March 17, 2020

Call to order 9:05
Introductions skipped given logistics of remote call.
December minutes approved (Goldman, Staats)

Reports and Updates

Legislative Report – Staats

- AB 1544: Community Paramedicine or Triage to Alternate Destination
    - EMSAAC/EMDAC Opposed
    - Bill has made it through both houses, likely to move forward, expect veto
- AB3114: EMS Provider Reporting
    - Work in progress, still in first house
    - Authors have contacted EMSAAC and EMDAC for input
    - No current position
    - Do not believe it is necessary, asks for info on wages and working conditions that are already being reported, and would create more work – likely will oppose if take position
- AB2300: California Youth Football Act
    - Watching with caution
- AB2447, AB3203, SB1443
    - Watching with caution, making changes to EMS Act that we do not agree with but nothing to openly oppose
- Cal Chiefs vs EMSA 3/12/20
    - Cal Chiefs: Regulations are void and unenforceable, ordering EMSA to stop
    - EMSA: moot point, since these were already stopped
- Annual Legislative Conference currently still on by likely to be cancelled
- California ACEP, board voting is May 15-31st –Staats is running
- Staats will send copy of ppt to the list serve

EMSA Report – Duncan

- Maintaining workforce
    - Emergency regulations are being developed to improve paramedic licensure
        - With respect to training, normally allow 10 of 40 contacts to by high-fidelity sim, want to increase to possibly 20
        - Not changing clinical requirements but allow seeking clinical experience from other areas, allow flexibility
        - Still need review by EMS Commission
        - Goal is to continue to get new paramedics licensed
        - EMSA going to extend expirations for paramedic licensure

            - Possibly a set extended date or a 2-month extension, to be determined
        - The changes will be temporary for this emergency
    - EMT cert extensions are supported, best served by the LEMSAs
        - EMSA will provide guidance regarding maintaining cadre of EMTs
    - Governor's order
        - Prehospital personnel can continue to practice after exposure if they are asymptomatic and self-monitor
        - EMSA will disseminate guidance to support LEMSAs
        - CDPH came out with guidance re Low-Medium risk exposures can work. Governor's order left open to return to work if asymptomatic.
        - Kazan via chat: "For our folks with a high risk exposure, if the patient is being tested for COVID, per CDC, they can continue to work for 48-72 hours while awaiting source patient results. We are NOT requiring them to wear surgical masks during the 48 hour window, since the incubation is 2-9 days. We are requiring them to be in active monitoring. This will help preserve some PPE"
    - Discussion re supplies
        - Gowns and surgical masks are issue.
        - Goldman: Gowns do not have expiration dates. If you are running out of surgical masks, are you using isolation masks - PPE say are better.
    - There will be guidance on expansion of workforce out today, credentialing for out-of-state licensing
    - Surge ability in the hospital environment
        - Concern is staffing. Will put together a stationary care optional scope for EMTs and Paramedics – to allow them to work in a stationary setting during the disaster declaration
    - Use of MDIs and spacers
        - Equivalent to nebs if you have a spacer, MDIs alone fairly useless
        - EMSA will create optional scope application template to support
        - Does already exist in fire line medic policy, but that may not apply to all or contain spacer
    - EMS Fellows
        - If any interested in supporting EMSA and getting involved in policy development - Contact Dave Duncan
    - COVID testing and swabbing
        - Possible scope expansion to allow paramedics to test. Not a lot of support at EMSA for this, valuable to LEMSA?
            - Koenig: Best to have it in place.
            - Rudnick: Some places do not have enough staff, want to use Paramedics and EMTs to assist with drive by testing.
        - M-G: Raised issue of getting paramedics tested, this has been an issue.
            - CDPH is working on options.

- Return to work plan without testing can be very long, until fully asymptomatic.
- Goldman: Similar experience, being told that a negative test in an asymptomatic patient is not reassuring (hasn't seen data).
- Schlesinger: Would like something from the state and local that requests to hospitals that they consider including first responders in the high risk priority for testing. Having trouble with hospital.
- Koenig: Support that but work with CDPH because they were tasked with that on the call today.
- Kazan: "For us...we are monitoring our folks out sick carefully...first step will be to reducing apparatus staffing (4 to 3/engine), then change response matrix before we consider letting people work sick. DPH testing 72 hour turnaround, QUEST/Labcorp is 5 days"

        - M-G: Noted that the issue is who is going to do the collection. Any physician can do the order. Need swabs and media, need to store that. This is a rate limiting step. Need to establish that relationship with LabCore. It takes 4 days to get result.
    - Kazan: Pearson Vue has shut down testing center, so paramedics cannot get their NREMT test complete.
        - Need to reach out to National Registry re options for provisional status.
    - Koenig: What about federal DMAT EMT/paramedics treat in local jurisdictions without local accred?
        - Duncan: Goal is to get the providers at the level we need, similar to credentialing of out-of-state licenses, consider mutual aid scenario, get them in early. Out of state licensing guidance will come out today.

Trauma Center Workgroup Update – Ghilarducci

- EMSA guidance is TC for each 350,000 persons
- Should this stay in place?
- Some LEMSAs have issue of over proliferation of TCs
- The group had no comments.

Treasurer's Report – Shepherd

- Report displayed via Zoom
- Received $29970.74, current balance given no meeting in person this month
- Outstanding $8800 dues – will email individually
- Ghilarducci – our expenses will be lower this year, maybe we can reduce the dues
- Lyon – the IRS has given us our tax exempt status back, pending hearing from state. Caught up on tax returns, 2019 already filed.

EMS Commission Report – Miller (provided during round-table due to audio issue)

- Chapter 13 will be an important topic for June
- Will discuss Buprenorphine study

Discussion Topics

1)COVID

Aerosolizing procedures

- Staats: Curious about guidance on aerosolizing procedures. One hospital in area has banned BiPAP. Might be ok with PPE? There is a lot of hospital guidance from Wuhan and Italy, what about prehospital experience?
    - Gilbert: Check with hospitals because some asking for it to be taken off before going into the hospital.
- Rudnick: What are implications for HEMS – hard to fly helicopter in full PEE? But BiPAP/ CPAP can prevent intubation.
    - M-G: What about decon? Intubation may be most appropriate.
    - Ghilarducci: Air crews tend to lean towards intubation anyway. Don't want to intubate in the air.
    - Uner: There are guidelines to decon. The pilots where same PPE, they can fly with N95. True that do not want to intubate in flight. If we run out of ventilators, this will get more complicated.
    - Goldman: In support of continuing CPAP in select cases in the field – is ventilating via ETT any less aerosolizing.
        - Rudnick: Our crews have filters.
    - Bosson: Anyone looked into filters?
        - Vaezazizi: Would need supply chain for filters since do not always come with bag.

Cardiac arrest resuscitation

- Lyon: Need guidance on triage for treatment in severely ill patients. Patients with COVID, if have cardiac arrest – too high risk. Not yet recommending no resuscitation in field if have symptoms .
- Ghilarducci: This is different from Ebola given the mortality risk for the exposed provider.
- Koenig: There is also force protection as well.
- Garzon: Response to Ebola was very different because people were infectious at end of their illness
- Lyon: If we end up in a situation where healthcare system fails, there will be no resources to care for cardiac arrest.
- Koenig: Some international colleagues have also suggested no role for ECMO. There is ECMO being done currently.
- M-G: We need to track the cases so that we know what phase we are in.

Predicting cases/impact

- Data from Hopkins Confirmed COVID19 Cases shared by Ghilarducci
- Used data to model Santa Cruz, going to run out of ventilators very quickly
- Website http://penn-chime.phl.io

Limiting exposures to crews and judicious use of PPE

- Gilbert: What about lack of gowns? Was having them launder between calls, too burdensome
- Ghilarducci: Main strategies are wiping down jacket, limiting number of providers that come in contact
- Yolo: Sent guidance to maintain 6 foot distance of first in crews, and forgo physical assessment until ALS until arrives for most patients
- Ghilarducci: Going to run an assessment unit to assess and refer. Would be good to develop a best practices
- Gilbert: How do you feel about having people on scene for a long time without vitals?
- Rosen: Most of our folks are EMTs, could hand patient pulse ox and get HR also. It would be helpful to know the ALS eta. Most of the BLS maneuvers do not apply.
- Ghilarducci: Suggested having ambulatory patients come out of house, to reduce exposure to fomites.
- Ajinder: Good also to maintain the 6 ft distance as you assess for need for PPE.
- Goldman: Are there protocols for PPE stewardship, instead of discarding after each use. As crews are seeing multiple patients per day.
- Rose: The CDC has this, there are approved ways to extend. Have implemented at Yolo.
- Hecht via chat: Has anyone considered the combination of surgical mask and reusable/ cleanable full face shield for patients?
    - Unclear if they are reusable, given foam lining
    - Suggestion for reusable P100, have a latex mesh that holds them in position
- Malmud: Any issues with policies for no contact until ambulance arrives.
    - Shafer: From Italy patients not profoundly dyspneic until sats are very low, could have false sense of security.
    - G-H: One provider goes in with PPE for assessment.
        - Same in San Mateo
    - Rosen: Directing to use local guidance at this point. Need adequate supply in order for one person to don PPE, mask the patient and do assessment. Is COVID an ALS process? Majority of what we are doing is trying to limit interventions to the hospital.
    - Discussion of sending initial provider in for assessment, can we limit use of PPE.
    - Gilbert: Likes Dave's suggestion of asking patient to come outside
    - Donofrio: Seattle is doing one provider in for screening. Agree with need to retake history, because chief complaint can be unrelated but then could also have fever/ cough… What about issue of limited gowns?

**Staats will set up Google Drive to help share policies.

2) Epinephrine draw up for EMTs - Rosen

- Looking for agreement between LEMSA Medical Directors to allow a standardized training program for draw up epinephrine so can train all EMTs statewide, since EMTs move between LEMSA. Not looking for decision now, table until after COVID.
- Lyon: Doing draw up epi
- Ghilarducci: Using half syringe for kids with standardized dosing. (Rudnick similar) There are issues of cost and how long they take to expire.
- Discussion of Certa Dose.
- Rosen: What is the plan to move forward? Want to be collaborative to share training docs and ensure it is happening safely.
- Ghilarducci: There are administrative tasks, need to accred EMTs locally to do this. Otherwise, can determine a plan for universal training.
- M-G: I like the epi right option, ensures more safety for the EMT. Our Innovations and Technology Committee reviewed the Certa Dose and we felt that it could be adopted in our county.
- Ghilarducci: What is the risk if you give too much epi to the kid? Worst is double dose.
- M-G: Given situation, relatively low.
- Plan is to revisit at June meeting

3) Unified Scope of Practice for HEMS Data Tool – Uner

- Reviewed proposed data collection tool, more extensive than initial contract ask
- Only 2 peds intubations
- Adult intubations data reviewed
    - Looking at complications and improvements
    - Operators
    - Have CA after intubation, probably reflection of sick patient not due to procedure
    - Also had hypoxia events after intubation, limited to patients not hypoxic prior
- Wants to know is this useful?
- M-G: Would be good to have reporting function, with totals.
- Uner: Clarifies only use VL, all video is reviewed
- Ghilarducci: A control chart would be helpful to see normal variation
- Group discussed that it would be good to have the global view in addition to granular data. This is also a model for how we can do this. Can come up with composite outcomes that the group in interested in.
- SGA data reviewed
- Discussion of CMAC and Glidescope use

4)Pediatric Readiness – M-G

- Presented information on Pediatric Readiness, takes 30-60 minutes to complete
- Any barriers? May not have capacity right now.

- Group discussed delaying it.

Staats: Two resources have been created, a Google Doc to share articles and summation websites and then a Dropbox where policies and procedures can be shared. Please email Kathy Staats if you do not receive an invite in the next couple hours.

Round-Table

Drive through testing
- Stanford has drive through testing. Will share plans via Dropbox.
- Expect a lot of use once widespread testing available.
- Data for Korea suggests people will stay at home.
- Kaiser doing all ordering by phone, getting drive through testing up.
- Tamkin: consider difference between expedited triage, and separation of respiratory patient vs drive through testing. Testing worried well can be done by medical assistant. If counties want to do for epi purposes.
- In San Mateo – set up at the expo center, just testing. Alternate is can do it as a quick medical screening exam – either intake or swab and send.

Discussion of using less PPE on patients without aerosolizing procedures
- Rec comes from CDC: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-for-ems.html
- Goldman will share Kaiser PPE stewardship doc

EMS resources
- Ghilarducci: looking at non-dispatch of Alpha calls, not there yet.
- Gene: Mechanism for refusal of transport for non-ill?
- M-G: Concern about liability. Not there yet.
- Gene: What would it take to enact this if needed?
- Gilbert: Feel this falls under declaration of emergency. If reach 'red' stop responding to Alpha, if 'black' stop responding to Bravo calls.
- Ghilarducci: Suggests establishing threshold and plan ahead of time.

Contra Costa working towards opioid intervention - Hern
- Seamless, integration with public health, designated opioid receiving center
- Going on line April first
- Buprenorphine trial study documents are submitted to Dave at EMSA
- Review of protocols was tabled for June
- EMSA has authority to approval trial study but want EMDACs input on protocols

Movement to MDI/Spacer
- Goldman: Anyone moving already to MDIs?

- Staats: AMR has purchased many MDIs, anticipating in Imperial moving away from nebs
- Farah: San Diego is moving in that direction, Chula Vista has purchased
- Malmud: Duncan mentioned need for local optional scope approval? Group agreed it is another route, should fall in scope, fire line medics already have. Need to clarify.
- Lyon: Clarified with Duncan, OK with using MDI as part of scope, will create template if people want to use it

EMS Personnel doffing PPE and transferring care in ambulance bay, not enter in PPE – Goldman
- Is that working?
- Gilbert: Working well in San Mateo

Language for potential patients in field - Gilbert
- Should we use 'EMS screen positive' because 'PUI' has definition and 'COVID positive' ?
- Greg plans to discuss at upcoming local meeting

San Francisco Update - Brown
Public Health Nurses going out for in field testing
- 8-10 calls per day for service
- Otherwise augmenting EMS system when first responders arrive and patient is stable with respiratory sx, can call for this vehicle
- Helping to minimize PPE usage

One person care provider
MDIs for mild/moderate respiratory disease protocol in development
- Supply is supposedly reasonable
- Or will use RDMHC supply
- Advised that need to leave MDI with the facility rather than patient on arrival

Working on surge plans
- Including alternate transportation methods, e.g., van vehicles
- Alternate sites as well

Multi-casualty ambulance buses for version of drive through testing
- Many SF residents do not drive
- Will be walk through testing
- Appropriate social distancing

Question for group – anyone involved in training, have any alternates for dispatch and ride-along experiences for residents?

Lyon: Received query re possibility of setting up an APRU with paramedics and PA, to go to known COVID patients and assess how they are progressing, to decrease 911 calls and provide reassurance
- M-G: generally get heads up from DPH

Santa Clara – Miller
- No changes in treatment protocols

- Tracking ILI
- 911 caller interrogation, those are becoming less and less valuable
- Advising hospitals in advance for handoff
- Ghilarducci: Any issues with staffing? – Yes 10% of one provider agency off due to exposure, change in CDC recs really helped. – Important to message providers re return to work policies.

Tuolumne – Freeman
- Seen decline in patients to ED
- Without timely access to testing
- No confirmed cases in county

Imperial – Staats
- If border with Mexico closes, we will lose providers who live there and commute
- Anyone have this issue, looking for guidance
- More of an issue for hospitals than providers
- Plan to have tents for screening but if not enough staff cannot implement

San Joaquin - Shafer
- Finding hesitance to test from public health, trying to find options for provider testing
- Initially had resistance to PPE from providers but now they want all patients screened, when this may not be needed. Looking for guidance.
- Lyon: Issue is testing capacity, long turnaround times. Since cannot test, do not know how much you have in your community
- Rudnick: From China experience, estimate 10 patients in community for every confirmed COVID patient
- Gilbert: Can also look at the number in ICU, deaths, and calculate back to estimate total. Advocates for working with public health officer to get more people screened.
- Lyon: Emphasized issue is that they do not have the test. Do not need PUI number if testing through Quest.
- Shafer: Utilizing guidance for return to work without testing, but challenge is getting healthcare workers back. Though ED volume has gone down.

Mackey
- Working on developing process for mass decon of PPE, will share once developed
    - Developing conex boxes with rack systems for mass decontamination 2-300 sets of PPE at a time.
    - Goal is issuing PPE as sets and decon, reuse - as long as it doesn't fall into CDC 'do not reuse'
- Pearson Vue has closed centers, was on conference call with National Registry
    - How can we continue to move competent providers into the system?
    - Some options that are being explored:
        - Relaxing psychomotor evaluation – pass rate almost 100%

        - Giving provisional licensing after cognitive test
        - Providing own proctors for testing
    - Discussion that critical thinking is most important, more than procedural skills