: Process in place to avoid issue with unsigned correspondence in the future.
- Kazan: I will resign from the leg committee as I am not included.
- Duncan: We should all be included. Don't resign Clayton.
- Ghilarducci: EMSAAC has a lobbyist that they hire that discusses approach to legislation. Broad input good, though LEMSA medical directors should be deciding.
- EMSAAC director: LEMSA medical directors should be the only on the leg calls.
- Duncan: We need to increase/improve our ability to communicate w our providers. We have to include people. Exclusion creates animosity. Whatever it takes to participate and communicate.
- Gautreau: We don't meet in secret. We don't hire a lobbyist with exclusive meetings.
- Duncan: We are all part of the same team.
- Donofrio: We have changed a lot. We should look more at who our voice is. Agency providers > LEMSA directors.
- Gausche-Hill: We should allow within our structure to allow others to vote. We are the advisors to the EMSA medical director. LEMSA medical directors play a different role. Consider looking at the bylaws to figure out a structure that is more inclusive.
- Ghilarducci: 2 classes of membership in the bylaws. Active = LEMSA and Assistant LEMSA. Associate = everyone else. Maybe a third class with different voting rights.

- Shafer: Maybe associate members could vote for their at-large member.
- Kazan: 1:33 ratio is better that 0:33. Provider agency directors will go away without a voice.
- Rob: Lots of input. Increase participation. Most of the time we don't clash. Maybe associate members can vote. Meeting vote was restricted to LEMSA directors. Maybe vote on associate members to be allowed to vote on some issues.
- Schultz: You have to be careful what you wish for. Rob was my fellow and is not a LEMSA medical director. He is here because he represents an agency. We don't see eye-to-eye on a fair number of issues. I could not vote to give you a vote. Cal ACEP doesn't let surgeons vote. We are fundamentally of LEMSA medical directors. It is valuable to bring in agency medical directors. It is still fundamentally that we were created as an agency to represent the LEMSAs.
- Donofrio: The preamble does not state only LEMSA medical directors. What is our future? What is our direction? Is this building us for the future?
- Schultz: When the preamble was written, we all agreed. It has become more politicized. If we don't have an agency that advocates for LEMSA directors, we will not exist in the future. In 10 years, you won't need a LEMSA medical director anymore.
- Bosson: There is an avenue in other ways for LEMSAs to represent themselves. The value of this group is amazing discussion from all different perspectives of how to improve medical care in the field. We are an example for the rest of the county because of all of the voices here. Everyone has their agendas, but we have the value of all of us at this table.
- Jim Dunford: We are going through something that physicians are going through in general. Physicians are losing control. We are not autonomous anymore. Someone else decides things that don't have MD at the end of their name. We can all write protocols, but what we are losing is the ability to execute on high power level. We need to be comfortable in the leg arena. We rely on counties and lobbyists. Do we have the ability to talk their language. We should write a bill. None opposed
- Kazan: EMS medical directors are not as different as surgeons and emergency physicians. I am double-boarded like many in this room. What will make EMDAC extinct is the exclusion of provider agencies. Just like the dinosaurs, if you don't evolve with it. I ask that you vote. If I am not included, I will not come.
- Schultz: I wouldn't take my toys and go home no matter what the vote is.
- Gausche-Hill: Suggest that we read bylaws, come up with ad hoc group to read and suggest changes for those bylaws from LEMSA directors and agency directors.

    - Motion made: ad hoc committee to review bylaws and statute and suggest changes
    - Second: John Rose

    - Third: Vaezazizi with point of discussion – how to appoint members of the committee? Should include LEMSA and non-LEMSA directors.
    - Brett Rosen – bylaws include LEMSA medical directors and CHP medical director as active members and should include Cal Fire, which is a state agency operating in most LEMSAs as an active member as well .
    - Opposed none.
    - Motion carried.
- Bylaws written in 1995.

Legislative issues

- Discussion re: Proactive vs reactive
- Leg problem somewhat from lack of communication between other stakeholders.
- Koenig: Create a list of principles
- Dave Chase Ventura: Many things we can achieve consensus. We could put together basic principles. The time is now to move ahead community paramedicine.
- Ghilarducci: If it doesn't bring value to the patient, we shouldn't consider it.
- Carl Schultz: From a 10,000 foot level, what does our organization advocate for? Community paramedicine? Public Health? LEMSA director autonomy? Broad leg goals we support and believe in as an organization
- Jim Dunford: Chair of commission. If there are some major bills out there that we haven't read, that's on us. Strengths and weaknesses of bills identified without reading it – not too good. We have that responsibility to wade in. Others will be very engaged and we will be the losers if we are not proficient in this.
- Goldman:
- Konik: Get a lot of info from local govt stakeholders. She doesn't know the stance of EMDAC. Doesn't feel we are strong. Feels we are behind.
- Schultz: Discussed need for leg committee (Goldman, Shafer, Schultz, Kazar) guidance and suggested leg committee draft leg goals and bring them back to EMDAC for review.
    - Kristi Koenig: Made a motion to direct EMDAC leg committee to develop draft leg goals for EMDAC review at next EMDAC meeting.
    - Clayton: Bills are tedious and just a few words change it. Really need to read in detail.
    - Ghilarducci: We are looking for guidance from the leg committee.
    - Dunford: It's not too hard.
    - Ghilarducci: 5 bullet points per bill
    - Missed the names of the second.
    - Motion carried.

Round Table:

- Troy Falck, SSV: All Trauma centers 1&2&3 ACS verified. Working on level 4's. Developed their own and will try on Fairchild in October. Happy to share.
- Brett Rosen, Cal Fire: Staff doubled. Thanks Dave for mentorship. Will be starting e-pcr ImageTrend starting Jan 1 to phase in. Does not affect cooperative agreements, but all state fire stations will get it eventually. Advise him of any issues. Data connection, HIE to be worked out.
- Katherine Shafer, San Joaquin: All protocols changed and in 45 day comment.
- Zita Konik, Napa: Rapid retriage getting pushback. Discussion of red box/blue box in other agencies helpful
- Daniel Shepherd, Ventura: System assessment eval current model. New primary stroke center. Pediatric out-of-hospital resuscitation being evaluated – little more stay and play, emphasis on good resus. More assessment factor and be objective. Multidisciplinary committee working on revision.
    - Schafer: No feedback because all kids get transferred out of county.
    - Gausche-Hill and Kazan: cognito is a program that requests feedback. Can be designed to request feedback from destination hospital. Free online form builder that is easy to use. https://www.cognitoforms.com/
- Greg Kann, MVEMS – I'm new. Head swimming.
- Kristi Koenig, San Diego: Starting to collect data for ketamine. Anecdotal so far. Dose may be too low. Asylum seeking migrant shelters run by Jewish Family Services. Public health screenings transitioned over to UCSD recently. 13,600 screenings from Dec on. Less than 1% went to ED. Only a handful went be ambulance. DHHS has come to learn from best practices.
- San Diego Fire: Police scoop-run vs EMS in MCI has been discussed locally. PD included in conversation. Laminated card of first aid, tourniquet, and number for each trauma hospital given to LE to help expedite care. Community paramedicine program rekindled. Weekly meetings. Has started to see improvements. Top superuser now ~100 calls/year.
- Jennifer Farah, UCSD – EMS physician on scene protocol underway. IRB approval for IV acetaminophen to see hospital outcomes.
- Clayton Kazan: LA County with a couple pilot projects pending. Advanced provider and telemedicine to use alternate destination. Grant app in to get PD to carry AEDs. AEDs are in jails. Not on mobile units for self/public. Working on board approval for looking at hiring 2 full-time assistant medical directors.
- Bosson LAC: 7 fellows in CA now. Distribute job opportunities on listserve.
- Kim Freeman, Tuolumne: pediatric i-gel use has not worked well. Despite appropriate use, cannot be handed to firefighter and be low maintenance. It is taking the medics attention to monitor/adjust when s/he needs to be addressing IO, meds, etc. 32 minute average transport time. Requested input from group. LMA Supreme, AirQ better outcomes anecdotally reported.

- Ken Miller Santa Clara: 2019 EMS update. Epcr documentation with new policies to tighten up documentation. Stroke center triage 10-15% of the time anticipated. Interesting haz-mat incidents recently. A form is being developed to help with haz-mat triage. Arrestee brought to jail with minor medical problem in past would get transported with high level response. Code to be developed with nurse and protocol 33 to change dispatch. Treat and refer in certain CAD addresses with high volume low acuity hx – response not changed, but alternative transport potential being developed.
- Jim Dunford, Commission: ILCOR published yesterday in Circulation re Utstein methodology. LE interested in diverting people away from jail and EDs. Meeting coming up in Jan on this topic. We could ride on coattails of LE- - pre-arrest diversion and how can EMS play a role. Sobering Summit coming up (sounds fun!). 1544 Gipson issue is whether sobering centers should be FQHCs. Most are currently not, and most current sobering centers will be disqualified. What should be the minimal criteria for a sobering center? 150 patients? Partnered with San Diego mental health. If not alcohol, other addictions 90% meth, 10% heroin. 3 times in 90 days will get prosecuted and will be mandated to go to jail or to treatment.
- Contra Costa received CDPH grant. Congratulations!

- Duncan: C goal of keeping our jobs. Ready Responders is taking that. They have many of the answers we are looking for in community paramedicine. Unified Scope – thank you. Initiated it in a few LEMSAs. Working to finalize databank and data dictionary. His position as Air Ambulance Rep needs to be transitioned. Atilla?
- Shira Schlesinger, Harbor-UCLA, Shira.schlesinger@gmail.com, is chairing a subcommittee for EMS related topics for ACEP 2020. If interested in speaking to a national audience, email her.
- Marianne Gausche-Hill, LAC: Stroke routing. Tracking. Fair number 16-24 hours. 75% in first 6 hours. 25% after 6 hours still receive procedure. Two-tier survey underway. Dr. Whitfield in Emergipress – shout out. ECG of the month. Cases from the field. Video. Great education. App of pediatric dosing being developed. There are issues with govt issue publishing an app. Will share when available. Will be free.
- Hernando Garzon, Sac County: controlled substance policy signature question?
- Atilla Uner, UCLA, Reach Air: Reach did 2000 transports in Dorian. All evacuations. No bills to patients. Air assets seem to be underutilized in disasters. Reach has a disaster group to deploy.
- Carl Schultz, Orange: Trauma center survey coming in next month
- Peter D'Souza, Stanford: State chapter NAEMSP meeting still trying to get sorted out. NAEMSP due-paying members only. Solutions for meeting to be discussed.
- Marc Gautreau, Stanford: NAEMSP chapter meeting next.

Adjourned at 1618.