



**PREHOSPITAL MEDICAL ADVISORY COMMITTEE MEETING AGENDA (PMAC)**

PMAC MEMBERS PER POLICY 8202:

Air Transport Provider Representative  
11-VACANT

American Medical Response  
5-Douglas Key  
Seth Dukes, MD (Chair)

BLS Ambulance Service Representative  
12-Lori Lopez

Cathedral City Fire Department  
5-Justin Vondriska

Corona Regional Medical Center  
1-Robert Steele, MD  
4-Tamera Roy

County Fire Chiefs' Non-Transport ALS Provider  
10-VACANT

County Fire Chiefs' Non-Transport BLS Provider  
9-Phil Rawlings

Desert Regional Medical Center  
1-Joel Stillings, D.O  
4-G. Stanley Hall

Eisenhower Health  
1-Mandeep Daliwhal, MD  
4-Tasha Anderson

EMT / EMT-P Training Programs  
6-Maggie Robles

EMT-at-Large  
13 David Olivas

Paramedic-at-Large  
14-Sarah Coonan

Hemet Valley Medical Center  
1-Todd Hanna, MD  
4-Victoria Moor

Idyllwild Fire Protection District  
5-Patrick Reitz

Inland Valley Regional Medical Center  
1-Zeke Foster MD  
4-Daniel Sitar

JFK Memorial Hospital  
1-Troy Cashatt, MD  
4- Evelin Millsap

Kaiser Permanente Riverside  
1-Jonathan Dyreyes, MD  
4-Carol Fuste

**This Meeting of PMAC is on:**

**Monday, August 24, 2020**

**9:00 AM to 11:00 AM**

**Virtual Session via Zoom**

1. **CALL TO ORDER & HOUSEKEEPING (3 Minutes)**  
Seth Dukes, MD (Chair)
2. **VIRTUAL ATTENDANCE (taken based on participant list)**  
Evelyn Pham (REMSA)
3. **APPROVAL OF MINUTES (3 Minutes)**  
February 24, 2020 Minutes— Seth Dukes, MD (Attachment A)
4. **STANDING REPORTS**
  - 4.1. Trauma System—Shanna Kissel (Attachment B)
  - 4.2. STEMI System— Shanna Kissel (Attachment C)
  - 4.3. Stroke System— Shanna Kissel (Attachment D)
5. **Other Reports**
  - 5.1. EMCC Report – Dan Bates
6. **DISCUSSION ITEMS, UNFINISHED & NEW BUSINESS**
  - 6.1. Unfinished Business – Misty Plumley
    - 6.1.1. PMAC Structure Review – (Attachment E)
      - 6.1.1.1. Resignation of Air Transport Providers Representative
      - 6.1.1.2. Changes in RCFCA Non-Transport ALS Provider position
    - 6.1.2. King Airway Data Review
  - 6.2. CQI Update – Lisa Madrid (Attachment F=Attached Reports/Literature)
  - 6.3. Education / Policy Update – Misty Plumley (Attachment G)
  - 6.4. Ketamine Study Published – Misty Plumley (Attachment H)
  - 6.5. COVID-19 Update: Ongoing Prep and Planning – Bates/Plumley
  - 6.6. LOSOP Application Update – Misty Plumley (Attachment I)
  - 6.7. Action Item Review – REMSA Clinical Team
7. **REQUEST FOR DISCUSSIONS**  
Members can request that items be placed on the agenda for discussion at the following PMAC meeting. References to studies, presentations and supporting literature must be submitted to REMSA three weeks prior to the next PMAC meeting to allow ample time for preparation, distribution and review among committee members and other interested parties.

Loma Linda University Med. Center Murrieta

1-Kevin Flaig, MD  
4-Kristin Butler

Menifee Valley Medical Center

1-Todd Hanna, MD  
4-Janny Nelsen

Kaiser Permanente Moreno Valley

1-George Salameh, MD  
4-Katherine Heichel-Casas

Palo Verde Hospital

1-David Sincavage, MD  
4-Carmelita Aquines

Parkview Community Hospital

1-Chad Clark, MD  
4-Guillean Estrada

Rancho Springs Medical Center

1-Zeke Foster, MD  
4-Sarah Young

Riverside Community Hospital

1-Stephen Patterson, MD  
4-Sabrina Yamashiro

Riverside County Fire Department

5-Scott Visyak  
8-Tim Buckley

Riverside County Police Association

7-Sean Hadden

Riverside University Health System Med. Center

1-Michael Mescica, DO (Vice Chair)  
4-Kay Schulz

San Geronio Memorial Medical Center

1-Richard Preci, MD  
4-Trish Ritarita

Temecula Valley Hospital

1-Pranav Kachhi, MD  
4-Jacquelyn Ramirez

Trauma Audit Comm. & Trauma Program Managers

2-Frank Ercoli, MD  
3-Charlie Hendra

Ex-officio Members:

1-Cameron Kaiser, MD, Public Health Officer  
2-Reza Vaezazizi, MD, REMSA Medical Director  
3-Bruce Barton, REMSA Director  
4-Jeff Grange, MD, LLUMC  
5-Phong Nguyen, MD, Redlands Community Hospital  
6-Rodney Borger, MD, Arrowhead Regional Medical Center

**8. ANNOUNCEMENTS (15 Minutes)**

This is the time/place in which committee members and non-committee members can speak on items not on the agenda but within the purview of PMAC. Each announcement should be limited to two minutes unless extended by the PMAC Chairperson.

**9. NEXT MEETING / ADJOURNMENT (1 Minute)**

November 16, 2020—Virtual Session via web platform

Members are requested to please sit at the table with name plates in order to identify members for an accurate count of votes

Please come prepared to discuss the agenda items. If you have any questions or comments, call or email Evelyn Pham at (951) 358-5029 / epham@rivco.org. PMAC Agendas with attachments are available at: [www.rivcoems.org](http://www.rivcoems.org). Meeting minutes are audio recorded to facilitate dictation for minutes.

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TOPIC	DISCUSSION	ACTION
1. CALL TO ORDER	Misty Plumley called the meeting to order at 9:03 a.m. and reviewed housekeeping items.	
2. PLEDGE OF ALLEGIANCE	PMAC Chair Dr. Seth Dukes led the Pledge of Allegiance.	
3. ROUNDTABLE INTRODUCTIONS	PMAC Chair Dr. Seth Dukes facilitated self-introductions.	
4. APPROVAL OF MINUTES		The October 21, 2019 PMAC meeting minutes were approved with no changes.
5. STANDING REPORTS		
5.1 Trauma System Updates	<p>Trauma Registry has been built and completed. Inland Valley Medical Center is the first to participate in data entry and has completed training; with an implementation date starting March 1<sup>st</sup>, 2020. The trauma registry, like STEMI and stroke will also link and match PCRs for patient outcomes returned to EMS personnel.</p> <p>Penetrating trauma protocol implemented October 1<sup>st</sup>, 2020. REMSA is CQI'ing all penetrating traumas pronounced in the field without making BH contact. In about 2 months, REMSA will have 6 months of data to report out.</p> <p>EMSA is continuing to work on updating Trauma regulations. A workgroup is in place and tentative timeline for regulation rewrite is about two years. How it affects the trauma centers we have now will require them to meet the newly revised regulations.</p> <p>Trauma Center Standards policy draft is complete and will be vetted through TAC. This is specific to the trauma center requirements and will have no effect on patient treatment or destination.</p> <p>RUHS-MC and DRMC will be going through ACS surveys this year.</p>	Information only.
5.2 STEMI System Updates	<p>STEMI Registry is 6 months into implementation with over 880 cases entered in the system. Will have close to 2,000 by the end of this year, which includes confirmed and suspected cases and full patient inclusion criteria with walk in patients and IFT. With the large increase in data a big focus is on creating quality reports and metrics that are underway.</p> <p>Nitroglycerin was placed fully back into standing orders as of October 1<sup>st</sup>, 2019, REMSA will continue to CQI this until October 1<sup>st</sup> this year. If data audits indicate there is no change in the</p>	Information only.

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	<p>use of nitrates and no increase in adverse events as a result of the change, the audit will be retired.</p> <p>Targeted education is being created as part of Policy Update Courses (PUC). About 30 minutes inserted for targeted education to ALS providers based upon identified educational needs and includes feedback on system-wide metrics. It is also optional and encouraged for hospitals to provide the education.</p> <p>ACS/STEMI treatment policy (#4402) for the streamlining of patient disposition section approved by the committee will take effect April 1<sup>st</sup>, 2020.</p> <p>The next STEMI Committee meeting is on April 9<sup>th</sup>, 2020.</p>	
<b>5.3 Stroke System Updates</b>	<p>Stroke Registry is also entering it's 6 month of implementation, with over 3350 suspected and confirmed stroke cases entered in the system already. Estimated number by end of the year will be close to 7,000. Data quality reports are also in development.</p> <p>Like with STEMI, stroke is also working on targeted education to be included in PUC. The content is based upon identified educational needs and includes feedback on system-wide metrics. Targeted for education to start on October 1<sup>st</sup>, 2020 or April 1<sup>st</sup>, 2021.</p> <p>The requirement for each designated stroke facility to have two CT scanners will take effect on July 1<sup>st</sup> this year. At that time, stroke diversion will be removed from the Ambulance Diversion policy (#6103) and stroke centers may only divert stroke patients during periods of internal disaster diversion.</p> <p>No stroke treatment policy changes at this time.</p> <p>REMSA is in the process of designating facilities as an interventional center, thrombectomy and comprehensive hospitals. One hospital has already surveyed for this, and REMSA will provide updates if the facility passes. REMSA is also waiting for this to fall in place to see if any changes need to be made on the stroke treatment policy.</p>	Information only.
<b>6. OTHER REPORTS</b>		
<b>6.1 EMCC Report</b>	Due to the restructure of the meetings in 2020, EMCC has not met yet. March 22 <sup>nd</sup> , 2020 is the next EMCC meeting.	Information only.
<b>7. DISCUSSION ITEMS, UNFINISHED &amp; NEW BUSINESS</b>		
<b>7.1 Unfinished Business</b>	Unfinished business	Information only.

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	<p>PMAC Structure review (attachment E) PMAC structure was edited per feedback received from shareholders. Attachment E redisplay the proposed structure that was developed and discussed with PMAC to see if members would like to continue with the new structure, change it, or leave our current structure as the same.</p> <p>Question was raised regarding, what happens if the newly appointed representatives does not attend the meetings? REMSA responded by confirming that attendance will be kept and tracked, if incase of a low attendance, we ask the group to appoint a different attendee or designate someone else from the organocation. If they are still unable to attend consistently, PMAC chair and REMSA will address it by a case by case basis and will consider taking separate action to remove their position.</p> <p>Cal Fire expressed their concerns that the goal was to have more prehospital representatives added, however on the proposed structure, they still do not see the changes reflected. Also, the concern for a distinction that needs to be addressed is having many more administrative positions as opposed to operational. They feel the need for more operational positions that come with experience in the field.</p> <p>RUHS-MC suggested to change the non-base hospital positions to base hospitals instead. However, REMSA responded that that was intended to get a different perspective from different hospitals.</p> <p>Another recommendation was brought up to add more educational training program representatives since our focus has been heavily relying on more education and training.</p> <p>PMAC agreed to continue sending more feedback to REMSA to come back with another draft to continue discussion and add will be discussed as an agenda item for the next PMAC meeting in May.</p>	
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<p><b>7.2 Provider Recognitions</b></p>	<p>Recognizing outstanding performance from our providers, Misty Plumley congratulated and thanked first responders and their team for exceptional service in patient care. The call highlighted the successes of team effort that recognized a critical penetrating trauma patient. This call reflects to much of the community outreach events we have been working on as a system using stop the bleed methodology and tourniquets.</p> <p>Awards of Excellence were given to the recipients below:</p> <p>Riverside City Fire</p> <ul style="list-style-type: none"> <li>• Patrick Anderson, Paramedic</li> <li>• Jesse Norton, Paramedic</li> <li>• Christopher Caceres, EMT</li> <li>• Cory Bruce, EMT</li> <li>• Jeff DeLaurie, Battalion Chief</li> </ul> <p>AMR</p> <ul style="list-style-type: none"> <li>• William Gayk, Paramedic</li> <li>• Nicolas The, EMT</li> </ul> <p>RCH MICN's</p> <ul style="list-style-type: none"> <li>• Julie Morris, MICN</li> <li>• Sabrina Yamashiro, MICN</li> <li>• Wendy McEuen, RN Trauma/Coordinator</li> </ul> <p>Award for Excellence for outstanding performance was also given to an individual who put in extraordinary efforts to help a patient while driving home from a shift.</p> <p>AMR Desert Cities</p> <ul style="list-style-type: none"> <li>• Ismael Esparza, Paramedic</li> </ul>	
<p><b>7.3 Riverside County Overdose to Action – RVC Public Health</b></p>	<p>Wendy Hetherington and Diana Leibrandt presented on the Riverside County Overdose Data to Action Plan.</p> <p>The 3 year multi-million-dollar grant's primary purpose is to enhance data activity around overdoses in both fatal and non-fatal, and to use data to guide implementation and prevention programs. The grant is partnering with EMS in the surveillance and prevention component.</p> <p>Funded jurisdictions to qualify needs to have over 395 overdose deaths in 2017.</p> <p>Surveillance Component Strategy 3: innovative morbidity/mortality surveillance Opened to 20 high impacted jurisdictions</p> <ul style="list-style-type: none"> <li>• Develop an overdose surveillance reporting protocol that integrates EMS data, ED data and death data through ImageTrend and Essence data</li> </ul>	<p>Information only.</p>

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	<ul style="list-style-type: none"> <li>• Develop overdose outbreak protocol and response strategy</li> <li>• Start a monthly death overdose review team. It will formally launch this in April 2020 and public health invites partners to come participate in discussing cases. Every month they will pick a theme to focus on death reviews. April focus' on injection deaths.</li> <li>• A Riverside County overdose dashboard will also be developed</li> <li>• Creation of an overdose risk index</li> </ul> <p>Prevention Component</p> <p>Strategy 4: Prescription Drug Monitoring Program (PDMP)</p> <ul style="list-style-type: none"> <li>• More for State review and is run by the DOJ</li> <li>• Increase the access and use of CURES data in Riverside County to guide overdose prevention efforts in Strategies 5, 6, 7 and 9</li> </ul> <p>Strategy 5: Integration of State and Local Prevention Efforts</p> <ul style="list-style-type: none"> <li>• Developing a strategic plan</li> </ul> <p>Strategy 6: Establishing Linkages to Care</p> <ul style="list-style-type: none"> <li>• Establish case management services with Public Health Nursing</li> <li>• Provide linkages to care for high-risk populations</li> </ul> <p>Strategy 7: Providers and Health Systems Support</p> <ul style="list-style-type: none"> <li>• Develop and implement an academic detailing program in collaboration with IEHP</li> </ul> <p>Strategy 9: Empowering Individuals to Make Safer Choices</p> <ul style="list-style-type: none"> <li>• Will have a presenter at the April preparedness summit</li> </ul> <p>Fentanyl statistics: Overdose in 2018 – 56 overdoses Overdose in 2019 – 130 overdoses, estimate close to 140 by the end of 2019 Any death including fentanyl, does not have to be purely fentanyl only. A lot of the overdoses are mixed in with other drugs. About 1/3 of the deaths are only fentanyl found in their system.</p> <p>What the hospitals have done to prevent overdoses, RUHS-MC about 2 years ago has put a stringent in opioid use and has implemented suboxone treatment instead. They have counselors in their department for drug counseling. Any Riverside county resident can access that hotline for access to treatment 24/7. Other facilities are focusing more on compassionate treatment of patients and limit the amount of prescribed narcotics medication to treat chronic patients. Community based practices have also been ongoing.</p>	
7.4 CQI Update	CQI update	

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	<p>Dec 4<sup>th</sup> at the MSAC meeting, REMSA met with CORE Measures to revise, review and modify the existing CORR Measures to ensure for more appropriate data collection. They generated feedback and a follow up meeting has been set for February 27<sup>th</sup>, 2020.</p> <p>REMSA data and research unit has pulled together an update of the REMSA CQI plan that has been submitted for review for approval by the CQI Authority.</p> <p>REMSA will continue monitoring the recent changes to the 2019-2020 policy manual such as the uses of Push-Dose Epi, Ketamine, TXA, airway management and resuscitation. REMSA reaches out to providers for feedback and request Currently we do not have a deadline for the CORE Measures submission yet, once we do we will inform the providers.</p> <p>Attachments include reviews of:</p> <p>TXA Charts were reviewed at CQILT to pull in specific education update in TXA for Spring PUC. The review displayed the inclusion criteria and how they were administered.</p> <p>Push-Dose Epi Total patients who received epinephrine from September to December 2019 was reviewed.</p> <p>Ketamine Ketamine charts revealed an issue that REMSA identified with weight-based administration, a disconnect with the calculation. More review will be covered and updated in Spring PUC.</p> <ul style="list-style-type: none"> <li>Managing this is difficult due to patients not being able to be properly weighed in the prehospital setting. It becomes a documentation issue as well, if patient was given a dosage based on visual presentation, providers need to document it properly. Dr. Vaezazizi also emphasized the importance of administering it slowly. But for the most part, Ketamine has been a very successful implementation.</li> </ul>	
<p><b>7.5 Education / Policy Update</b></p>	<p>Spring PUC 2020 Train to trainer will finish off today. There has been lots of involvement from hospitals and partners. Several agencies are still missing training calendars. Misty requested for them to please submit their calendars as soon as possible.</p>	



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	<p>EMS for children/pediatric survey for first response and ground transports were contacted directly via email to participate in the survey that went out last week. Looking to have surveys completed prior to March 2020.</p> <p>October policy changes Changed policy regarding King Airway use, was to collect data for 6 months following the policy change, then come back to make a recommendation solidly one way or another. REMSA has been monitoring it and so far, have found two uses in OHCA. At the May PMAC meeting, REMSA will have the full 6 months of aggregate data piece to present and to make a final decision on King Airway use.</p> <p>As a formal announcement, a System advisory will be sent out regarding carrying Ketamine and TXA. As of April 1<sup>st</sup>, 2020, we have completed the Ketamine and TXA LSOP. Providers are required to carry both as part of the drug and equipment list, effective April 1<sup>st</sup>.</p>	
<p><b>7.6 PMAC Schedule Update for May 2020</b></p>	<p>May PMAC meeting has been changed to May 11<sup>th</sup>, 2020. Previous date for meeting was on May 18<sup>th</sup>.</p>	
<p><b>7.7 Action Review</b></p>	<ul style="list-style-type: none"> <li>• PMAC structure, and plan to send out updated attachment for May PMAC meeting</li> <li>• King Airway will be on the agenda for May</li> </ul>	
<p><b>8. REQUEST FOR DISCUSSIONS</b></p>	<p>Open for discussion for anyone who wants to add to the next agenda.</p> <p>Cal Fire would like the Rheart presentation discussed and cleaned up before it is used in the field. Current implementation date, April 1<sup>st</sup>, 2020. REMSA has reviewed their program. There will be a trail study program for the first 6 months for data collection and CQI for any respiratory arrests to QI those differently and Epi dosing. Cal Fire raised their concern with the change and feels it does not follow the protocol since it will propose conflict on scene with providers using different protocols. Lisa Higuchi responded and will set up a review with Cal Fire if needed to review more on the key differences.</p> <p>Cal Fire requested to add single syringe use of adenosine, at the next PMAC meeting. They feel it is more effective if given at once in a single syringe and be able to do this in the field as well.</p> <p>On behalf of RUHS, they thanked REMSA and partners in their preparation and efforts in the mitigation of the corona virus incident at March Airbase, it has been great, and they are very</p>	

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	proud that our County has taken a proactive approach to this case.	
<b>9. ANNOUNCEMENTS</b>	RUHS-MC ED conference March 20 <sup>th</sup> at the hospital. Dr. Mesisca will be speaking and will include the March Base Airforce event as a topic.	Information only.
<b>10. NEXT MEETING/ADJOURNMENT</b>	Monday, May 11 <sup>th</sup> , 2020 (9:00 – 11:00 a.m.) 4210 Riverwalk Parkway First Floor Conference Rooms.	Information only.

DRAFT

**FOR CONSIDERATION BY PMAC**

DATE: August 1, 2020

TO: PMAC

FROM: Shanna Kissel, RN, Assistant Nurse Manager

SUBJECT: Trauma System

1. Riverside Community Hospital designated by REMSA as a Level I Trauma Center meeting state regulations. This designation does not affect field level triage to trauma centers.
2. IVMC doing direct data entry in the ImageTrend Trauma patient Registry since April 1, 2020. The hospital is able link the prehospital pcr's into the trauma registry.
3. Penetrating trauma protocol implemented October 1, 2019. REMSA is continuing to CQI all penetrating traumas pronounced in the field without making BH contact. Data to be presented at TAC in August.
4. EMSA trauma regulation rewrite workgroup on hold due to COVID activity at the state level. Will update once activity with this committee resumes.
5. New Trauma Center Standards for adults and pediatrics policy #'s 5304 and 5305 implemented on July 1, 2020. This is an Administrative policy specific to the trauma center requirements and designation.
6. American College of Surgeons surveys extended until further notice due to COVID.

ACTION: PMAC should be prepared to receive the information and provide feedback to REMSA.

**FOR CONSIDERATION BY PMAC**

DATE: August 1, 2020

TO: PMAC

FROM: Dan Sitar Specialty Care Consultant RN  
Delivered by Shanna Kissel, RN, Assistant Nurse Manager

SUBJECT: STEMI System

1. STEMI projects, data, and reports have been delayed due to the additional burden of coronavirus. Data reports will resume by the next STEMI meeting in quarter 4 of this year.
2. Image Trend STEMI Patient Registry is one year into implementation. To date there are over 1500 suspected and confirmed STEMI cases entered into the registry. Development of useful data quality reports and metrics are in progress.
3. STEMI volume is down nearly 20% in the first six months of 2020 (Jan 1<sup>st</sup>-June 30<sup>th</sup>) compared to the last six months of 2019 (July 1<sup>st</sup>-Dec 31<sup>st</sup>). It is unclear as to the cause for this decrease, although cardiac arrest volume has increased by a similar proportion. Further review of the data and discussion will take place at the next STEMI Committee meeting in October.
4. Nitroglycerin was placed fully back into standing orders as of October 1<sup>st</sup>, 2019. Data audits indicate there is no change in the use of nitrates and no increase in adverse events as a result of the change. If this data trend holds, the audit will be discontinued as of October 1<sup>st</sup>, 2020.
5. Targeted STEMI education has been created as part of Policy Update Courses with a tentative implementation during the Spring 2021 PUC. Options for an online delivery of the content are being explored.
6. Until further notice, all STEMI Committee meetings will take place via video conference such as Zoom or WebEx. Invites will be updated with the appropriate links. Please note, video conference meeting invites should not be forwarded or shared with outside entities. Case reviews will resume at the October meeting and 1157.7 peer review protections must be maintained.
7. Policies: No STEMI policy changes pending.

Next STEMI Committee meeting is on October 8, 2020 via video conference

Action: PMAC should be prepared to receive the information and provide feedback to the EMS Agency

**FOR CONSIDERATION BY PMAC**

DATE: August 1, 2020

TO: PMAC

FROM: Dan Sitar, Specialty Care Consultant RN  
Delivered by Shanna Kissel, RN, Assistant Nurse Manager

SUBJECT: Stroke System

1. Stroke projects, data, and reports have been delayed due to the additional burden of coronavirus. Data reports will resume by the next Stroke Committee meeting in quarter 4 of this year.
2. The Image Trend Stroke patient registry is a full year into implementation with over 6700 suspected and confirmed stroke cases entered thus far. Progress continues to develop useful data quality reports and data metrics.
3. Countywide stroke volume for the first six months of 2020 is consistent compared to the last six months of 2019. The data will be further analyzed to see if there has been an impact on stroke mortality or morbidity during the pandemic period.
4. Targeted Stroke education has been created for EMS personnel as part of Policy Update Courses with a tentative implementation during the Spring 2021 PUC. The content is based upon identified educational needs and includes feedback on system-wide metrics. Options for an online delivery of the content are being explored.
5. Stroke diversion was retired as of July 1, 2020. The option for facilities to trigger stroke diversion in ReddiNet has been disabled.
6. The requirement for each designated stroke facility to have a recorded, dedicated phone or radio line for EMS arrivals will take effect on July 1<sup>st</sup>, 2021. Recordings of EMS arrivals are intended to facilitate quality assurance processes.
7. Desert Regional Medical Center has joined Riverside Community Hospital as a designated Comprehensive stroke center. Please note this does not affect field triage of stroke patients.
8. Until further notice, all Stroke Committee meetings will take place via video conference such as Zoom or WebEx. Invites will be updated with the appropriate links. Please note, video conference meeting invites should not be forwarded or shared with outside entities. Case reviews will resume at the October meeting and 1157.7 peer review protections must be maintained.
9. Policies: No changes to stroke policies are pending.

Next Stroke Committee meeting is on November 12, 2020 via video conference

Action: PMAC should be prepared to receive the information and provide feedback to the EMS Agency

**FOR CONSIDERATION BY PMAC**

DATE: August 4, 2020

TO: PMAC

FROM: REMSA Clinical Team / Stakeholder Comment Compilation

SUBJECT: Proposed Updates for PMAC Structure

- Proposed Structure after compiled feedback

**REMSA  
PREHOSPITAL MEDICAL ADVISORY COMMITTEE**

**APPOINTMENTS**

MEMBER NAME	PMAC POSITION	# OF REPS	APPOINTING AUTHORITY
	Trauma Hospital Physician	2	Trauma Center/TAC
	Pediatric Critical Care Physician	1	Pediatric Critical Care Hospital
	Non-Trauma Base Physician	2	Non-Trauma Base Hospitals
	Non-Base Hospital Physician	1	Non-Base Hospitals
	Public Transport Medical Director	1	Public Transport Providers
	Private 9-1-1 Transport Medical Director	1	Private Transport Providers
	Private Transport Medical Director	1	Private Transport Providers
	Fire Department Medical Director	1	Fire Chiefs
	PLN Committee Representative	2	PLN Committee
	EMS Officers	1	EMS Officers Committee
	Public Transport Medical Rep (Paramedic/RN)	1	Fire Chiefs
	Private Transport Medical Rep (Paramedic/RN)	1	Ambulance Association
	Specialty Center Medical Director	1	Specialty Center Committees
	Specialty Center (Trauma or STEMI or Stroke) Coordinator or designee	1	Specialty Centers Committees
	Private Air Transport Medical Director	1	Air Transport Providers
	Public Air Transport Medical Director	1	Air Transport Providers
	Medical Examiner's Office Pathologist	1	Riverside County Coroner's Office
	PSAP Medical Director	1	PSAPs
	Training Program representative	1	Training program
	Medical Director Appointee	1	REMSA Medical Director
	Behavioral Health Medical Director	1	
	Law Enforcement Representative	1	Riverside County Police Chief's or similar aggregate LEO group

# Epinephrine 1: 100,000 Administration

Total Patients received Epinephrine Jan to Mar:94

Epi Admini., Count	Jan	Feb	Mar	Total Patient
1	17	21	16	54
2	6	8	5	19
3	5	3	4	12
4		1	2	3
5	2		2	4
8		1		1
10			1	1
<b>Total Patient</b>	<b>30</b>	<b>34</b>	<b>30</b>	<b>94</b>

## Patient Average Initial/Last BP

Epi admini., Count	Avg Initial Sys BP	Avg Initial Diastolic BP	Avg Last Sys BP	Avg Last Diastolic BP
1	84	53	100	58
2	82	52	99	53
3	77	46	103	59
4	86	49	104	58
5	90	52	62	35
8	84	42	119	86
10	161	65	198	62
<b>Average</b>	<b>84</b>	<b>52</b>	<b>99</b>	<b>56</b>

\* Initial systolic BP is based on Agency who first administered Epinephrine.

\* Final Systolic BP is based on Transporting agency

Saline Admini., Count	Jan	Feb	Mar	Total Patient
1	16	16	21	53
2	1	4	2	7
3			2	2
4		3		3
Not Administered/ Not documented	13	11	5	29
<b>Total Patient</b>	<b>30</b>	<b>34</b>	<b>30</b>	<b>94</b>

## Primary Impression of Patient who received Epinephrine

Primary Impression	Total Patients
Cardiac arrest	30
Shock/Hypotension	12
Altered mental status	10
Sepsis	6
Syncope / fainting [Syncope and collapse (fainting	6
General weakness	4
Respiratory failure/Respiratory Arrest	3
Overdose/Poisoning/Ingestion	3
ST elevation myocardial infarction (STEMI)	2
Seizure - Postictal	2
Abdominal Pain/Problems (GI/GU)	2
Cerebral infarction (stroke/CVA)	2
Respiratory distress - other	2
Cardiac arrhythmia	1
Allergic reaction	1
Upper GI bleed/(vomiting blood)	1
Anaphylactic shock	1
Abdominal pain / problems	1
Abnormal uterine/vaginal bleeding	1
Traumatic Arrest	1
Fever	1
Alcohol Intoxication	1
Respiratory distress-Pulmonary edema/CHF	1
<b>Grand Total</b>	<b>94</b>

\*emedications.03=Epinephrine 1:100,000

\* Excluding medications administered by other.

\* Report range: Jan - Mar 2020

\* Primary impression is based on Agency who first administered Epinephrine.

# Medical Cardiac Arrest- 4/1/2019- 12/31/2019

"911 Response", "Cardiac arrest during EMS event is not blank ", Primary or Secondary impression "Cardiac arrest"

	2019				2020				Total		
	Qtr2		Qtr3		Qtr4		Qtr1				
Total Incidents	1317		1255		1381		1649		5602		
Total Approx., Patients	938		886		992		1175		3991		
By Age group	Children (<=12)	15	2%	23	3%	9	1%	12	1%	59	1%
	Adolescents (13-17)	6	1%	6	1%	4	0.4%	7	1%	23	1%
	Young Adults (18-35)	70	7%	59	7%	70	7%	94	8%	293	7%
	Adults(36-64)	328	35%	296	33%	335	34%	392	33%	1351	34%
	Adults( 65-79)	296	32%	283	32%	334	34%	371	32%	1284	32%
	Older Adults (>=80)	223	24%	218	25%	239	24%	299	25%	979	25%
ROSC	Yes	195	21%	161	18%	156	16%	233	20%	745	19%
	No	743	79%	725	82%	836	84%	942	80%	3246	81%
Cardiac Arrest during EMS event	Yes, Prior to EMS Arrival	855	91%	822	93%	926	93.3%	1079	91.8%	3682	92.3%
	Yes, After EMS Arrival	83	9%	64	7%	64	6.5%	94	8.0%	305	7.6%
	No					2	0.2%	2	0.2%	4	0.1%
Disposition	Treated and Transported	288	31%	257	29%	248	25%	323	27%	1116	28%
	Pronounced in Field	650	69%	629	71%	744	75%	852	73%	2875	72%



	2019						2020		Total	
	Qtr2		Qtr3		Qtr4		Qtr1			
<b>Total Transports</b>	<b>288</b>		<b>257</b>		<b>248</b>		<b>323</b>		<b>1116</b>	
<b>STEMI center</b>	<b>143</b>	<b>50%</b>	<b>139</b>	<b>54%</b>	<b>140</b>	<b>56%</b>	<b>190</b>	<b>59%</b>	<b>612</b>	<b>55%</b>
Riverside Community Hospital	49	34%	53	38%	41	29%	64	34%	207	34%
Desert Regional Medical Center	21	15%	23	17%	28	20%	34	18%	106	17%
Loma Linda University Medical Center, Murrieta	24	17%	18	13%	30	21%	33	17%	105	17%
Eisenhower Medical Center	29	20%	15	11%	14	10%	30	16%	88	14%
JFK - John F Kennedy Memorial Hospital	9	6%	21	15%	19	14%	23	12%	72	12%
Temecula Valley Hospital	11	8%	9	6%	8	6%	6	3%	34	6%
<b>Non-STEMI Center</b>	<b>145</b>	<b>50%</b>	<b>118</b>	<b>46%</b>	<b>108</b>		<b>133</b>	<b>41%</b>	<b>504</b>	<b>45%</b>
Hemet Valley Medical Center	25	17%	24	20%	26		34	26%	109	22%
Riverside University Health System Medical Center	30	21%	15	13%	22		21	16%	88	17%
Corona Regional Medical Center	17	12%	10	8%	10		17	13%	54	11%
San Geronio Memorial Hospital	13	9%	14	12%	11		13	10%	51	10%
Inland Valley Medical Center	15	10%	10	8%	6		10	8%	41	8%
Parkview Community Hospital Medical Center	9	6%	11	9%	6		7	5%	33	7%
Kaiser Permanente, Riverside	11	8%	5	4%	4		12	9%	32	6%
Menifee Valley Medical Center	7	5%	5	4%	8		5	4%	25	5%
Kaiser Permanente, Ontario	5	3%	9	8%	1		2	2%	17	3%
Palo Verde Hospital	2	1%	6	5%	3		3	2%	14	3%
Rancho Springs Medical Center	3	2%	2		5		3		13	3%
Kaiser Permanente, Moreno Valley	2			0%	2			0%	4	1%
Redlands Community Hospital	1		2					0%	3	1%
Loma Linda University Medical Center	1	1%		0%					1	0%
Hemet Valley Healthcare Center	1	1%							1	0%
Kindred Hospital, Ontario					1			0%	1	0%
Facility name not available	3		5		3		6	5%	17	3%

Median Time		2019			2020		
		Qtr2	Qtr3	Qtr4	Qtr1		
Patient contact time (etimes07-etimes03)	First Response	0:06:57	0:07:08	0:07:39	0:07:07	<b>0:07:13</b>	
	Ground Transport	0:08:11	0:08:28	0:09:08	0:08:48	<b>0:08:39</b>	
	<b>Total</b>	<b>0:07:34</b>	<b>0:07:48</b>	<b>0:08:23</b>	<b>0:07:58</b>	<b>0:07:56</b>	
Scene time (etimes09-etimes07)	First Response	0:20:19	0:23:06	0:20:00	0:22:34	<b>0:21:30</b>	
	Ground Transport	0:17:08	0:18:21	0:16:44	0:18:03	<b>0:17:34</b>	
	<b>Total</b>	<b>0:18:43</b>	<b>0:20:44</b>	<b>0:18:22</b>	<b>0:20:18</b>	<b>0:19:32</b>	
First CPR to Determination of Death (earrest15-earrest19) Disposition : "Dead at Scene"	First Response	0:25:01	0:26:00	0:24:57	0:25:00	<b>0:25:15</b>	
	Ground Transport	0:27:03	0:26:52	0:24:45	0:26:21	<b>0:26:15</b>	
	<b>Total</b>	<b>0:26:02</b>	<b>0:26:26</b>	<b>0:24:51</b>	<b>0:25:41</b>	<b>0:25:45</b>	
First CPR to Transport (etimes09-earrest19)	First Response	0:23:30	0:26:00	0:23:20	0:25:01	<b>0:24:28</b>	
	Ground Transport	0:22:21	0:23:53	0:22:51	0:24:45	<b>0:23:27</b>	
	<b>Total</b>	<b>0:22:56</b>	<b>0:24:56</b>	<b>0:23:06</b>	<b>0:24:53</b>	<b>0:23:58</b>	
Patient contact to transport time (etimes11-etimes07) Dispo= "Patient treated and transported by this unit"	First Response	0:26:00	0:43:26	0:27:03	0:33:56	<b>0:32:36</b>	
	Ground Transport	0:27:48	0:27:57	0:27:56	0:29:28	<b>0:28:17</b>	
	<b>Total</b>	<b>0:26:54</b>	<b>0:35:41</b>	<b>0:27:29</b>	<b>0:31:42</b>	<b>0:30:27</b>	
Patient contact to determination of death (earrest15-etimes07)	First Response	<b>0:11:46</b>	<b>0:12:13</b>	<b>0:11:52</b>	<b>0:12:00</b>	<b>0:11:58</b>	
	Dead at Scene, No Resuscitation, No Transport	0:01:00	0:01:00	0:00:44	0:01:00	<b>0:00:56</b>	
	Resuscitation Attempted, Dead at Scene, No Transport	0:22:32	0:23:26	0:23:00	0:23:00	<b>0:23:00</b>	
	Ground Transport	<b>0:12:37</b>	<b>0:12:10</b>	<b>0:11:33</b>	<b>0:11:33</b>	<b>0:11:59</b>	
	Dead at Scene, No Resuscitation, No Transport	0:02:00	0:01:05	0:01:36	0:01:07	<b>0:01:27</b>	
	Resuscitation Attempted, Dead at Scene, No Transport	0:23:14	0:23:15	0:21:31	0:22:00	<b>0:22:30</b>	
		<b>0:12:12</b>	<b>0:12:11</b>	<b>0:11:43</b>	<b>0:11:47</b>	<b>0:11:58</b>	

*\*Data is based on Incidents and documentation*

90th percentile Time		2019			2020		
		Qtr2	Qtr3	Qtr4	Qtr1		
Patient contact time (etimes07-etimes03)	First Response	0:11:25	0:11:07	0:11:23	0:10:28	<b>0:11:06</b>	
	Ground Transport	0:14:16	0:16:17	0:14:13	0:15:40	<b>0:15:06</b>	
	<b>Total</b>	<b>0:12:50</b>	<b>0:13:42</b>	<b>0:12:48</b>	<b>0:13:04</b>	<b>0:13:06</b>	
Scene time (etimes09-etimes07)	First Response	0:38:04	0:38:41	0:34:30	0:38:17	<b>0:37:23</b>	
	Ground Transport	0:30:31	0:32:12	0:30:38	0:32:46	<b>0:31:32</b>	
	<b>Total</b>	<b>0:34:17</b>	<b>0:35:27</b>	<b>0:32:34</b>	<b>0:35:31</b>	<b>0:34:27</b>	
First CPR to Determination of Death (earrest15-earrest19) Disposition : "Dead at Scene"	First Response	0:37:10	0:41:54	0:37:33	0:35:00	<b>0:37:54</b>	
	Ground Transport	0:39:00	0:40:00	0:38:23	0:38:06	<b>0:38:52</b>	
	<b>Total</b>	<b>0:38:05</b>	<b>0:40:57</b>	<b>0:37:58</b>	<b>0:36:33</b>	<b>0:38:23</b>	
First CPR to Transport (etimes09-earrest19)	First Response	0:42:23	0:41:00	0:41:02	0:44:18	<b>0:42:11</b>	
	Ground Transport	0:38:40	0:40:18	0:40:40	0:39:07	<b>0:39:41</b>	
	<b>Total</b>	<b>0:40:31</b>	<b>0:40:39</b>	<b>0:40:51</b>	<b>0:41:43</b>	<b>0:40:56</b>	
Patient contact to transport time (etimes11-etimes07) Dispo= "Patient treated and transported by this unit"	First Response	0:45:35	1:00:06	0:41:00	0:42:18	<b>0:47:15</b>	
	Ground Transport	0:44:01	0:46:11	0:43:14	0:46:19	<b>0:44:56</b>	
	<b>Total</b>	<b>0:44:48</b>	<b>0:53:09</b>	<b>0:42:07</b>	<b>0:44:18</b>	<b>0:46:06</b>	
Patient contact to detemination of death (earrest15-etimes07)	<b>First Response</b>	<b>0:19:16</b>	<b>0:19:31</b>	<b>0:17:47</b>	<b>0:17:12</b>	<b>0:18:26</b>	
	Dead at Scene, No Resuscitation, No Transport	0:04:32	0:04:38	0:03:09	0:03:33	<b>0:03:58</b>	
	Resuscitation Attempted, Dead at Scene, No Transport	0:34:00	0:34:24	0:32:25	0:30:51	<b>0:32:55</b>	
	<b>Ground Transport</b>	<b>0:18:00</b>	<b>0:18:54</b>	<b>0:17:45</b>	<b>0:17:32</b>	<b>0:18:03</b>	
	Dead at Scene, No Resuscitation, No Transport	0:03:59	0:05:54	0:06:00	0:04:05	<b>0:05:00</b>	
	Resuscitation Attempted, Dead at Scene, No Transport	0:32:00	0:31:53	0:29:30	0:31:00	<b>0:31:06</b>	
		<b>0:18:38</b>	<b>0:19:12</b>	<b>0:17:46</b>	<b>0:17:22</b>	<b>0:18:15</b>	

*\*Data is based on Incidents and documentation*

# Traumatic Cardiac Arrest- 7/1/2018- 3/31/2020

"911 Response", "Cardiac arrest during EMS event=Yes", Cardiac arrest Etiology="Trauma"

	2018				2019				2020		Total							
	Qtr3		Qtr4		Qtr1		Qtr2		Qtr3			Qtr4						
Total Incidents	122		126		112		159		153		147		137		956			
Age	Average Age		38		48		39		40		42		44		39		42	
	Median Age		35		44		37		40		40		40		35		40	
By Age group	0-9		8 7%		4 3%		8 7%		14 9%		10 7%		2 1%		7 6%		53 6%	
	10-14		2 2%		4 3%		1 1%				3 2%		1 1%		1 1%		12 1%	
	15-24		19 16%		14 11%		10 9%		26 16%		10 7%		16 11%		23 21%		118 12%	
	25-34		32 26%		28 22%		32 29%		20 13%		35 23%		41 28%		34 30%		222 23%	
	35-44		19 16%		13 10%		17 15%		27 17%		26 17%		18 12%		26 23%		146 15%	
	45-54		15 12%		16 13%		19 17%		26 16%		19 12%		22 15%		15 13%		132 14%	
	55-64		16 13%		13 10%		6 5%		30 19%		24 16%		24 16%		9 8%		122 13%	
	65-79		6 5%		18 14%		16 14%		13 8%		22 14%		16 11%		8 7%		99 10%	
	80+		5 4%		16 13%		3 3%		3 2%		4 3%		7 5%		10 9%		48 5%	
By Ambulance Zone	Northwest Zone		37 30%		29 23%		31 28%		41 26%		40 26%		39 27%		46 41%		263 28%	
	Desert Zone		21 17%		30 24%		34 30%		32 20%		32 21%		30 20%		18 16%		197 21%	
	Southwest Zone		18 15%		26 21%		15 13%		29 18%		21 14%		20 14%		19 17%		148 15%	
	Central Zone		16 13%		9 7%		16 14%		25 16%		29 19%		22 15%		25 22%		142 15%	
	San Jacinto Zone		24 20%		11 9%		6 5%		18 11%		16 10%		24 16%		20 18%		119 12%	
	Pass Zone		2 2%		15 12%		7 6%		6 4%		7 5%		5 3%		4 4%		46 5%	
	Mountain Plateau Zone		2 2%		4 3%		1 1%		4 3%				0%		5 3%		4 4%	
	Palo Verde Zone		2 2%		2 2%		2 2%		3 2%		8 5%		2 1%		1 1%		20 2%	
Injury Mechanism	Blunt only		68 56%		80 63%		58 52%		99 62%		73 48%		78 53%		76 68%		532 56%	
	Penetrating		25 20%		27 21%		21 19%		29 18%		40 26%		36 24%		34 30%		212 22%	
	Blunt and penetrating		6 5%		3 2%		4 4%		2 1%		3 2%		3 2%		3 3%		24 3%	
	Burn				3 2%						1 1%		1 1%				5 1%	
	Blunt and Burn		1 1%				2 2%						0%		4 4%		7 1%	
	Other		16 13%		8 6%		19 17%		18 11%		25 16%		16 11%		10 9%		112 12%	
	Not documented		6 5%		5 4%		8 7%		11 7%		11 7%		13 9%		10 9%		64 7%	
Odomeater Reading	Total Incidents documented Odometer reading		23		35		28		30		31		29		25		201	
	Sum of Odometer Reading		111		260		180		160		168		296		259		1433	
	Average of Odometer Reading		5		7		6		5		5		10		10		7	
	Max of Odometer Reading		22		23		15		14		25		26		26		26	

	2018				2019				2020				Total			
	Qtr3		Qtr4		Qtr1		Qtr2		Qtr3		Qtr4				Qtr1	
<b>Total Transports Dispo:Treated and Transported by this unit</b>	<b>23</b>		<b>35</b>		<b>28</b>		<b>30</b>		<b>31</b>		<b>29</b>		<b>25</b>		<b>201</b>	
<b>Trauma center</b>	<b>14</b>	<b>61%</b>	<b>25</b>	<b>71%</b>	<b>15</b>	<b>54%</b>	<b>17</b>	<b>57%</b>	<b>21</b>	<b>68%</b>	<b>21</b>	<b>72%</b>	<b>17</b>	<b>68%</b>	<b>130</b>	<b>65%</b>
Riverside Community Hospital	7	30%	6	17%	5	18%	7	23%	8	26%	7	24%	2	8%	42	21%
Riverside University Health System Medical Center	4	17%	7	20%	3	11%	4	13%	7	23%	8	28%	6	24%	39	19%
Desert Regional Medical Center	1	4%	6	17%	4	14%	3	10%	3	10%	4	14%	5	20%	26	13%
Inland Valley Medical Center	2		6	17%	3	11%	3	10%	3	10%	2	7%	4	16%	23	11%
<b>Non-Trauma Center</b>	<b>9</b>	<b>39%</b>	<b>10</b>	<b>29%</b>	<b>13</b>	<b>46%</b>	<b>13</b>	<b>43%</b>	<b>10</b>	<b>32%</b>	<b>8</b>	<b>28%</b>	<b>8</b>	<b>32%</b>	<b>71</b>	<b>35%</b>
Hemet Valley Medical Center	1	4%	6	17%	2	7%	2	7%	2	6%	4	14%		0%	17	8%
JFK - John F Kennedy Memorial Hospital	1	4%			1	4%	3	10%	1	3%	2	7%		0%	8	4%
Corona Regional Medical Center	1		1		2		2	7%				0%	1		7	3%
San Gorgonio Memorial Hospital			2	6%	3	11%			1	3%			1	4%	7	3%
Eisenhower Medical Center					1		3		1		1				6	
Palo Verde Hospital	1		1		2				1						5	
Rancho Springs Medical Center	2				1		1				1				5	
Menifee Valley Medical Center	1						1		1				1		4	
Kaiser Riverside Medical Center	2	9%				0%			1	3%			1	4%	4	2%
Loma Linda University Medical Center, Murrieta		0%		0%									4		4	2%
Temecula Valley Hospital		0%					1		2	6%					3	1%
Parkview Community Hospital Medical Center				0%	1										1	0%
	2018				2019				2020				Total			
<b>Base Hospital contact("Yes/No") (itdisposition.007)</b>	<b>Qtr3</b>		<b>Qtr4</b>		<b>Qtr1</b>		<b>Qtr2</b>		<b>Qtr3</b>		<b>Qtr4</b>				<b>Qtr1</b>	
	<b>122</b>		<b>126</b>		<b>112</b>		<b>159</b>		<b>153</b>		<b>147</b>		<b>112</b>		<b>956</b>	
<b>Yes</b>	<b>34</b>	<b>28%</b>	<b>47</b>	<b>37%</b>	<b>29</b>	<b>26%</b>	<b>46</b>	<b>29%</b>	<b>42</b>	<b>27%</b>	<b>47</b>	<b>32%</b>	<b>30</b>	<b>27%</b>	<b>275</b>	<b>29%</b>
First Response	18	15%	20	16%	16	14%	24	15%	21	14%	23	16%	19	17%	141	15%
Ground Transport	16	13%	27	21%	13	12%	22	14%	21	14%	24	16%	11	10%	134	14%
<b>No</b>	<b>88</b>	<b>72%</b>	<b>79</b>	<b>63%</b>	<b>83</b>	<b>74%</b>	<b>113</b>	<b>71%</b>	<b>111</b>	<b>73%</b>	<b>100</b>	<b>68%</b>	<b>107</b>	<b>96%</b>	<b>681</b>	<b>71%</b>
First Response	60	49%	56	44%	49	44%	77	48%	73	48%	69	47%	64	57%	448	47%
Ground Transport	28	23%	23	18%	34	30%	36	23%	38	25%	31	21%	43	38%	233	24%

Median Time		2018		2019				2020	
		Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	
Patient contact time (etimes07-etimes03)	First Response	0:08:50	0:08:33	0:08:10	0:07:32	0:07:59	0:08:10	0:07:48	0:08:09
	Ground Transport	0:09:24	0:08:47	0:09:21	0:07:09	0:09:18	0:07:37	0:08:28	0:08:35
	<b>Total</b>	<b>0:09:07</b>	<b>0:08:40</b>	<b>0:08:45</b>	<b>0:07:20</b>	<b>0:08:39</b>	<b>0:07:53</b>	<b>0:08:08</b>	<b>0:08:22</b>
Scene time (etimes09-etimes07)	First Response	0:13:10	0:16:06	0:16:36	0:10:06	0:16:00	0:12:12	0:14:52	0:14:09
	Ground Transport	0:07:25	0:10:57	0:08:19	0:09:03	0:08:52	0:08:34	0:10:06	0:09:02
	<b>Total</b>	<b>0:10:17</b>	<b>0:13:31</b>	<b>0:12:28</b>	<b>0:09:34</b>	<b>0:12:26</b>	<b>0:10:23</b>	<b>0:12:29</b>	<b>0:11:36</b>
First CPR to Determination of Death (earrest15-earrest19) Disposition: "Res., attempted, Dead at Scene"	First Response	0:20:30	0:15:00	0:32:00	0:22:00	0:23:30	0:23:00	0:24:00	0:22:51
	Ground Transport	0:20:30	0:20:53	0:33:00	0:23:00	0:20:18	0:26:30	0:29:23	0:24:48
	<b>Total</b>	<b>0:20:30</b>	<b>0:17:56</b>	<b>0:32:30</b>	<b>0:22:30</b>	<b>0:21:54</b>	<b>0:24:45</b>	<b>0:26:42</b>	<b>0:23:50</b>
First CPR to Transport (etimes09-earrest19)	First Response	0:25:43	0:04:10	0:18:00	0:08:43	0:05:01	0:12:35		0:12:22
	Ground Transport	0:13:10	0:12:38	0:14:00	0:06:46	0:08:18	0:16:13	0:21:13	0:13:11
	<b>Total</b>	<b>0:19:26</b>	<b>0:08:24</b>	<b>0:16:00</b>	<b>0:07:44</b>	<b>0:06:39</b>	<b>0:14:24</b>	<b>0:21:13</b>	<b>0:12:48</b>
Patient contact to transport time (etimes11-etimes07) Disposition: "Patient treated and transported by this unit"	First Response	0:20:18	0:25:40	0:28:04	0:19:16	0:17:30	0:20:11	0:31:00	0:23:08
	Ground Transport	0:16:04	0:22:07	0:19:11	0:15:04	0:17:30	0:24:10	0:25:56	0:20:00
	<b>Total</b>	<b>0:18:11</b>	<b>0:23:53</b>	<b>0:23:37</b>	<b>0:17:10</b>	<b>0:17:30</b>	<b>0:22:11</b>	<b>0:28:28</b>	<b>0:21:34</b>
Patient contact to determination of death (earrest15-etimes07)	<b>First Response</b>	<b>0:08:00</b>	<b>0:08:18</b>	<b>0:15:19</b>	<b>0:11:34</b>	<b>0:11:00</b>	<b>0:09:37</b>	<b>0:08:52</b>	<b>0:10:23</b>
	Dead at Scene, No Resuscitation, No Transport	0:01:00	0:01:37	0:01:39	0:02:10	0:02:00	0:01:00	0:01:00	0:01:29
	Resuscitation Attempted, Dead at Scene, No Transport	0:15:00	0:15:00	0:29:00	0:20:58	0:20:00	0:18:15	0:16:45	0:19:17
	<b>Ground Transport</b>	<b>0:12:14</b>	<b>0:13:17</b>	<b>0:14:24</b>	<b>0:11:24</b>	<b>0:09:42</b>	<b>0:11:36</b>	<b>0:09:50</b>	<b>0:11:47</b>
	Dead at Scene, No Resuscitation, No Transport	0:02:00	0:03:00	0:00:48	0:02:00	0:01:30	0:02:13	0:01:32	0:01:52
	Resuscitation Attempted, Dead at Scene, No Transport	0:22:28	0:23:35	0:28:00	0:20:47	0:17:53	0:21:00	0:18:09	0:21:42
		<b>0:10:07</b>	<b>0:10:48</b>	<b>0:14:52</b>	<b>0:11:29</b>	<b>0:10:21</b>	<b>0:10:37</b>	<b>0:09:21</b>	<b>0:11:05</b>

Average Time		2018		2019				2020	
		Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	
Patient contact time (etimes07-etimes03)	First Response	0:11:55	0:13:20	0:12:47	0:09:38	0:09:59	0:09:33	0:10:46	0:11:08
	Ground Transport	0:10:07	0:11:38	0:11:55	0:10:53	0:14:50	0:09:42	0:08:31	0:11:05
	<b>Total</b>	<b>0:11:01</b>	<b>0:12:29</b>	<b>0:12:21</b>	<b>0:10:15</b>	<b>0:12:24</b>	<b>0:09:37</b>	<b>0:09:39</b>	<b>0:11:07</b>
Scene time (etimes09-etimes07)	First Response	0:17:12	0:24:04	0:17:57	0:15:24	0:14:47	0:19:36	0:25:06	0:19:09
	Ground Transport	0:15:46	0:12:33	0:09:59	0:09:46	0:12:41	0:11:11	0:13:32	0:12:13
	<b>Total</b>	<b>0:16:29</b>	<b>0:18:18</b>	<b>0:13:58</b>	<b>0:12:35</b>	<b>0:13:44</b>	<b>0:15:24</b>	<b>0:19:19</b>	<b>0:15:41</b>
First CPR to Determination of Death (earrest15-earrest19) Dispo= "Res., attempted, Dead at Scene"	First Response	0:21:00	0:15:29	0:32:00	0:22:40	0:24:00	0:22:39	0:19:18	0:22:27
	Ground Transport	0:20:30	0:20:53	0:33:00	0:24:34	0:21:10	0:24:43	0:30:08	0:25:00
	<b>Total</b>	<b>0:20:45</b>	<b>0:18:11</b>	<b>0:32:30</b>	<b>0:23:37</b>	<b>0:22:35</b>	<b>0:23:41</b>	<b>0:24:43</b>	<b>0:23:43</b>
First CPR to Transport (etimes09-earrest19)	First Response	0:25:43	0:04:10	0:18:00	0:08:43	0:05:01	0:12:35		0:12:22
	Ground Transport	0:12:19	1:18:46	0:13:24	0:09:11	0:13:42	0:15:53	0:16:58	0:22:53
	<b>Total</b>	<b>0:19:01</b>	<b>0:41:28</b>	<b>0:15:42</b>	<b>0:08:57</b>	<b>0:09:21</b>	<b>0:14:14</b>	<b>0:16:58</b>	<b>0:18:02</b>
Patient contact to transport time (etimes11-etimes07) Dispo= "Patient treated and transported by this unit"	First Response	0:22:58	0:26:35	0:28:04	0:19:16	0:17:30	0:20:11	0:31:00	0:23:39
	Ground Transport	0:16:10	0:28:52	0:20:13	0:17:01	0:20:18	0:27:35	0:25:30	0:22:14
	<b>Total</b>	<b>0:19:34</b>	<b>0:27:43</b>	<b>0:24:09</b>	<b>0:18:08</b>	<b>0:18:54</b>	<b>0:23:53</b>	<b>0:28:15</b>	<b>0:22:57</b>
Patient contact to detemination of death (earrest15-etimes07)	<b>First Response</b>	<b>0:09:29</b>	<b>0:10:46</b>	<b>0:16:40</b>	<b>0:11:43</b>	<b>0:09:45</b>	<b>0:09:35</b>	<b>0:08:12</b>	<b>0:10:53</b>
	Dead at Scene, No Resuscitation, No Transport	0:01:46	0:02:44	0:04:20	0:04:56	0:02:26	0:01:49	0:02:55	0:02:59
	Resuscitation Attempted, Dead at Scene, No Transport	0:17:11	0:18:49	0:29:00	0:18:31	0:17:05	0:17:21	0:13:30	0:18:47
	<b>Ground Transport</b>	<b>0:11:09</b>	<b>0:14:22</b>	<b>0:14:24</b>	<b>0:11:30</b>	<b>0:09:44</b>	<b>0:11:18</b>	<b>0:11:36</b>	<b>0:12:00</b>
	Dead at Scene, No Resuscitation, No Transport	0:02:00	0:02:28	0:00:48	0:01:55	0:01:30	0:02:19	0:02:14	0:01:53
	Resuscitation Attempted, Dead at Scene, No Transport	0:20:18	0:26:16	0:28:00	0:21:04	0:17:59	0:20:18	0:20:58	0:22:08
		<b>0:10:19</b>	<b>0:12:34</b>	<b>0:15:32</b>	<b>0:11:36</b>	<b>0:09:45</b>	<b>0:10:27</b>	<b>0:09:54</b>	<b>0:11:27</b>

# ONLY ONE

## FLOWSAFE II® DISPOSABLE CPAP SYSTEM

### Flow-Safe II® Disposable CPAP Therapy System

- Ideal for wherever CPAP therapy is appropriate
- Pre-hospital or in hospital use
- Compact and easy to store – no extra parts
- Color-coded manometer verifies delivered CPAP pressure
- Uses 50% Less Oxygen Consumption than the original Flow-Safe
- Comfortable head harness with quick disconnect clips for easy access to patient's face
- Forehead support reduces pressure on the nose and easily adjusts
- Easy Set up & Training – just attach to standard flowmeters/Flow determines CPAP pressure. Yellow Flow/CPAP chart on all devices illustrates flow rate with corresponding delivered CPAP pressures.



#### CONNECT TO FLOW SOURCE ONLY FLOWSAFE II

CPAP/PEEP (cm H <sub>2</sub> O)	Flow (LPM)
5.0	8 - 9
7.5	10 - 12
10.0	13 - 14
13.0 (MAX)	FLUSH



# ONLY ONE

## FLOWSAFE II® DISPOSABLE CPAP SYSTEM

Flow-Safe II® Disposable CPAP Therapy System  
Compared to Non-invasive Mechanical Ventilation



Contents lists available at ScienceDirect

American Journal of Emergency Medicine

Journal homepage: [www.elsevier.com/locate/ajem](http://www.elsevier.com/locate/ajem)



Is the flow-safe disposable continuous positive airway pressure (CPAP) system as effective as non-invasive mechanical ventilation (NIMV) in the treatment of acute cardiogenic pulmonary Oedema?

Ilhan UZ, MD<sup>a,\*</sup>, Güçlü Selahattin KIYAN, MD<sup>a</sup>, Enver ÖZÇETE, MD<sup>a</sup>, Sercan YALÇINLI, MD<sup>a</sup>, Mehmet Birkan KORGAN, MD<sup>a</sup>, Yusuf Ali ALTUNCI, MD<sup>a</sup>, Murat ERSEL, MD<sup>a</sup>, Funda Karbek AKARCA, MD<sup>a</sup>, Oğuz YAVUZGİL, MD<sup>b</sup>

<sup>a</sup> Department of Emergency Medicine, Ege University Faculty of Medicine, Izmir, Turkey

<sup>b</sup> Department of Cardiology, Ege University Faculty of Medicine, Izmir, Turkey

According to this recent American Journal of Emergency Medicine, For acute cardiogenic pulmonary oedema, (ACPO) patients, the Flow-Safe® Disposable CPAP device is “as effective as NIMV, in improving blood pressure, pulse, respiratory rate and blood gas.”

Flow-Safe II, Flow-Safe II EZ® and Flow-Safe II+® can be solutions for situations where non-invasive mechanical ventilation equipment is scarce or unavailable.



### ORDERING INFORMATION

Part #	Description	Packaged
#10-57203	Flow-Safe II CPAP System w/o mask	5/Box
#10-57209	Flow-Safe II CPAP System w/ large adult deluxe mask w/ straight swivel port, head harness	5/Box
#10-57210	Flow-Safe II CPAP System w/ medium/small adult deluxe mask w/ straight swivel port, head harness	5/Box
#10-57211	Flow-Safe II CPAP System w/ child deluxe mask w/ straight swivel port, head harness	5/Box

\* Other configurations available



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# ONLY ONE

for CPAP & BiLevel Masks

## Deluxe Masks w/ Straight Connector

### ORDERING INFORMATION

Part #	Description	Packaged
#10-57103	Large adult deluxe contoured mask with straight connector, head harness	5/Box
#10-57104	Medium/Small adult deluxe contoured mask with straight connector, head harness	5/Box
#10-57105	Child deluxe contoured mask with straight connector, head harness	5/Box



## Deluxe Masks w/ Straight Connector & Mask Ports

### ORDERING INFORMATION

Part #	Description	Packaged
#10-57112	Large adult deluxe contoured mask with straight connector, 2 mask ports, head harness	5/Box
#10-57113	Medium/Small adult deluxe contoured mask with straight connector, 2 mask ports, head harness	5/Box
#10-57114	Child deluxe contoured mask with straight connector, 2 mask ports, head harness	5/Box



## Deluxe Masks w/ 90° Elbow, Anti-Asphyxia

### ORDERING INFORMATION

Part #	Description	Packaged
#10-57100	Large adult deluxe contoured mask with 90° elbow, anti-asphyxia, head harness	5/Box
#10-57101	Medium/Small adult deluxe contoured mask with 90° elbow, anti-asphyxia, head harness	5/Box
#10-57102	Child deluxe contoured mask with 90° elbow, anti-asphyxia, head harness	5/Box



## Deluxe Masks w/ 90° Elbow, Anti-Asphyxia & Mask Ports

### ORDERING INFORMATION

Part #	Description	Packaged
#10-57109	Large adult deluxe mask with 90° swivel port, anti-asphyxia, 2 mask ports, head harness	5/Box
#10-57110	Medium/Small adult deluxe mask with 90° swivel port, anti-asphyxia, 2 mask ports, head harness	5/Box
#10-57111	Child deluxe mask with 90° swivel port, anti-asphyxia, 2 mask ports, head harness	5/Box



# ONLY ONE

## Low FiO<sub>2</sub> Elbow

### Low FiO<sub>2</sub> Elbow:

The Flow-Safe® II has an optional Low FiO<sub>2</sub> Elbow that can be used for specific patients that may require low FiO<sub>2</sub> delivery. The elbow is easy to connect and reduces the delivered FiO<sub>2</sub> to approximately 35%.

### Intended Use:

The Flow-Safe II Low FiO<sub>2</sub> elbow is intended for use with Flow-Safe II **ONLY**, without nebulizer.



### ORDERING INFORMATION

Part #	Description	Packaged
#10-57128	Low FiO <sub>2</sub> Non-vented Anti-Asphyxia Valve Elbow	10/Box



Disclaimer: The product is enlarged for illustrative purposes only.

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# ONLY ONE

## FLOW-SAFE II +<sup>®</sup>

Disposable BiLevel CPAP System

BiLevel & CPAP Disposable System in One

Flow-Safe II+<sup>®</sup> is the only available Disposable BiLevel CPAP System! The lightweight disposable feature allows for easy CPAP or BiLevel CPAP therapy set up and delivery during transport. All devices include an integrated manometer for verifying CPAP, IPAP and EPAP pressures. The Disposable Flow-Safe II+ System is ideal for situations where backup BiLevel CPAP equipment is scarce or unavailable.

- First Disposable BiLevel Device with CPAP or BiLevel Mode switch allows easy transition from CPAP to BiLevel Mode
- No Extra Parts – Flow Determines CPAP or BiLevel IPAP Pressure, Easy EPAP Dial adjusts expiratory pressure
- Verify CPAP & BiLevel Pressures with Integrated Manometer (available on all models)
- Easy to transport
- No Capital Equipment – Ideal for Acute Care and Pre-hospital Settings

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## FLOWSAFE II +®

Disposable BiLevel CPAP System

### How the System Works

By connecting the Flow-Safe II+® BiLevel CPAP System to a flowmeter/regulator start with the green knob in the CPAP position. By adjusting flow rates up and down, various CPAP pressures can be achieved and verified with the manometer.



Blue knob adjusts EPAP Pressure

Green knob selects CPAP or BiLevel pressure mode

#### CONNECT TO FLOW SOURCE ONLY



Flow (LPM)	CPAP MODE (cm H <sub>2</sub> O)
6	2.0 - 3.0
10	6.0 - 7.0
12	8.0 - 9.0
15	11.0 - 12.0

**CAUTION:** CPAP pressure will decrease when BiLevel is activated & increase when BiLevel is deactivated. Verify CPAP pressure with manometer & adjust flowmeter as needed.

#### CONNECT TO FLOW SOURCE ONLY



Flow (LPM)	BiLevel MODE (cm H <sub>2</sub> O)
14	8 - 9 IPAP
15	9 - 10 IPAP
16	11 - 12 IPAP
17 (MAX)	12 - 13 IPAP

**CAUTION:** CPAP pressure will decrease when BiLevel is activated & increase when BiLevel is deactivated. Verify CPAP pressure with manometer & adjust flowmeter as needed.

For BiLevel therapy, simply switch the green knob to the BiLevel position. The CPAP pressure now becomes the Inspiratory Positive Airway Pressure (IPAP). Adjust the blue EPAP knob to obtain desired Expiratory Positive Airway Pressure.

### Flow-Safe II® Disposable CPAP Therapy System Compared to Non-invasive Mechanical Ventilation



American Journal of Emergency Medicine

Journal homepage: www.elsevier.com/locate/ajem

Is the flow-safe disposable continuous positive airway pressure (CPAP) system as effective as non-invasive mechanical ventilation (NIMV) in the treatment of acute cardiogenic pulmonary oedema?

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<sup>1</sup> Department of Emergency Medicine, Ege University Faculty of Medicine, Sıhhiye, Turkey

<sup>2</sup> Department of Cardiology, Ege University Faculty of Medicine, Sıhhiye, Turkey

According to this recent American Journal of Emergency Medicine, For acute cardiogenic pulmonary oedema, (ACPO) patients, the Flow-Safe® Disposable CPAP device is "as effective as NIMV, in improving blood pressure, pulse, respiratory rate and blood gas."

Flow-Safe II, Flow-Safe II EZ® and Flow-Safe II+ can be solutions for situations where non-invasive mechanical ventilation equipment is scarce or unavailable.

#### ORDERING INFORMATION

Part #	Description	Packaged
#10-57400	Flow-Safe II+ BiLevel CPAP w/ Large Adult	5/Box
	Flow-Safe II+ BiLevel CPAP w/ Medium/Small Adult	
	Flow-Safe II+ BiLevel CPAP w/ Small/Child Full Face Mask w/ Straight Swivel Port & Headstrap	
#10-57403	Flow-Safe II+ BiLevel CPAP w/o Mask	5/Box

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## FOR CONSIDERATION BY PMAC

Attachment G

Page 1 of 1

DATE: August 3, 2020  
TO: PMAC  
FROM: Misty Plumley, Senior EMS Specialist  
SUBJECT: Education / Policy Update

Policy Changes were made in July 2020 (effective July 1<sup>st</sup>) to remove stroke diversion from REMSA 6103, with an adjacent overlap to REMSA 2202 ReddiNet. Changes made with Stroke System committee direction and forward planning.

Minor administrative changes to report title were made to REMSA 2101 Emergency Medical Dispatch to more accurately title reporting mechanisms.

REMSA 8101 Resource List – Hospital page, was updated with changes in hospital capabilities as noted in Stroke Updates. Those stroke updates do not impact current field triage of stroke patients.

Additional trauma policies related to Trauma Center Standards, and Pediatric Trauma Center Standards were added to administratively align with contract periods, and were effective July 1, 2020.

REMSA 3307A will continue to evolve along with the COVID pandemic, and as treatment standards evolve.

Policy Manual Changes effective October 1:

- Addition of ketamine as BHO to REMSA 4606 Snakebite (for continuity of controlled substance administration through all traumatic injuries protocols).
- Addition of COVID Surge plan protocols:
  - o Assign and Refer – only activated as EMS COVID XRI Surge triggers are met
  - o COVID XRI with specific triggers for COVID surge thresholds.

ACTION: Informational sharing with PMAC, after review please provide any feedback to REMSA.

**FOR CONSIDERATION BY PMAC**

Attachment H

Page 1 of 1

DATE: August 3, 2020  
TO: PMAC  
FROM: Misty Plumley, Senior EMS Specialist  
SUBJECT: Ketamine Study Published

Our Ketamine study was published. It is in a peer-reviewed online publication and will have a PubMed ID number (PMID). Both ICEMA and REMSA are noted as contributing agencies.

Thank you to all REMSA EMS Providers who participated, and to your personnel for their contributions to further patient care initiatives and adding to the Local Optional Scope of Practice for Riverside County.

Please post, and share this article link below for your field personnel as well. The article has an SIQ score in the top left when accessed online. The more our article is shared, read and rated the better the SIQ score will be.

<https://www.cureus.com/articles/33489-evaluation-of-safety-and-efficacy-of-prehospital-paramedic-administration-of-sub-dissociative-dose-of-ketamine-in-the-treatment-of-trauma-related-pain-in-adult-civilian-population>

ACTION: Informational sharing with PMAC, PMAC participants should share this article with colleagues, and agency personnel and encourage reading, review and rating.

**FOR CONSIDERATION BY PMAC**

DATE: August 3, 2020  
TO: PMAC  
FROM: Misty Plumley, Senior EMS Specialist  
SUBJECT: LOSOP Application Update

REMSA is completing a Local Optional Scope of Practice (LOSOP) application with CA EMSA to facilitate Static Site Practice. This LOSOP application would further facilitate:

- EMT and Paramedic functioning within their scopes of practice at long term care facilities (LTCF) as needed during times of surge (and only when specifically deployed by REMSA)
- Paramedic assistance with vaccination points of distribution (POD's) or vaccination clinics. This would serve as part of a planning effort for the upcoming flu season and associated vaccination efforts done in tandem with RUHS Public Health.

ACTION: Informational sharing with PMAC, after review please provide any feedback to REMSA.