EMS MEDICAL DIRECTORS' ASSOCIATION OF CALIFORNIA, INC.

AGENDA

March 16, 2021

https://zoom.us/j/94415296110?pwd=dlVCZnJIQlRreU85S1o2RXVVSWd0UT09
Meeting ID: 944 1529 6110
Passcode: 10100

Scope of Practice Committee and EMDAC Discussion: 0830-0955

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1. Local Optional Scope Requests (Dr. Miller)
    a. Central California: Jim Andrews, Verapamil renewal.
        i. No significant change for request. Base call required for administration.
        ii. Also discussed from Andrews whether change to diltiazem would be better. That would require a separate application and was deferred for this scope meeting.
        iii. Motion from Freeman. Seconded. Approved. No objections.
    b. El Dorado: Renewal for Nitrous Oxide.
        i. Kimberly Freeman is Interim Medical Director and presented the application.
        ii. Would be used for pts that can manage mask themselves
        iii. Not used in close containers.
        iv. No diversion reported.
        v. Anecdotally less opiates are used.
        vi. 100% QA
        vii. Question from Gausche-Hill: 50/50 mix versus 70/30?
            1. Not known for raw dosage. Has to be adjusted to 60/40 for altitude.
        viii. Q from J. Brown – why not other opiate alternatives?
            1. A: Allows potentially for ease of use and better mentation

ix. Uner motion made. Bosson second.

x. Approved. No objections.

c. Napa iGel – Konik

i. Currently use King tube by most. Many agencies moving towards this. Will give option for both.

ii. Will introduce for adults initially. Potentially add for pediatrics after review.

iii. Q from J Brown: < 14 yo what do you do?

1. Bagging only

iv. Motion – Brown, Second – Bosson

v. Approved.

d. Sierra-Sacramento – renewal for iGel - Troy Falck

i. Q from Gausche-Hill – Any seating issues with pediatrics?

1. Falck – none in the small number of uses

ii. Motion – Uner, Second – Bosson

iii. Approved.

e. North Coast – new request for IV abx – Matthew Karp

i. Trying to reduce barriers for ICU and rural hospitals

ii. Bosson feedback – change language to "begin infusion at least 15 minimums prior to transport"

iii. Uner feedback – why limit only one medication in the IV line?

1. Karp – safety as it is a new initiative, and to avoid potential confounders if adverse reactions occur.

iv. Motion – Bosson. Second – Brown.

v. Approved.

2. Adjunctive ketamine with opiates (Dr. Koenig)

a. Instead of limiting to Ketamine only, allow for use with opiates
    i. Many studies exist with this information justified
b. Other change would be dosing change
c. Proposal from Miller – Is June too soon if approved?
    i. Koenig – That is too soon. Would like to discuss initially first at EMDAC and potentially have off cycle meeting to discuss further.
d. Open discussion
    i. Reza – thinks we have had this conversation before.
        1. Some protocols allow switching to other pain management.
    ii. Schultz – reports no significant adverse outcomes when combining based on data
    iii. Many in agreement from the chat
e. Proposal from Miller – have a conference call before the next EMDAC meeting. Will allow Koenig to develop a plan before this meeting.
    i. Feedback from J Brown – Data sharing would be helpful, but concern getting data out to the state is burdensome. Would want to confirm this is acceptable for Koenig.
    ii. Trujillo & Miller would plan for scope to meet ahead of time for discussion.

3. Unified Scope (Dr. Uner)
    a. Shared REACH data from Unified Scope of Practice
    b. Focus on airway presentations
        i. Went into details of pediatric presentation
    c. No cases of paralytic without sedative
    d. Gausche-Hill – personally thank Uner for taking this on.
        i. Would like this to be sent to EMDAC group for review.

e. Reza – reminded that there may be lack of reporting from other agencies

f. Donofrio-Odmann – Were there hospital outcomes?

i. Uner - no

4. Define the SOP options (Dr. Miller)

a. Discussion regarding moving LOSOP items to basic state scope, particularly regarding SGA

i. Donofrio-Odmann – requested all LEMSAs using pediatric supraglottic airways, please send her the information for analysis.

ii. General consensus there is interest in the proposed idea.

General EMDAC Meeting:

1. Minutes

a. Brown – motion to approve minutes. Gilbert – second. No oppositions to opposing minutes

2. Treasurer Report (Shepherd)

a. See attached report

b. Current person managing the EMDAC website is leaving. Three options for the website:

i. If someone in EMDAC is good with code, the current website curator can teach the interested EMDAC individual

ii. EMDAC can find another talented person to take over this responsibility

iii. Finally we could create a new website. May be $5,000 to start. Up front a lot of work, but could potentially be easier to maintain.

iv. Consensus is generally to hire someone separately to fill the role with that kind of experience rather than create a new website.

EMDAC GENERAL MEETING: 1000-1430

3. Joint session with EMDAC/EMSAAC

EMS MEDICAL DIRECTORS' ASSOCIATION OF CALIFORNIA, INC.

a. EMSA Report (Dr. Duncan)

i. COVID update

1. State – Current 0.74 R effective. Lowest 0.7 recently
2. At peak 1.4 R effective in some areas
3. Continuing to trend down in test positivity 1.8%
4. Has been as high as 15-20% in Dec/late Jan
5. Variants
    a. Wreaking havoc in Europe and Brazil
    b. Likely UK variant is the most transmissible
    c. Have seen South African and Brazilian variants in California
    d. Suspect variants will cause fourth surge

ii. Vaccination:

1. 16 million doses in California
2. 8.2 million with one dose
3. Total people 4.1 million with both doses

4. Tiers
    a. Many counties are getting out of purple tier
5. EMSA
    a. ACS/surge hospitals
        i. All in warm status
        ii. Some are still doing monoclonal antibody infusion
    b. EMSA Supported Staffing for COVID
        i. Currently 50% of what was being staffed at peak
        ii. Stretching out current staffing to allow for potential resurge
    c. Community paramedicine - AB 1544

i. Instituted advisory group

1. Have had two meetings, occurring every two weeks.

ii. Goal for most medics in California to have ability (not requirement) to practice as community paramedics with training

iii. CMS during this emergency/disaster will allow paramedics to bill for treat and release

iv. Reza interested in continued work group for CP/Alternative destination with many areas attempting to complete ET3

v. Sporer. There are multiple comments on ET3 - 1. Dispatch redirection- needs no new changes. 2. Assess and Refer with telemedicine. Needs no new regulation. 3. Alternate Destinations- needs new regulation or law. Applications require that you have an alternate destination not that you have to use them. The hardest part will be getting the other payers to take part in this endeavor.

d. Chapter 13 Workgroup

i. Reinstituted

ii. Break for last COVID surge

iii. 3/11/2021 restarted work group

1. Made through remainder of comments pending

iv. No timeline for when to submit to public comment

e. Reminder that the 2020 EMS Awards are to be completed by March 31, 2021

f. Reminder for EMS memorial bike ride: https://nemsmbr.org/rides/virtual/

g. Reminder for Legislative Report: https://emsa.ca.gov/legislative_activity/

6. National Pediatric Readiness Assessment beginning May 1 (Dr. Gausche-Hill)

a. Last assessment was in 2012

i. 83% of hospitals responded to survey

b. Hospitals that are NPRA ready have 4 times lower mortality for pediatrics

i. Regardless of pediatric volumes

c. Submit to pedsready.org between May 1, 2021 and July 31, 2021.

i. Only one submission per hospital.

d. Important for LEMSAs to know which hospitals have responded

e. Reach out to Dr. Gausche-Hill for questions

7. Travis Kusman with EMSAAC

a. 2nd-3rd June – EMSAAC Conference to occur this year

8. Nicole Bosson

a. Stroke and STEMI Summit

i. June 8th and 9th, 2021

EMDAC Meeting Restarted

9. Restarted discussion of IT

a. Based on overall discussion

i. Will hire new IT person to maintain current website

ii. Motion – Ghilarducci. Second – AJ.

iii. None opposed. Motion passed.

10. EMS Commission (Dr. Miller)

a. Working group on Community paramedicine meeting shortly

i. Working on step by step through legislation out there

ii. Plan for one level for education and certification for CPs

iii. Another level for education and certification for alternative destination paramedics

b. Will need another nomination on Wednesday due to current chairman coming up on third potential appointment

11. EMS-C (Donofrio-Odmann)

a. To get SGA f/up

i. Will f/up with EMDAC listserv separately

b. Pediatric respiratory distress and seizures

i. Working group getting together to look at benchmarks

12. CalACEP (Gulati)

a. Undergoing legislative review cycle

b. Statewide COVID numbers reporting downtrending

c. Vaccination of many members

d. Work force and psychiatric health are main foci of this year

e. 1 out of 2 residents is having difficulty securing spot

f. Bills that CalACEP is co-sponsoring:

i. Psychiatric transfers/emtala

ii. Downcoding

1200: Break

13. Bylaws Presentation (Dr. Gausche-Hill)

a. Bylaws discussion and vote on bylaws (if agreement to do so)

i. Defines membership

ii. Comment brought up by Dan Shepherd on differentiation of paying or non-paying members

1. Associates = must be physicians

2. Liaisons previously were allowed as non paying members

3. Could potentially continue to allow this

a. They should pay for their lunch

4. Reza – Liaisons are excellent additions

a. Proposed:

i. Invite only for liaisons

ii. Limit on number

5. Rosen – consider we already have many non-physicians, and changing this may be detrimental
6. Miller – transparency is important, and maintaining non-physician attendance is likely also important
7. Ghilarducci – would recommend group to discuss this separately, rather than try to nuance the bylaws.
8. Kazan – would vote for associate members to be physicians. Would recommend especially since this is the "EMS Medical Directors Association" would recommend keeping to physicians only
9. Roderick – thinks it is important for associate members to be allowed to continue

iii. Gausche-Hill update on bylaws continued:

1. Proposed change - limit two official members per LEMSA
2. Kazan – would argue 1 LEMSA, 1 vote due to the fact that the associate members would be outweighed potentially by 66 other votes (33 LEMSAs, 2 votes each)
3. Miller – it is important to nail this down as when votes occur, they are very important.

iv. Gausche-Hill: this will best be served by a vote. The question as posed in the Zoom chat: "The bylaws should remain as is, 2 votes per LEMSA."

1. Yes vote – support up to two votes
2. No vote – only supports one vote per LEMSA
3. Pending official numbers from Gausche-Hill ***

v. One vote per LEMSA was decided. Those that did not assign a proxy, would have more than one vote potentially with those directors that have multiple LEMSAs. Potentially those that are medical directors for different LEMSAs could vote differently for each LEMSA.

b. Gausche-Hill bylaws updates continued:

i. EMS Fellows are included to participate as members

ii. Board discretion language added to allow for things not considered in the bylaws

iii. Membership fees to be decided by the BOD

iv. Hybrid or virtual meetings included

v. Telegraph option for communication removed

vi. A proxy position is included and explained

1. You must be a member to vote. You do not need to be active. They could be associate.

vii. Availability of virtual meeting – language updated

viii. Directors on the board

1. Changed from 7 > 9 members
2. Allow Secretary to be active or associate member
3. Minimum 6 active members, maximum 7 active members
4. Max 3 associate members, guaranteed 2 on the board
5. Former pathway to presidency was ascendancy from secretary
    a. There is no longer ascendancy from secretary
        i. This is to allow associate members to be secretary
    b. It is now president elect > president > past president
6. Associate members would nominate and elect the two seats on the board for associate members
7. The secretary would be nominated by the nominating committee which is made of active members only, but the secretary position can include active or associate members nominees.

ix. Removal of board members

1. Section added
2. Cause is included per attorney recommendation

x. Scope committee:

1. Includes active and associate members

xi. Legislative committee:

1. Includes active members only

xii. Medical Advisory Committee:

1. Will include active and associate members

xiii. Updated secretary position to have multiple years potentially in role

xiv. Treasurer position remains the same to potentially have multiple years in role

xv. Vacancies

1. Temporary leave of absences are not addressed by the vacancy. Vacancy is only if long-term cannot fulfill duties.

c. Liability policy (Dr. Lyon)

i. Advantage for purchasing policy is if EMDAC or members get sued

ii. Likely scope and legislative is the highest risk

iii. Thomas James (EMS policy salesman) two options –

1. Would create an EMS policy that would cover the entirety of EMDAC
    a. Would cover officers and directors specifically – the committee parts
    b. $6400/year
2. If you already have policy with this company, just add EMDAC

iv. Discussion:

1. There is not necessarily reason to get med mal and that increases costs unnecessarily
2. EMDAC has shallow pockets and would not necessarily be the target for a suit and maybe we don't need this policy
3. Others feel strongly that we can get sued and should get the protection based on previous suits from organizations frequently interacted with

d. Discussed new positions and committees created by new bylaws

i. Ultimate decision made to allow updated copy of bylaws to be distributed, read and reprocessed before voting

1300: Break (5 minutes)

14. Treat and Release Policy (Dr. Staats)

a. History – Assess and Refer or Treat and Release policies have been used for a long time in California by several systems

b. With the first surge of COVID in 2020, several systems developed new policies to address limited resources

c. High variability between policies

d. Some policies used COVID specific policies

e. Some listed triggers

f. Some vital signs listed, some did not

g. Requested review from CalACEP

h. Task Force begun with EMDAC for guidance document

i. Task Force begun with CalACEP for feedback

j. EMDAC Task Force provided feedback for guidance document that was sent out during last COVID surge for COVID specific Assess and Refer document

k. This COVID specific guidance document is currently under review by CalACEP Task Force

l. Discussion – what would be the ultimate outcome of this feedback from CalACEP? It is important we are not establishing a precedent for perceived "permission" from this group

i. A: the goal would be a final document would be a guideline (not required for LEMSAs) to use for future Assess and Refer policies. It would also serve as evidence of shared efforts between two organizations with a shared interest of collaboration and promote future collaborative efforts between the two groups.

15. Legislative Update (Dr. Staats)

a. AB1234/Arambula is requesting support from EMDAC/chest seals

i. Discussion – is this bill needed? Aren't the stop the bleed campaign kits out there already?

ii. Sporer – This doesn't appear harmful. And potentially this could aid in political capital in the future

iii. Koenig - We don't want to "just ignore it" as we think the chest seal is dangerous in the hands of lay persons

iv. Gausche-Hill - I agree remove chest seals - I just feel this bill is not necessary and has cost. we can comment but not endorse it

v. Kazan - I am not too afraid of the cost of the kits sans the chest seals. There's competition in the market for tourniquets and in the hemostatic gauze. Truly, it would be a very good idea to have more AEDs and likely, at least, some tourniquets with every AED. Definitely seen someone bleed to death, never seen someone lose a limb from an inappropriate tourniquet.

vi. Freeman – overall we will get more information before endorsing.

b. AB 805:

i. **This bill would require, during a health-related state of emergency in California proclaimed by the President of the United States or by the Governor, the MHOAC to report specified information relating to the**

distribution of personal protective equipment, as defined, to the Office of Emergency Services on a weekly basis. The bill would require, at all other times, the MHOAC to report that information on a monthly basis. The bill would require the medical and health disaster plan to include this reporting, as specified. By creating new duties for MHOACs, the bill would impose a state-mandated local program.

ii. The bill would require the Office of Emergency Services to publicly post and update the above information on its internet website according to the same timeframes.

iii. Overall likely unnecessary use of time.

iv. EMSAAC reps meeting with CHEAC. F/up pending.

c. AB 909/Steinorth/ POLST bill:

i. This **bill would define "trauma kit" to mean a first aid response kit that contains specified items, including, among other things, at least 2 tourniquets. The bill would require a person or entity that supplies a trauma kit to provide the person or entity that acquires the trauma kit with all information governing the use, installation, operation, training, and maintenance of the trauma kit.** The bill would apply the provisions governing civil liability described above to a lay rescuer or person who renders emergency care or treatment by the use of a trauma kit and to a person or entity that provides training in the use of a trauma kit to provide emergency medical treatment, or certifies certain persons in the use of a trauma kit.

ii. Joint statement from EMSAAC/EMDAC:

iii. "We respectfully request that the following language be removed from Section 1714.27: *"(3) Four chest seals that are inspected for replacement no less than every three years*".

iv. Based on EMDAC's review of current medical literature, chest seals' use and application should be reserved for trained medical responders."

v. Our support of the bill with an amendment requested and by EMSAAC (joint EMDAC/EMSAAC letter pending)

vi. Goldman – funding may be a challenge. Hesitate to join on with this.

vii. Freeman – will need more information before endorsing

d. AB 1229. Spot bill

i. The Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act establishes the Emergency Medical Services Authority. The act requires the authority, among other things, to assess existing emergency medical services for the purpose of determining the need for additional emergency medical services, coordination of emergency medical services, and the effectiveness of emergency medical services.

ii. **This bill would require the director to establish the Ambulance Patient Offload Delays Task Force, as an advisory body to the authority, for the purpose of addressing the chronic challenges encountered by local emergency medical services systems in achieving established ambulance patient offload time interval standards.**

iii. This bill would declare that it is to take effect immediately as an urgency statute.

iv. Current plan is to watch. This bill will likely be updated.

e. AB 862 –

i. Medi-Cal: Emergency Medical Transportation Services

ii. The bill would redefine "emergency medical transport provider" to mean any provider of emergency medical transports, except during the entirety of any Medi-Cal managed care rating period for which the program is implemented, in whole or in part, that excludes any public provider of emergency medical transports, including any provider who meets prescribed requirements. With respect to the quality assurance fee, commencing in the 2022–23 state fiscal year, and for each state fiscal year

thereafter, the bill would require the Director of Health Care Services to comply with specified requirements, including calculating the annual quality assurance fee applicable to a specified program period at least 150 days before the start of the state fiscal year, and would make conforming changes. The bill would delete the above-specified limitation on the provision relating to Medi-Cal managed care health plans and their obligation to provide emergency medical transports and payment to noncontract providers.

iii. **Overall appears to increase reimbursement for EMS. Watch.**

f. AB 389. Ambulance contracting

i. This **bill would authorize a county to contract for emergency ambulance services with a fire protection district that is governed by the county's board of supervisors and provides those services, in whole or in part, through a written subcontract with a private ambulance service. The bill would authorize a fire protection district to enter into a written subcontract with a private ambulance service for these purposes.**

ii. Main goal is to provide input and oversight for contracting emergency ambulance services.

iii. The authors will be interested in speaking further with EMDAC and EMSAAC when Chapter 13 is completed.

16. Chapter 13 update (Dr. Sporer, Dr. Shepherd)

a. Sporer – updated on process. Currently pending EMSA's final document after gathering feedback from all voluntarily participating parties.

b. Discussion – medical oversight, challenges for RFPs, transport contractors all topics

17. Opioid Pilot Update for Contra Costa (Dr. Hern)

a. Rates of death from opiate overdose increased in 2020, less from prescription drugs

i. Great success with using buprenorphine

b. California Opiate Paramedic Education (COPE)

i. Three different modules

ii. Free CME

18. Patient elopement during psych transfers (Dr. Salvucci)

a. No updates this time

19. Interest in continuing Initiatives to keep following end of disaster declaration

a. Vaccination

b. Ability of providers to work in designated field sites

c. Ability of Local EMS jurisdictions to go to those sites

d. Protocols for Assess and Refer

e. Sampling for COVID-18 testing

f. Discussion –

i. What is the best way forward? Legislation? EMSA? Regulations? Move things from scope to accepted practice through Scope?

ii. John Brown volunteered to lead this charge.

iii. Opportunity to partner with our fire colleagues.

20. Roundtable

a. LA county (Bosson) – doing ECMO pilot

i. OHCA focus on education this year

ii. Focus on mental health disorders

1. Will expand to include olanzapine

2. Will attempt to include PD with planning for these emergencies

iii. Assess, Treat and Release policy updated and will be shared

1. Goes to commission tomorrow

b. Marin (Ballard) –

i. COVID robust response

   ii. Submitted EMS-C application

c. SF (Brown) –

   i. Looking at centralized dispatch system – will likely result in some write-ups

   ii. 2 of 6 crisis response teams active currently.

   iii. EMS Agency is moving to department of emergency management and also moving physically

d. Duncan (EMS Agency)

   i. Local optional scope for vaccination may be limited for vaccination

e. Tuolumne & El Dorado (Freeman)

   i. Continuing with COVID response

f. San Mateo (Gilbert)

   i. Looking forward to mobile stroke unit report tomorrow

   ii. New CAD system

   iii. New base hospital is Stanford and has been working well with one base

   iv. Began ECMO program

   v. Working on video laryngoscopy trial - have been using Vividtrach, now trialing AirTrach

Ross Fay – California Association of Aeromedical Services

21. Is available for any EMDAC questions.

Senai Kidane – Contra Costa

22. Successful use of EMTs/Paramedics for vaccination efforts
23. EOA contract including largest fire department, subcontracts with AMR, selected as ET3 site
24. Represents EMS as part of a large group of stakeholders on mental health crisis, looking at ways to decrease LE involvement, and developing alternate MH and detox programs and hoping EMS can participate in alt destination program
25. Looking at mental health emergency management, considering increasing midazolam to 10mg

Jeff Kepple – Nor Cal

26. Last year biggest focus has been what we can do to support the counties and agencies, including continuing education. Have revamped the website, revised policies/procedures, combined BLS/ALS, made them more accessible. Starting virtual quarterly CE. May approach EMDAC members about guest speaking, if anyone is interested please reach out.

Ken Miller – Santa Clara

27. Also many changes in behavioral health management. Meeting regularly with DMH.
28. Ebola Virus – initiated a plan with DPH to notify EMS if a patient screens positive coming into California
29. COVID – continuing current protocols through May and then reassess. There have been 20 weeks between peaks thus far, so that is the May target.
30. Stepping into EMS for Children, readdressing peds assessment and then will look at triage/destination.

Karl Sporer – Alameda

31. Started CAT team to transport psychiatric patients, dedicated unit, have 4 units 10 hours a day, working towards 10 units 16 hours per day by the end of the year. Integrated into the 911 system.
32. Applying for Ketamine
33. Looking at palliative care, planning to implement protocols this fall
34. Looking at prehospital impact of rapid EEG, feasibility study, evaluating status epilepticus
35. Working on HIEs with ESO, within a few months expect to have first hospital online, two year process

Carl Schultz – Orange County

36. Put up several mobile field hospitals to support multiple facilities, set up 4, worked very well
37. Still vaccinating people using the EMS division personnel at a high school
38. Ambulance Ordinance is engendering a lot of pushback, feels it is benign, but working through people's concerns, want to update it since it has not been for 30 years

Brett Rosen – Cal Fire

39. Would be in favor of moving much of LOSOP to Basic Scope. One concern could be different devices in different LEMSAs being a challenge for providers working across multiple LEMSAs, which could increase AEs. It would help to make things as uniform as possible.
40. Cal Fire has a lot of people in Alameda and LA to support vaccination sites.
41. Working towards an ePCR, should happen shortly, will let LEMSA MDs know when it impacts their area

42. Has lots of personnel vaccinating at the Alameda and LA sites. Very supportive of moving local optional scope to basic scope but wants to have uniformity as will be very difficult to have personnel trained in multiple devices (i.e. SGAs). Low use of each will lead to more errors. ePCR coming imminently.

Dan Shepherd – Santa Barbara and Ventura

43. Implementing triage for LVO in Santa Barbara
44. Just finished EMS Update virtual format
45. Ventura implemented Handtevy in November, too early for data but feedback has been positive
46. Implemented iGel
47. Looking at education platform
48. Santa Barbara crafting RFP

Reza Vaesazizi – San Bernadino, ICEMA

49. Launched telemedicine project in dispatch
50. Loma Linda has been approved for an EMS fellow, integrated into EMS Agency
51. San Bernadino working with Arrowhead re portable US pilot in EMS
52. Currently have 4 trauma centers, do not see a need for more but there are some interested hospitals - assessing accommodating interested hospitals to join as level 4 trauma centers
    a. Ken Miller queried how level 4s would be used in the system?
    b. Reza said not clear yet, but the same group of physicians is staffing the TC and the level 4 hospital. May define what cannot go to level 4 rather than what can go.
    c. Karl Sporer – Doing same thing in Alameda. Have hired a consultant to explore.
    d. Reza – May be opportunity for collaboration. Level 4 would include ED, helipad, some basic surgery capabilities.

Adjourn at 1430