EMDAC

December 8, 2020

Scope of Practice

Call to order by Ken Miller 9:02

1. LA County iGel Application
   - Nichole Bosson described plan to roll out iGel as a pilot in several provider agencies for ALS providers and adult patients to start. If successful will expand to all LA County and then include pediatric patients. Will replace King and be the preferred advanced airway for adults and backup for peds when cannot ventilate with BMV.
   - Issue of dislodgment in pediatrics was discussed. Tuolumne has had that issue and switched to LMA supreme. Discussed lack of hooks to allow seating with the straps similar to the adult version.
   - Atilla suggested clarification to oral trauma.
   - Group discussed potentially pooling data either retrospective or conducting prospective study to identify complications.
   - Scope recommended approval. (Eric Rudnick, Kim Freeman)

2. Marin County iGel Application
   - Dustin Ballard reviewed plan for Marin County iGel. A single provider agency has expressed interest at this time.
   - Atilla Uner suggested a clarification on the language regarding squeezing the reservoir bag.
   - John Brown queried whether provider agencies can choose which SGA to use. Dustin clarified that the decision is at the Provider Agency level, not individual provider.
   - Scope recommended approval. (John Brown, Kim Freeman)

3. North Coast Ketamine
   - Nichole Bosson asked for clarification on dose.
   - Mathew Karp clarified that the dosing is on the drug sheet not on the policy, 0.3mg/kg IV/IO, 0.5mg/kg IV/IN
   - Discussed whether there was a max dose recommended previously by Scope, recalled 30mg, multiple agreed this to be the prior suggested max, reflects what others are doing.
   - Discussed whether slow IV push could result in dissociation, this occurred in Riverside. Some LEMSAs are doing push others IVPB
   - Atilla raised question about versed for emergence reactions.
   - John questioned the IV pain med route for pediatrics, since they have moved away from that in pediatrics, whether IM routes would be considered?

- Mathew Karp clarified that the drug sheet includes dosing IM and IN
- John pointed out that the pediatric dose differs from adult and does not include the IM/ IN routes. Group suggested mirroring adult dosing for pediatrics.
- Nichole Bosson reminded that prior suggestion was max dose: 0.3mg/kg IV/IO/IM or 0.5 mg/kg IN. Brian commented on IN dosing.
- Dave Duncan commented that NASEMSO suggests infusion
- Mark Luoto commented that they followed the 0.5mg/kg IN, a colleague who is a pain specialist has suggested even higher dosing 0.75 mg/kg.
- Nichole Bosson summarized the suggestions to include the adult dosing regimen for pediatrics with the 0.3mg/kg parenteral and the 0.5mg/kg IN.
- Scope recommended approval with those changes. (Atilla Uner, Kim Freeman)

4. North Coast Lasix Renewal
   - Group discussed concern about misuses of Lasix. Mark Luoto explained this is why it was removed in his county.
   - Discussed strengthening language for indication to require patient to be on a loop diuretic rather than administering in Lasix naïve patients.
   - Scope recommended approval with that change (Erick Rudnick, Kim Freeman)

5. Solano Lasix New Application
   - Bryn Mumma explained plan for physician driven administration of furosemide as a community paramedicine pilot. Targeting recently discharged patients with CHF participating in the pilot
   - Jimmy P clarified will all be on physician order, not medic driven.
   - Group discussed shift to care outside of the hospital and the changing role of EMS.
   - Scope recommended approval. (Kim Freeman, Nichole Bosson)

Joint EMSAAC-EMDAC 10:05

- Dave Duncan shared data on COVID hospitalization trends. The rest of the nation spiked earlier as we were relatively flat. One impact that has had is it put us behind in receiving contract staff. The trajectory of the curve is impressive.
- Considering the case rates, we are at an average of 23K (in blue, which are 7 day moving averages). This almost doubles case rates in July. This equates to 10% hospitalizations in about 10 days. The trajectory is important. This is what led to the stay at home orders that have been invoked.
- COVID burden in the population is about 10%
- Reviewed comparison of regions.
- Hernando Garzon reviewed hospital data: 21% of hospitalized patients are COVID in the state, 40% of ICU beds are COVID. Currently state has 19% availability for ICU. Built in a calculation factor for the raw ICU availability, based on COVID burden, because if you are

heavily impacted by COVID because COVID length of stay is longer and less capacity to manage other patients. So raw # is 19% availability but using the corrected number of 13.3%. Clarified these are staffed available beds (currently or within a 'reasonable timeframe' = approx. 72 hours). 14 counties are already at <15% ICU.

- Group discussed focus on patient care capacity rather than bed counts. Hernando explains that staffing is a major issue. What better metric is suggested?
    - Kristy Koenig explained that in SD is trying to identify 'can you take this person in the ED into your ICU now?'. Hospitals are not likely using the same data dictionary and that is polluting the data. And what is being reported is likely more than what our hospitals can achieve. We need to report apples to apples.
    - Kris Lyon agrees that there is a major disconnect between beds hospitals are reporting and what he sees in the ED with the number of boarders.
    - Hernando discussed the differences between the local bed polls and the state data. In terms of planning, they want to know what the ability is to surge in the short term. If you know that staff/bed availability is coming, this is important data to track, surge that is coming and surge that is currently available.
    - Kristi Koenig agrees, there are two different metrics and we are mixing them. The planning does not help the patient who needs immediate care – can we literally accommodate the next stemi or stroke patient? There is a lack of clarity over these two metrics. The immediate care capacity is not reflected in the metrics which are overly reassuring.
- Erick Rudnick comments that our small area gets lost, currently no ICU beds, positive test rate is 32% this week. Understand focus on large populations, but do not overlook rural areas.
- Larry Karsteadt echoed this, normally transfer patients out to hospitals that are now currently surging.
- Hernando Garzon agreed that using the regional metric is problematic, do not want to overlook individual county issues.
- Brett Rosen raised the issue around vaccination for EMS Provider. Many EMS Agencies providers do not live in the counties they work in. How will they get vaccinated if the counties do not know where they live? Are they requiring hospitals to test providers?
    - Dave Duncan suggests coordinating with the local health officer. The state has not gone to that level of detail. Feel good about getting out the initial vaccines, but have not felt the need to get to that detail yet, probably in January. Will query the task force
    - Clayton Kazan raised concern about lack of information from the local health department.
- Dave Duncan shared a graph demonstrating that threshold of <20% ICU capacity and >40% ICU COVID patients is a problematic threshold.
- Kristi Koenig questioned the new quarantine guidance. The CDPH guidance states 'after day 5' for testing utilizing the 7D+testing for return to work, this seems to contradict CDC

who states testing can be done from day 5. Hernando clarified that the language should be 'on or after day 5' for testing.

- Clayton Kazan via chat : "Speaking broadly...public health need to understand that firefighter=EMS=healthcare worker in Cali. Firefighters are nationally listed as 1B, EMS is 1A. Working in both spaces, I would much rather have EMS workers get vaccinated because they are going into rampantly contaminated environments, carrying people out of their homes vs. treating in a relatively controlled environment of the hospital ED or very controlled in-patient environment."
    - Marianne G-H commented that initial push for LA DPH will likely be to hospitals given storage issues. But EMS will be in 1A.
    - Dave G heard comment that everyone in the hospital should be vaccinated before moving to the next group. Concerned that EMS risk is higher.
    - Lauri McFadden commented that these providers go in and out of longterm health facilities so getting them vaccinated and SNF staff is important for controlling outbreak.
    - Larry Karsteadt states there is a strong recommendation for vaccinating EMS in first tier.
    - Clayton Kazan commented on how many providers that are out due to COVID. Concerned EMS will be buried yet we have the staff to begin vaccinating immediately.
    - Kris Lyon questioned if Clayton has polled employees on who will take – Clayton says its about 1/3 who will refuse.
    - Kevin Mackey echoed similar numbers and is rolling out some training including data on the rNA vaccine. Will share.
    - Group discussed side effects are generally mild. Fevers, body aches… Moderna has highest rate. Pfizer has more reaction on second dose.
    - Jeff Kepple wondered how many would be amenable to vaccine if recently positive. Marianne explained if those who are positive need to wait 90 days, this is to allow for others to get since they may have some immunity. Karl Schultz agreed but the message is still that you need to be vaccinated, those persons should not be told no vaccine.
    - Kristi Koenig commented that one still needs to use NPI because vaccine shown to prevent illness but not necessarily infection and infectivity.
    - Travis Kusman questioned further prioritization relative to frequency and length of exposure, who should be prioritized first, given there will not be enough vaccine initially.
    - Clayton Kazan is working on this right now – 1300 paramedics will go first, amonst that group tiering by age.
- Dave Duncan discussed programs to expand capacity around the state.
    - Imperial County implementing an oxygen at home program. Paired with a home health agency and paramedics, now that paramedics are providing home care,

idea is increase the home health agency capabilities to maintain patients at home. Up to 4L NC. EMSA program, have a medical director assigned. Anyone interested can reach out to Dave Duncan or Kathy Staats. Paramedics need to work in conjunction with an existing home health agency, do a few visits per week. Other issue is payment, yet to be determined. Willing to share program design with those interested. Rate limiting step continues to be staff. Currently Imperial County is very thin on paramedics.

- San Bernadino began a program to limit response to certain level of calls, this was highlighted in the news.
- The State has reached out to for hospitals in the Humboldt region to discuss building additional bed capacity. 80 additional beds expected. Feel this is a better use of staff than an alternate care facility. Also working on staffing, requires a joint approach. Targeting RNs, LVNs, paramedics.
- Other hospitals have offered to build out additional beds IF they can get staff, so they are looking at the centers that can build out the most beds per staff.
- EMSA just launched, in conjunction with CHA, nurse just in time training to prepare nurses for work in the ICU, for those who do not typically work in the ICU. Incentive is free CEs. It's a two day training, core knowledge day 1, optional day 2. 30 nurses have signed up so far, no limit on signups.
- EMSA added additional staffing contracts.

[Computer crashed 5 minute gap in minutes - NBosson.]

EMDAC Main Session 11:19

Review and approval of the minutes. (Kim Freeman, Marianne Gausche-Hill)

Treasurers Report – Daniel Shepherd

- Reviewed expenditures including lawyer for bylaws, paypal fees. No major anticipated costs given remote meetings. We have adequate funds.
- Kris Lyon questioned whether there are any other payment options that are cheaper than PayPal.
- Karl Sporer explained it was set up a long time ago, likely cheaper options now if someone wants to look into it.
- Kim Roderick suggested Cube may be cheaper.
- Dave G discussed potential costs for hybrid meetings in future.
- Daniel Shepherd queried whether should request dues from new member.
- Marianne proposed requesting payment, Erick Rudnick second. Jay Goldman countered with the idea that one could join for a year. Nichole Bosson questioned how this would relate to voting rights. Vote 65% yea, 13% nay, 22% abstain. Group further discussed. Marianne suggested it vests them in the organization. Brett Rosen had expressed similar. Motion passed. New members will pay dues.

- There will be no additional dues for current paying members.

Liability Policy - Kris Lyon

- There is a line in the bylaws that requires a general liability insurance for the organization. We do not have it. If it is required, we should have it. Suggests getting quotes.
- Marianne reached out to the lawyer who reviewed the bylaws. We as an organization need to determine if we need it. We are free to remove it if we choose.
- Katherine Shafer commented in the chat that we should have liability insurance.
- Kris Lyon pointed out that there are organizational agendas in the state, and could we be involved in the future in any of those lawsuits. It would make sense to assess the cost.
- Erick Rudnick explained he recently had challenges getting liability insurance, but worth exploring.
- Kris Lyon stated his contract initially required this for him, but the County ultimately removed because it was not needed. But its different from what we are discussing for our group. Different than malpractice policy.
- Marc Gautreau questioned what we would be liable for since we only make recommendations to EMSA, don't take action.
- Group agreed to explore cost, Marianne will work with Kris.

EMS Commission - Ken Miller

- Reviewed agenda planned for tomorrow:
- Starting a new legislative cycle.
- There are some regulations update, anticipated regs to support what was 1544.
- There is a report on AB2293, did not see anything that would prompt much discussion.
- Commentaries on emergency regulations, in person, in hospital, skill variation for EMTs suspended due to COVID.
- Update on community paramedicine projects.
- Update on wildland responses
- First required report on APOT. Report lists LEMSA compliance but curious about possible conclusions to be drawn.
- “Clinical care and restraint of aggressive and combative patients” is on the agenda for discussion – references NAEMSP position paper but there are no other specifics.
- There are nominations for officers for next year
- Posted the meeting dates for 2021, usual pattern 3rd Wednesdays of March, June, September, December. The proposed meeting locations for Calendar Year 2021 are:
- March 17, 2021, in Garden Grove, June 16, 2021, in Sacramento, September 22, 2021 in San Diego, December 8, 2021, in San Francisco, March 16, 2022, in Garden Grove, June 15, 2022, in Sacramento, September 21, 2022 in San Diego, December 14, 2022, in San Francisco

Bylaws - Marianne Gausche-Hill

- Acknowledged co-chair Sam Stratton
- Reviewed changes
- Retained two types of members.
    - The Active Members are the LEMSA Medical Directors and up to 1 additional Assistant or Associate LEMSA Medical Director (at the discretion of the LEMSA)
    - Associate members are active EM/EMS physicians with specifics given to roles that quality, broad.
- Discussed whether there would be non-physicians, decided to maintain as physician-based organization.
- Board of Directors would decide the dues and could vary by type of membership.
- Expanded board from 7 to 9 members
- Associate or Active could be Secretary.
- Treasurer is Active member.
- President elect and President must be active members and President elect ascends to President the following year.
- Scope of practice will have 4 active and 2 associate members. Chair is elected by committee members
- Active members are voting members.
- Clarified if a president elect changes status, there would be a new vote for president. Dave G suggested this language should clarify any such situation.

Board member vote – Dave Ghilarducci

- Votes submitted via polling
- Secretary – Kathy Staats 96% - 27 votes, 1 abstain
- Treasurer – Daniel Shepherd 93% - 26 votes, 2 abstain
- Active at Large:
    - Carl S – 7 (27%)
    - Katherine S – 7 (27%)
    - Reza V – 10 (38%)
    - Abstain – 2 (8%)
- Associate at Large:
    - Claus Hecht – 9 (28%)
    - Clayton Kazan – 17 (53%)
    - Marc Gautreau – 5 (16%)
    - Abstain - 1

Cal ACEP – Vic Gulati

- Will be responding to AB890, board voted to respond but have not formulated plan yet.

- Encouraged people to reach out to Dr. Gulati, Kathy Staats and/or Atilla Uner with any questions/issues.
- Discussed resistance to vaccinations, encouraged collaboration and peer outreach
- Group discussion:
    - Brett Rosen raised concerns about AB890's effect on EMS and serves as AAEM's representative to NAEMSP task force addressing NPs and PAs in EMS.
    - NPs fall under board of nursing.
    - Psych patients were already a challenge to find appropriate beds/care, not more challenging with COVID. Potential use of Binax kits to r/o COVID. Binax is an antigen test, 15 minute turnaround, supposed to use only in symptomatic patients.
    - Consideration for use of Binax kits for providers who may develop symptoms at work?
        - Kevin Mackey explained need a Clia waver, will be implementing soon. In chat "If your public health is performing the test, no CLIA is needed. If you are having the test sent to you from the county and conducting them yourself, a CLIA is required according to CDPH"
        - Peter Benson using Binax with high sensitivity, if positive then can immediately react, if negative can await PCR test. They have had several patients testing positive for both COVID and influenza, not necessarily sicker. The rapid turnaround is helpful operationally to react quickly to potential new cases.
        - Dave G explained had outbreak in the jail, using Binax for symptomatic patients and exposures, all followed up with PCR confirmation. Frequency of testing may overcome some of the test characteristics limitations.
    - Dave G brought up issues re vaccination – Could people mix vaccines. Issue of acceptance around 40%. Committing to second injection.

Treat and Release Policy – Kathy Staats

- Meeting with Cal ACEP board and EMDAC Task Force, really productive discussions.
- Clarified that this will not be a mandated document.
- Initially was focusing just on COVID but will expand to address all patients.
- Dave G queried what the biggest challenges were – Kathy reported that there were educational needs on both sides to align everyone.
- Dave G raised the issue of extensive exclusion criteria making it challenging to implement in the field. Too much complexity would be unworkable. – Kathy explained that by not making it required this reduced the concern that it would be too complex, as many LEMSAs already had similar exclusion criteria.

- Senai Kidane asked what the timeline was for distribution – Kathy hopeful for end of week.

Group discussion of Alternate Destination transport during COVID

- Jay Goldman queried rules re AD during COVID.
- Dave Duncan clarified that we have emergency order to transport patients to alternate destination. EMSA supports alternate destination for both COVID and nonCOVID patients. AFL is just a reminder that we can take COVID patients to the ACS. An AFL cannot direct EMS per se, its really for hospitals and licensed entities, ACSs are licensed.
- Marianne raised proposal in LA that a Base hospital could direct BLS patients to a nearby Urgent Care. Queried whether this would be an application or would fall under executive order? Dave Duncan stated he replied to Cathy that EMSA would approve under LOS. Have latitude here; Dave will review order and see if it requires EMSA approval or if these projects can move forward under the existing emergency authorization.
- Kristi Koenig mentioned that it is important to understand the capabilities of the Urgent Care.
- Kris Lyon also raised issue that Urgent Cares are in it for cash and if the patient does not have the right payor, they will not care for the patient. They are also seeing a lot of volume, not sure it will take much load of the EDs.
- Dave G put in chat : "Alternate care sites have all of the following:

  Staffing that includes a combination of physicians, nurse practitioners, physician assistants, nurses, personal care attendants, respiratory therapists, behavioral health workers, pharmacists, supportive medical care providers, and social workers
  Basic laboratory testing and x-ray capabilities
  Ability to provide limited IV fluids/medications and low-flow oxygen (no more than 4 L NC)
  Nebulizer treatments and suctioning, if the appropriate personal protective equipment (i.e. N95) and setting (single room) are available.
  Many UCs also are geared to serve their own members…eg Kaiser, Sutter"
- Shira Schlesinger discussed the issues with the OC Alt Destination pilot; lots of issues with the Urgent Cares varying the type of patients accepted based on the individual providers. Even though the care was covered under the pilot, additional services (labs, xrays etc) were not covered, so UCs refused to do or asked for payment out of pocket.
- Jay Goldman: "Agree with Ken and Shira that UCC should prob not be considered as similar ilk as ACS. ACS is intended to hold or even "admit" pts who need low level inpatient care."

- Gary Tamkin – The issues were are having are the minor boarder (psych etc) that have no place to go. The minor patients that would be diverted to UCs are the patients they want to see
- Atilla Uner – Raised concern for opening a door to financially lucrative patients to be siphoned off to specialty centers (example hip fractures to ortho center).
- Kris Lyon – Will patients be reimbursed for transport to Urgent Care?
- Clayton Kazan – Unless we do something about APOT, we will have no ambulances to send. Doing AD for pysch, good low hanging fruit, since EDs do not provide good psych care anyway and they take up a bed for a long time. (Sobering Centers still shut down.) Sensitive to $ for ER groups but current pathway is unsustainable.
- Dave G – Raised issue of needing lab capabilities, do the EMSA ACS have lab capabilities?
    - Dave Duncan explained is a send out process. Mobile xray, simple plain films, next day read. Not rapid deployment.

Legislative Committee Report – Kathy Staats

- There is continued work by EMSA on Chapter 13 discussions (Dr. Sporer representing EMDAC)

- CalACEP is working on an EM exemption for AB-890 (Independent NP Practice Bill)

- Upcoming meeting to discuss development of our legislative goals for the 2021 year

Chapter 13 Update - Karl Sporer

- Background: Cal Chiefs raised concern that Ch 13 are underground regulations. To fix this, moving the language to regulations. That started this process.
- The workgroup status: Mostly agree with language that exists. Will be finished with public input in the next month or so. After that EMSA will put out proposed regulation. Expects litigation after.
- Goal is to maintain medical control at the LEMSA level the way it is now.
- Dave Duncan discussed challenge of not having Cal Chiefs at the table.

Unified Scope of Practice Update – Atilla Uner

- 17 LEMSAs participating currently
- Any concerns, reach out to Atilla
- Seen a slight rise in COVID air transfers, but given current rise in COVID everyone, questions whether there will be less long haul transfers
- New data in March

- Dave G questioned how many additional counties have not adopted this, that have an Air Base in their county – Atilla was not sure of exact number but expects low since 17 of 33 LEMSAs have adopted.
- Kristi Koenig raised question about the use of a paralytic without induction agent, what is the QI on this, for those who have Unified Scope in place. Atilla said on closer look believes there was only 4 cases, there is a push in the company to avoid paralytic-only intubation, we are sharing all of the data.
- Kristi clarified the issue of needing to oversee QI but have no oversight of nurses so how are LEMSAs handling?
- Katherine Shafer raised concern about adopting Unified Scope, feels her concerns are not taken seriously with air providers.
- Marianne Gausche-Hill emphasized direct communication and working together.
- Dave Duncan provided perspective from the Air Medical Director experience – focused on training, followed Ron Walls guidance for crash intubation, adding paralytic for GCS 3 with trismus only, otherwise everyone got sedative unless severely hypotensive and then shifted to Ketamine to address that. Worked with Gary McCulla on this, he was of the same perspective. They did allow rare circumstances of awake intubation with Ketamine/sedative only. These are rare circumstances, so cautions making a mountain out of a mole hill.
- There is universal QI plan to go along with Unified Scope. Marianne clarified the plan is quarterly data to the LEMSAs and report to EMDAC semi-annually, the next report is in March.
- Ken Miller suggests polling the LEMSAs who have adopted Unified Scope regarding what data they are receiving and then determine if there are any gaps.
- Atilla Uner explained that can only speak for Reach Air, LEMSAs should be receiving but if just joined may be a bit of delay… No one on call indicated they are from Mercy Air. Atilla will reach out to them.

Opioid Pilot Contra Costa – Gene Hern

- 4 Components
    - Narcan distribution – 103 doses distributed thus far, two already used for reversals
    - Warm handoff – use First Watch to do Opioid OD trigger, send to counselor at bridge site, who reaches out to patients who do not go to hospital
    - Hospital designated as OD receiving center – have not seen a big uptick in transports, but in first stages of rollout, anticipate will increase when include rest of county in Bup portion (PEC just accepted opinion piece re receiving centers)
    - Bup trial – up and running, few patients, all seemed to be improved on hospital arrival

- If programs want to implement, have 'plug and play' resources, will send note when website is built
- Dave G alerted the group about recent LAHAN re wound botulism.

Patient elopement during pysch transfers – Angelo Salvucci

- Background: Years ago SB approved for olanzapine for IFTs. In discussions with AMR, issue has arisen that there are different approaches to ensure patients do not elope from the back of the ambulance. Working on how to make this safest possible environment. There are legal issues around restraint. Clarified that CA has a substantial number of cases, unsure why. Queried if anyone has worked on this issue?
- Jay Goldman commented that they deal with this quite a bit. Mostly BLS. Happy to talk offline.
- Dave Duncan has been hearing about this issue for a while, AMR wanted to discuss ways to improve this. EMSA is taking a hard look at it, COVID has been a delay, Luis will be looking at it.
- Kris Lyon queried whether an ambulance is the appropriate mode of transport. Their typical approach for psych transport is a contracted security officer with DMH in a car that has security lock so that they cannot elope.
- Mark Luoto states experienced same, use cage cars without events for many years, but recent mandate requires BLS ambulance, psych transfers go up to Reading with a 6-8 hour turnaround and there is already a shortage of ambulances. Cage cars worked well. The BLS ambulance mandate is causing big delays.
- Kim Freeman has similar issue. Call them 'safety cars' rather than 'cage cars'.
- Atilla Uner brought up issue of treating mental health patients like criminals.
- Dave G suggested guest speaker next year with some expertise in this area.

Round Table

San Francisco - John Brown

- Working on routing to reduce APOT and diversion, pending data
- Working on SNF outbreak stabilization, have 3 in need of additional staff, mostly able to handle in county but have reached out to neighboring county and state
- Working on distribution of antibodies to non-inpatient settings
- Now have comprehensive stroke center, so looking at stroke routing
- Community Paramedicine with behavioral health team member dispatched to BH emergencies that are unlikely to have safety issues, reduce LE involvement. Approved as part of CP pilot which will transition to LOSOP.

Tuolumne – Kim Freeman

- Self swabbing for EMTs/paramedics pending approval

EMDAC

Peter Dsouza – Stanford

- queried who is doing asymptomatic testing
- Peter Benson described their programs, provided resources, no mandatory program.
- San Mateo is exploring Binax now beginning and end of tour, possibly trialing in the next week or two.

Joelle Donofrio – EMSC

- Will be sending around query soon. Will update more at next meeting.

Marin – Dustin Ballard

- EMS Agency hosting grand rounds with Dave Witt and Micky Kline, will be recording and can send out the link. Trying to address concerns about vaccine hesitancy.
- Local pilot using BinaxNow with health clinics, reasonable NPV in asymptomatic, PPV in symptomatic. No current plans to do in EMS workforce.
- Most providers using Curative, build directly to insurance, self swab send out, no supply chain issues that he has heard of.
- Moved to King airway as primary for airway and success rates are much better and near 100%. And will also incorporate iGel.
- Ambulance regulations revised after 20 years or so, redo included asking for data on IFT providers so can monitor better.
- Marin Health has new hospital tour, with some capacity increase, but has not improved diversion. Diversion policy is 2-4-2 (max 4 hours in a day 2 hours at a time separated by 4 hours)
- Devin Tsai added working on MCI plan, formalizing a process to deal with an increase flux of patients, pandemic related, in response to San Quentin.
- Dustin clarified that idea is to trigger a distribution process.

Kaiser – Jay Goldman

- Stroke centers all migrated from Alteplase to Tenectaplase, do not have enough patients yet but bleeds are same thus far.
- It is still off label. The American Stroke Association has changed to the more generic term ‘thrombolytic’
- Kim Freeman commented that there was not a financial incentive for approval.

LA County – Marianne Gausche-Hill

- A lot of stress in the system, working on innovative ways to deal with wall times. Will be actively putting hospitals on diversion that have long APOTs who are not putting themselves on diversion.
- Working with DPH on vaccination. Frustration on lack of information.
- At least 2/3 of system will be vaccinating their own workforce.

- 834 Task Force is ongoing, not specific for COVID.
- OHCA Task Force that is almost done, will be updating our protocols to accommodate that work.
- Behavioral Task Force (ad hoc from Commission) looking at current policies, for AD and psychiatric crisis, developing 'care of the agitated patient' MCG, possibly including olanzapine as part of local optional scope.

San Mateo – Greg Gilbert

- Video laryngoscopy QI project ongoing, looking at reviewing in real time video and providing guidance
- Working on vaccination roll out

San Diego – Kristi Koenig

- Limited ICU capacity, working on building surge, staffing is biggest challenge.
- Wall times rising, boarding patients rising.
- Recently implemented QR code quick survey that paramedics can use if being asked to wait outside ER, so can take action in real time.
- Positivity rate is 9%, all time high
- Doing lots of flu vaccinations, planning to mobilize for COVID soon.
- County has done >2 million tests to which paramedics have contributed
- ECMO consortium to monitor ECMO capacity, shifting resources around to ensure equitable access

Kern - Kris Lyon

- Discussed US use by providers
- One provider would like to use US, not aware of any legislation would prohibit.
- Reza V planning pilot to look at indications, whether beneficial, delayed start
- Peter Dsouza – residents looked at this, need robust QI
- Ken Miller suggests feasible to obtain quality images
- Kris suggested perhaps identification of free fluid could be used to determine if air transport to TC required for generally stable patient. Possibly to confirm pnx prior to needle T.
- Discussion of whether there are any legal barriers for paramedics performing US
- Nichole Bosson raised question of it being a special skill for ED physicians. But silence in legislation would allow paramedics to just perform. How to develop and maintain skill in paramedics. Need to clearly identify how it will be used.
- Chris Kahn explored this in OC for determination of death in OHCA, transmission of images to MD.

NorCal EMS - Jeff Kepple

- Commented that rural areas are not shielded from COVID. Seeing more masking compliance in his community. Grateful for this group.

Santa Clara – Ken Miller
- Including a pathway for violent patients in their protocol for AD
- Use midazolam currently, noted that the AD policy is being used more liberally that intended. Have not considered olanzapine yet.
- LE holds tend to be very short, considers that many may be unnecessary, behavioral health may get involved and make appropriate referrals with SW assessment

Alameda – Karl Sporer
- CAT community assessment and treatment team started, have high rate of 5150s, the CAT team is a new 911 service, purchased 10 Chevy Tahoes with barrier between clinician and client. Have behavioral health specialist and EMT who respond
- Operating 4 units 10 hours a day, planning to expand
- Finding they make different decisions, about half the time decide transport is not needed at all. Once they decide to transport, we only transport ED 10%, most go to alternative destinations available to behavioral health.
- Call usually comes in from LE, 5150, ask about violence, if nonviolent send CAT

Orange County – Carl Schultz
- COVID has overwhelmed their agency, 'COVID response agency'
- Placing lower priority on bamlanivumab, and regeneron, and made first come first serve without specific allocation. Sending as requested. Regeneron limited to acute care hosptials.
- Developing disaster resource center.
- Some FDs using Binax Now to test, obtained CLIA waiver, they are compliant, allowing them to do.

LA County Fire – Clayton Kazan
- Appreciates discussion on bylaws
- Giving talk at NAEMSP on fire department pharmacist
- Advocating for personnel getting vaccination

Imperial – Kathy Staats
- Attempting to roll out skills training, need to do remote, if anyone has ideas on how to do, please reach out.
- Thank your for sending T&R policies, send yours if you have not already
- If you have residents with an elective coming up, invite them to join Cal-MAT and staff an ACS.

Ventura/SB – Daniel Shepherd

- Launched Handtevy for peds drug dosing recently – provider feedback as been good
- Launched iGel - using hooks for adults, pulling strap right over the device for the smaller ones 'Handtevy minute' video shows the process
- Trying to do an RFP which has been challenging with COVID response
- Implementing First Pass as part of First Watch to improve QI
- Preparing vaccination
- Stroke system work

Cal Fire – Brett Rosen

- Rolling out ePCR Image Trend, starting first quarter 2021, expanding throughout the year
- Fires have continued
- Dr Backer is the medical director of Cal MAT been working closely on testing in the camps, been able to isolate and contain because of testing. Clarified using antigen test first, if positive then run PCR on those exposed. Symptomatic people go home, cannot stay in camp.
- Residents can also help at Fire Camps
- EMS Medical Directors taking pictures getting vaccines will help promote to our EMS providers
- CDC just released yesterday some new guidance on wildland fire response, discussing 'family unit'.

ICEMA / Riverside – Reza Vaezazizi

- Did not have an Assess and Refer policy prior to COVID, developed one in April to mitigate surge on EMS calls. 5 tier process, one of the tiers kicks in Assess and Refer. Had not used but now in the last surge implemented second tier, very few uses, was picked up by media with incorrect info.

Meeting adjourned 2:34pm

Next meeting March 16, 2021 – Via Zoom