EMS MEDICAL DIRECTORS' ASSOCIATION OF CALIFORNIA, INC.

June 15, 2021

EMDAC

SCOPE OF PRACTICE

CALL TO ORDER 8:35 KEN MILLER

1. UNIFIED SCOPE OF PRACTICE HEMS, MONTEREY AND SAN LUIS OBISPO
   A. No deviations from Unified Scope in applications
   B. Approved – Freeman, Uner

2. CONTRA COSTA TXA
   A. Atilla Uner - Clarify contraindications
   B. Nichole Bosson - Clarify exclusion of controlled extremity hemorrhage, other approved protocols have focused on uncontrolled truncal hemorrhage with shock.
   C. Senai Kidane – will clarify in protocols
   D. Approved with above changes – Freeman, Uner

3. MONTEREY TXA
   A. Atilla Uner – Clarify age
      i. Went with 16 and older due to Crash study data
   B. Nichole Bosson – Consider 'OR' between CI of controlled extremity hemorrhage and likely reimplantation, since controlled extremity hemorrhage would not be indication for TXA w/w/o reimplantation

C. Approved – Freeman, Brown

4. SSV RENEWAL OF TXA
   A. Troy Falck - had submitted for TXA renewal, this was not in the Scope Committee packet for review. Change to add Base Contact.
   B. Atilla Uner – Concerned about approval without review.
   C. Group agreed to review prior to approval, sent by email and then further discussed.
   D. John Brown – How will the Base direct the medic on administering TXA
      i. Troy Falck - QI processes showed some noncompliance with the protocol primarily significant blood loss without hypotension and not trying other measures first. Did re-education but still had some protocol violations. Added Base Contact for guidance and compliance went up to 90%. Base MICNs and physicians were OK with this.
      ii. John Brown – Clarified that this is an additional QI step to confirm criteria met. Do you have direct contact with providers and physician? Or is this via MICN?
         1. Troy – usually MICNs
      iii. Atilla Uner – How does this fit in with the study in California demonstrating paramedics could administer safely? Concerned about making exceptions, based on trauma center/ trauma surgeon individual requirements
         1. Troy – Acknowledged political challenges
      iv. Kim Freeman – Experiencing similar pushback and understands political pressure. In rural counties, do have communication challenge caveat.
      v. Dave Duncan – One of the reasons this is still LOSOP, need a bit more data to convince some of the trauma community
      vi. Ken Miller – Any concerns about age related increase in BP threshold? (For 65 and older threshold for BP is 100)
      vii. Approved – Brown, Freeman

5. ALAMEDA KETAMINE
   A. Nichole - max dose for IV/IO – clarify that it is 30mg per dose?
      i. Karl Sporer – will clarify

B. Discussed dosing by route

i. Nichole Bosson - Prior decision was 0.3mg/kg IV/IO/IM vs 0.5mg IN when ketamine was first approved, but this could be changed based on current experience?

ii. Kristi Koenig - Limited evidence on IN dosing, got dose from military colleagues

iii. John Brown – Would be good to standardize across systems, there are paramedics that work across systems

iv. Karl Sporer – agrees with standardization, 0.3mg IV/IO/IM, 0.5mg IN

v. Approved with that modification – Brown/Uner

6. MONTEREY

A. John Beuerle – Explained rationale for not including IN route, concerned about repeat dosing with incomplete absorption

B. Atilla Uner – suggest clarifying the age contraindications

i. John Beuerle – this was recognized and corrected, will be 9 and older throughout the protocol

C. Approved – Rudnick/Brown

7. MERCY AIR UNIFIED SCOPE PRESENTATION – CHRISTIAN SLOANE

A. Airway management data presented for 2021

i. No sedation only or paralytic only intubations

ii. No SGA usage in peds, none in adults in 2021

B. IO placement is majority by RN and more humerus than tibia

C. Ventilator data presented

D. Reza Vaezazizi – Do you review for the clinical appropriateness of the procedure

i. Christian Sloane – All airway management flagged for review. Have not had concerns in reviews re decision-making. If any questions, debrief with the crew.

8. LOSOP VACCINATION – DAVE DUNCAN

A. Some of the LOSOP will need to transition on September 30th however there are components that we can continue

B. All vaccination LOSOPs need to go through SOP and then approved by EMDAC, template has been created

C. Goal is to continue COVID and influenza vaccinations

D. If you want to do something different, still encourage all LEMSAs to use the template and bring any further expansions to SOP in a separate application

E. Kristi Koenig – What about PPDs?

F. John Brown – As the age range changes, will it be a challenge for EMS providers to vaccinate additional ages?

G. Dave Duncan – Felt appropriate to leave at 12 and older, with pediatrics separate given potential issues of different location for vaccine

H. Kim Freeman – Influenza vaccinations already being done in younger age, and deltoid is location for ages around 5-6 and older

I. Austin Trujillo – Will send to EMDAC once clarifications are added from this conversation

J. Kris Lyon – Please ensure all documents go to EMDAC in future, including those pertinent which were sent to EMSAAC

K. Kristi Koenig – Proposed adding ‘for FDA-approved ages’ and ‘with appropriate training’

L. Brian H via chat - “the current2021-2022 Flu Vaccine in the vial by the manufacturers are for patients that are 4 years of age and above”

M. John Brown – The VAERS may provide a great opportunity to show that EMS clinicians have no more errors in administrations/complications than other clinicians. If we are not able to flex to younger ages, we may be denying access to pediatric patients; we want to be peds-centric.

N. Kim Freeman via chat – “Vaccinating pediatrics will also help EMS providers get more familiar and comfortable with this age group.”

O. Dave Duncan – This is a hot button issue and we must be careful moving forward. We must demonstrate conservative approach, uniform training module

P. John Brown – Willing to work with peds advisory to create pediatric training modifications.

Q. Austin Trujillo – With the template, will still need to go through SOP committee because it's in regulations, but it will be rapid using the template. Further modifications should be submitted separately. Applications should be submitted as soon as possible. There will be a forthcoming memo that the LOSOP will be retired in September, so will review these at a conference call and September EMDAC.

R. Dave Duncan – Still considering a standard easily approved LOSOP for 12 and older with a separate application for pediatrics.

EMDAC/EMSAAC JOINT SESSION

CALL TO ORDER 10:00 KIM FREEMAN

9. BIOSPATIAL – JOE FERRELL
   A. No cost to LEMSAs to view these data
   B. Data Reports
      i. Demand analyses – can look at call volume, set date range
      ii. Can break down by days of week, hours of day to see where the heavy volumes are and relate to APOT
      iii. Can filter by Provider Impressions ('Syndromes')
      iv. Can filter metric by mean, median, percentile…
   C. Data Explorer Widget
      i. Can slice and dice data in a lot of different ways
      ii. Example exploring which Provider Impressions have highest APOTs, can also classify further by other factors, e.g., patient acuity
         1. Explore subgroups, counts,
      iii. Can set threshold for query e.g., all APOTs > x, includes records review to look into individual cases
   D. Data Management
      i. Can save queries to pull up later
      ii. Can set who has access
      iii. Can subscribe so they go to your inbox
      iv. There is a data explorer widget within this
      v. Data completeness

E. Data Accuracy

i. Can query outliers and look into records to find bad data

F. Data Flow/Access

i. Receive data from Image Trend Managed State Data Repository

ii. Believes all ePCR data goes into this

iii. Access to data view/reports can be granted - Agreement is with EMS Authority, issue access based on EMSAs authorization

iv. Adrianne Kim confirms all LEMSAs have been given access, can contact her for access info

1. Adrienne can be reached at adrienne.kim@emsa.ca.gov

10. EMSA REPORT – DAVE DUNCAN

A. COVID-19

i. Today we return to a normal economy, stay at home order goes away

ii. Provided summary of current COVID numbers and vaccination rates

iii. The delta variant is currently a 'variant of concern'

iv. 628 cases in California in the past 24 hours, all time low

v. 59% vaccinated, 3.7 million positive cases, approaching herd immunity threshold

vi. Kristi Koenig via chat – "RSV is rising too. We should be alert for covid coinfections in these unvaccinated kids with everything now open."

B. Executive Orders - 4 executive orders impacted EMS

i. Allowance to transfer patients to non-hospital destinations, alternate care sites for both COVID and nonCOVID

1. No one is utilizing
2. Does not affect alternate destinations in effect pre-COVID
3. This will go away at the end of the month

ii. March 4, 2020 Paragraph 3 – EMSAs ability to permit out-of-state personnel to provide services

1. This is continued through the end of September
2. Contractors have 3 months to put providers through normal channels or end contracts with providers from out-of-state
3. This will include dialysis techs

iii. N-28-20 Paragraph 4 - EMSA can increase Scope of Practice

1. This includes stationary care, testing, COVID vaccination, and influenza vaccination
2. This is continued through the end of September
3. EMSA will create standard template for LOSOP applications for COVID and influenza vaccinations for 12 years and older to be approved to continue this past the September end date

iv. N39-20 Paragraph 6 – Extension of training requirements for EMS personnel
1. This will continue through the end of September
2. After that, will need to meet old training requirements
3. Brian Christison – How does this impact hybrid classes?
   a. Clarification is that any class starting AFTER September 30th will need to follow routine guidance. Education that begins prior can have an allowance.

v. Brett Rosen via chat – "When does EMT skills verification waiver for renewals expiring?"
1. Austin Trujillo - EMT skills verification was set to expire at the end of the pandemic
2. Dave Duncan – we need to get clarification on the end date on this
3. Kim Roddick – Need notice in advance for planning
4. Louis Bruhnke via chat – "Per Dr. Duncan's memo from March 19, 2021 https://emsa.ca.gov/wp-content/uploads/sites/71/2021/03/EMSPersonnelGuidancePolicy-Revised3.19.2021.pdf
   the waiver for EMT skills verification extends until the end of the Emergency Proclamation. EMSA surveyed certifying entities who did not see a need to extend the waiver for EMT skills testing verification beyond the end of the Emergency.
5. Dave clarified further near end of meeting:
   a. All provisions that allowed providing care with expired license were withdrawn in April.
   b. A memo was circulated that describes allowances on training exceptions etc. 3 allowances use language 'for the duration of the COVID-19 emergency', will be expiring 9-30. Will forward memo, which is also posted to the website.

vi. Dave will share document to clarify the document that was released by the Governor regarding end-dates for individual executive orders

C. Clarification on masking

a. Likely will be individual agency interpretations of CDPH recommendations
b. Dave G – Cal OSHA meeting Thursday to discuss new emergency standard, expect new guidance. Healthcare setting is exception that still requires masks.
c. Marianne G-H – Clarifying firehouses?
d. Dave G – still need mask if unvaccinated individual in the mix.
e. Atilla Uner – Posted guidance from CDPH to chat : https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/guidance-for-face-coverings.aspx
f. Ken Miller – Firehouse is non-patient care; Cal OSHA prior guidance is currently in place.
g. David G – Cal OSHA decision Thursday will likely take a month to go into effect and Governor cannot override. Therefore if any unvaccinated person, must mask. And in healthcare setting must mask.

D. In-person meetings

i. Leaning toward virtual
ii. EMS Commission will be starting in-person in March
iii. Eric Rudnick – Likes in person but suggests hybrid model
iv. Nichole Bosson via chat – “We will need to invest in the technology to facilitate hybrid meetings”
v. Kris Lyon – Proposed use of funds since saved money from no in person meetings last year. Brett Rosen and Kristi Koenig concurred.

E. Scope of Practice – Adult Supraglottic Airways Insertion for Paramedics

i. Sent memo which moves this to Standard Scope of Practice
ii. Limited to the 3 currently in use since there are available data

MAIN MEETING

11. ACEP REPORT – VIK GULATI

A. The Treat and Refer policy is complete and expects it to be approved by the board

B. 1544 – from Cal ACEP perspective, there should be allowance for new policies, willing to work on language and legislation as needed

C. Workforce issues are a big focus

12. COVID STATEMENT FROM EMDAC/EMSAAC – JOHN BROWN

A. Joint effort with members of EMSAAC

B. Would like to support positive changes during COVID, not one size fits all, meant to support individual LEMSA implementation, but also provide structure so we are similar regarding triggers to implement different strategies.

C. Hopes this will support EMSA in their plans

D. Preserves the progress that was made during COVID, so it can be reimplemented quickly during future needs

13. APPROVAL OF MARCH MINUTES

A. Approved – AJ Singer/Marianne Gausche-Hill

B. No oppositions

14. TREASURER'S REPORT – DANIEL SHEPHERD

A. Two new members, $400 additional dollars

B. There are some automatic payments made by administrators, we lose some money due to PayPal fees for duplicate payments, so check with your administrators

15. LIABILITY COVERAGE DISCUSSION

A. Kim Freeman – Checked were her LEMSA and was told she was covered

B. Kris Lyon – The attorneys felt it was optional and not necessarily needed. If you have your own insurance, can usually add your EMDAC duties onto that and be covered at no additional cost.

C. Eric Rudnick – Confirms he was able to add EMDAC without any issues. No additional cost.

D. Kim Freeman – This was brought up because there was concern for individual liability, feedback is that liability as a group is minimal, and given able to cover individually, a group policy does not make sense

   i. No opposition

16. WEBSITE MANAGEMENT – DANIEL SHEPHERD

A. Identified person to manage, Mr. Rose

B. Fee was $4000 annual, appropriate for market rate

C. Queried if group would support contracting with Mr. Rose

D. Clarified that the fee would encompass entire scope of the work

E. Motion to further engage discussions and proceed with contract – Eric Rudnick, Marianne Gausche-Hill

   i. No opposition

17. EMS COMMISSION – KEN MILLER

A. One remaining agenda item from Atilla Uner on Mental Health Emergencies

   i. Atilla Uner - Subcommittee was looking at mental health emergencies, improving collaboration, and reducing harm. Subcommittee will bring to vote recommendations at the main commission. Plan to recommend that the NAEMSP guidelines be used as the approach. And that EMSA gather information from LEMSAs to understand current policies in place.

18. REGULATIONS – KEN MILLER

A. On track for public comment in August

B. Current regs sunset in 2024

19. FUTURE MEETINGS DISCUSSION

A. Kim Freeman shared results of survey

i. December was a preferred meeting for in-person, others were about 50%
ii. Most did not object to moving meeting locations to Long Beach and/or East Bay for respective meetings
iii. 50/50 split for June meeting with EMSAAC Conf vs EMSC in Sacramento

B. Group discussion

i. Nichole Bosson – Proposed that if we invest in technology, can do hybrid for all meetings.
ii. Ken Miller – Pointed out how much more attendance we are getting with the virtual options.
iii. Reza Vaezazizi – Cautioned that we will absolutely need the technology.
iv. Eric Rudnick – Issue will be cost to rent from hotels, more cost effective to purchase our own.
v. Nichole Bosson – Proposed hosting at EMS Agencies where equipment already exists
vi. Jay Goldman – Queried whether everyone could join on their laptops. Group discussed challenges of feedback loops.
vii. Dave Duncan – Raised issue of bandwidth at hotel.
viii. Kim Freeman – Proposed clustering in groups with a single input/ output and mic control. Group discussed that there are options to make this work, bringing hotspots etc.
ix. Brett Rosen – Suggested exploring alternative sites rather than hotels.
x. Kim Freeman – Reminded that we had planned to use UC Davis.
xi. Kris Lyon – EMSAAC would be in another location so would need to join via zoom.

C. Vote

i. Group voted 76% in favor of June being remote
ii. Group voted 62% for 50/50 split in 2022
iii. Group was divided on December vs September for other remote meeting in 2022 – President decision, favor September remote given June is in NorCal, March and December in person, can revisit September after experience in March/June
    1. Motion to approve as stated above – Reza/Marianne
iv. Group voted 53% for in-person December 2021 (vs 40% virtual)

1. Group discussed logistical challenges, Karl Sporer will look into hosting and get back to the group.

20. BYLAWS – KIM FREEMAN
    A. Bylaws passed by vote
    B. Thanks to Sam Stratton and Marianne Gausche-Hill for leading the charge

21. FILLING VACANCIES – KIM FREEMAN
    A. Need to fill two at-large members
    B. Please provide nominations to exec committee by the end of the month
    C. Temporary appointment through December; all positions except President and Ex-President will be voted on in December during usual cycle

22. PEDIATRIC READINESS PROJECT – MARIANNE GAUSCHE-HILL
    A. Currently active, due July 31st
    B. Would like 100% participation in California, currently at 44%
    C. Data has shown for critical illness, if in highest tier of readiness, 4x less mortality compared to lowest readiness. Also significant for trauma. Independent of pediatric volume.
    D. ACSCOT will be surveying all TCs about peds readiness
    E. What are LEMSAs doing to encourage hospital participation?
        i. Kris Lyon – His group raised issue that it was not their role to follow up on this. Can you get list of hospitals that have not filled out the form?
        ii. Marianne Gausche-Hill – The list has been sent, but not sure who it went to, will confirm the lists are sent to the Medical Director as well.
        iii. Devin Tsai via chat – “We learned that if you go to the website and put in your county(ies), any hospitals that are listed have NOT filled out the survey. Once a facility completes the survey, it drops off.”
        iv. Dustin Ballard – They partnered with DPH, put out a press release which got local media attention, seemed helpful to push reluctant hospitals.
        v. Jay Goldman – Suggested LEMSAs send reminder letters to all hospitals stating that LEMSA is assessing its level of readiness

vi. Marianne will send press release templates and sample letters and talking points to the group

23. STANDARDIZING DRUG FORMULARY – MARIANNE GAUSCHE-HILL

A. Maintaining a single concentration of medications with pre-calculated volumes reduces errors and providers feel more empowered and have more time to focus on patient care

B. Showed the LA County Color Code, also includes adults

C. Have a mobile app for LA County as well, consider possibility of free app for all of California. Can see frequency of use.

D. Would like to assess interest from this group.

i. Atilla Uner – Will this apply to critical care transport? Marianne - no discussing 911 responses, not to expand to those with larger formularies

ii. Atilla Uner – Raised concern about limiting to certain vendors.

iii. Ken Miller – Seconded concern, does not want to be limited to certain concentrations because of shortages. Suggests solution at LEMSA level instead.

iv. Marianne Gausche-Hill – We did not have issues in LA. Can save money and effort by aligning together rather than each LEMSA doing their own.

v. Kristi Koenig via chat – Suggested backup options in formulary. Supports exploring.

vi. Kris Lyon – Kern is transitioning to Handtevy starting July 1st. Would consider switching if the move is to go statewide. Need to consider the cost of maintaining if we were to go to that scale.

vii. Kim Freeman – Proposed convening a small committee to look at this further and then bring to subsequent meeting.

24. OPIOID PILOT UPDATE – GENE HERN

A. SF now has 2 deaths per day from ODs, ODs on the rise

B. Opioid deaths moving westward, now in crisis in California

C. Response to OD is a spectrum which includes responses before and after the OD

D. Contra Costa has a 'Narcan Left Behind' program. EMS has given out about 200 doses. 14 ODs have been reversed with this distribution (7% usage)

E. Use First Watch triggers divided by sector to identify cases

F. Substance use navigator can provide phone or in-person consultations if contact information available

G. Designated Overdose Receiving Center (County Hospital)

H. EMS initiated 1st dose MAT

   i. QR code COWS score, call on-call physician

I. 360 triggers total:

   i. Nearly half still too altered, 40 no w/d, 22 declined, 5 eloped, 52 other stimulants, 35 severe illness, 6 recent methadone.

   ii. 27 (7.5%) missed chances vs 17 (4.7%) doses given.

J. Future plans to expand to other LEMDAs – Alameda, SF, Fresno, Kern

K. Challenges: Bup Call line ?Poison Control, Resources for tracking

25. OPIOID RESPONSE AND POISON CONTROL INTEGRATION – DAVE DUNCAN, STU HEARD, CRAIG SMOLLIN, RAIS VOHRA

A. Background from Poison Control

   i. Stu Heard

      1. Working with the state on MAT
      2. Working with UCSF to offer 24/7 substance use line to assist physicians in decision-making around MAT

   ii. Craig Smollin –

      1. Poison center is already a resource for the PH setting and looking to see how they can support this effort
      2. Initial work has been in supporting Emergency Physicians/ frontline providers, partnering with addiction medical specialists to start help line
         a. Pharmacists typically answer the phone, received training
         b. Provide help with COWS score, considering decision to start, issues/complications that can arise
      3. Can be a resource for EMS when scaling Gene's program
      4. Opens to group, how can PC best support?

iii. Rais Vohra – Concurred happy about this project and would like to support. There are opportunities for collaboration.

iv. Stu Heard – Open to discussion, would like to understand from EMS, how they may be able to help. Options include education and help line support for decision-making. Where are EMS needs and how can PC fit in?

B. Dave Duncan – Currently Gene's program has 6 on-call physicians. In order to expand, we could potentially have Medical Director oversight with Poison Control supporting a decision line. Fells both education and 'modified base' opportunity in the substance use line would be helpful.

C. Gene Hern – Contra Costa is about 1 million population. As we expand, a centralized expertise for paramedics would be very helpful. There are some cases which do not clearly meet criteria and require further decision support.

D. Kim Freeman – Rural areas have significant opioid use but has been difficult to engage physicians so sees value in this.

E. Rais Vohra – Training requirements are now gone, so that lowers barrier. https://cabridge.org/general/new-hhs-practice-guidelines/

F. Gene Hern – Some of their biggest successes have been with follow up of the substance use coordinator after discharge from the ED without prescription.

G. EMS resources page: https://cabridge.org/resource/engagement-of-emergency-medical-services-project-summary/

26. EPOLST – JAY GOLDMAN

A. A prior ePOLST bill died because of lack of funding

B. The current bill is a two-year bill, so no action this year, however, there is an urgent proposal to fund the ePOLST

C. California Commission for Compassionate Care as EMDAC to support

D. Exec Committee voted unanimously to support the funding proposal for ePOLST; went through budget committee and to Governor's desk

27. LEGISLATIVE UPDATES – KATHERINE SHAFER

A. A few bills about Mental Health Crisis

i. 644 – Working with EMSAAC to encourage bill writers to include an EMS voice in committees so that we are involved.

ii. AB450 – Support if amended submitted. Concern that it does not specify EMS Physician, only EM physician. Felt there should be more physician involvement in general and particularly EMS physician. And addition of RN with EMS experience. Not a lot of clarity on investigation process. Sam Stratton authored letter, which was reviewed by Exec and submitted.

iii. 1544

1. Jay Goldman - does not prohibit pilot studies, there is no reason why they would. It does end existing pilot studies at some future date. It does not seem clear why OSHPD would reimplement a pilot study ongoing for 6 years. It does limit pilots to substance abuse pilots and hospice the like. Feels there needs to be a separate legislative effort.
2. Kristi Koenig – Concurs, very unusual for OSHPD to continue the pilots as long as they did.
3. Dave Duncan - 1544 does allow continuation of existing programs. It is unlikely they would support new programs. ACEP was a co-author of the bill. We are in support of new programs but challenging to bring on board. Query if ACEP can show us how this can be done within the bill.
4. Jay Goldman – Clarified only until 2024 then they terminate.

iv. Chapter 13

1. Karl Sporer – group has not met in 3-4 months, group submitted comments and EMSA is reviewing.
2. Dave Duncan – optimistic that draft regs may exist in a few months, and will go to the group and then for public comment.

28. RESILIENCY IN EMS – KIM FREEMAN

A. COVID has been long and trying, many are fatigued and burnt out, what can we do about it? Any suggestions for mitigation strategies?

B. Kristi Koenig – Chip Striver will be talking about exposure to trauma and resiliency, everyone invited to attend.

C. Kim Freeman - Suggested that we all share activities in our LEMSAs and ideas for interventions. Opening up channels of communication and

29. ROUNDTABLE
    A. Los Angeles – Nichole Bosson
        i. I-gel pilot started June 1st for 4 months, looking at provider experience, compression fraction, interruptions in resuscitation, capno
            1. Dave Chase noted that their capno tracings were improved after move to the i-gel
        ii. ECMO pilot enrolling
        iii. Mental Health TF, developing MCG, will share when complete
        iv. STEMI and Stroke Summit presentations will be posted to the EMSA website, can view there
    B. Imperial - Amelia Breyre
        i. Will get first STEMI Center soon
        ii. Overhauling all protocols
    C. Tuolumne – Kim Freeman
        i. New protocols released a few months ago
    D. El Dorado – Kim Freeman
        i. Protocol edits
    E. Sacrament County – Hernando Garzon
        i. Expanding two new positions in EMS office, not approved for additional QI analyst, expect future growth
        ii. Putting together a committee to address Wall Times – current wall times are 10x state average
    F. Santa Cruz / San Benito - Ghilarducci
        i. 16 months experience with EMS Innovator program, EMS Case Manager focusing on frequent flyers among other things
        ii. Mortality is very high in this group – 10%
        iii. Has been successful in connecting with services like DMH and MAT programs, has shown how important it is that EMS stay connected with these other services
    G. San Diego – Kristi Koenig
        i. Implementing new protocols as of July 1st
        ii. Co-administration of ketamine and opioids
        iii. Moving to push-dose epi
        iv. Hospital system hit by cyber attack is in recovery
    H. Napa – Zita Konik

i. RFP was released and received proposal, which will be reviewed
ii. Will have a primary stroke center
iii. Focused on sexual assault violence policy for education, well received

I. Kern – Kris Lyons

i. Handtevy starting July 1st
ii. APOT task force started, seeing improvements
iii. Highest APOT hospital has assigned dedicated offload RN, have not had any delays over an hour in the past several weeks

J. Contra Costa – Senai Kidane

i. New Treatment Guideline going into effect for Behavioral Emergencies and including some year-end training on this topic
ii. Included a larger project exploring how the County responds to these emergencies. Lots of political will from cities right now to limit PD involvement, trying to bring everyone together around comprehensive plan. Feel mental health specialists should be responding and EMS and PD have limited roles unless their expertise is particularly needed.

K. Cal Fire – Brett Rosen

i. Question re certa dose, needle is ½ inch, which for many people may not go IM. Anyone with experience?
    1. Marianne Gausche-Hill– LA County reviewed and allowed as optional, no known experience/issues.
ii. Fire season starting now
iii. Plan to publish experience medical care during wildland fires in some of the large incidents last year
iv. ePCR will be implemented, will let LEMSAs know as it comes to their area
v. Dave G – Queried if antigen testing will be in camps.
vi. Brett – Yes will have rapid testing kits.

L. Alameda – Karl Sporer

i. Moving forward with health data exchange, will have first hospital on board in about a month, Kaiser by end of year, rest by mid 2022. Using Zoll.
ii. Staffing issues at hospitals
iii. Requests from cities re Mental Health Reponses. Have County response vehicles, have 6 currently, going up to 8, not enough to meet need. Several cities have tried to hire MH clinicians due to problem

incidents. Hard to find MH clinicians to hire. Asking County MH Director to approve paramedics to assist with MH emergencies. There are city dollars and cannot control at County level.

M. Ventura – Daniel Shepherd

i. Flipping staff back from COVID activities back to EMS has been challenging
ii. RFP is taking time
iii. Renewed ambulance contracts, things are currently business as usual
iv. Introduced the i-gel and has been well received
v. Launched Handtevy, main feedback is that providers appreciate the cognitive offload and focus on patient. Hospital providers also liked the approach.

N. Atilla Uner

i. Promoted to GMR Medical Director for Pacific Region, California and Hawaii, over all ground and air operations

30. SAN BERNADINO AND RIVERSIDE – REZA

A. 15-20 paramedics will participate in US pilot, plan for training this fall

B. Requests from several hospitals to become Trauma Centers

i. One is remote and filled a gap, looking for level IV trauma designation, made sense on review
ii. Another interest in a similar area, wanted to be level II but volume isn't there, then requested level IV but do not have the optimum location or relationship with other TCs, so told them no
iii. A challenge is defending decisions and having clear processes
iv. Dave G – For level IV, had you considered trauma destination for field triage? Or just walk in?
    1. Working into field triage, based on what cannot go there, vs what can. They have ortho so will expand depth of trauma services in the region.

31. FINAL ANNOUNCEMENTS – KIM FREEMAN

A. Please let Kim know if you want to be involved in the standardized formulary committee and/or want to be nominated/have a nominee for the open board positions.

ADJOURNED KIM FREEMAN 14:47

Next Meeting 9-21-2021 via Zoom