



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

PMAC MEMBERS PER POLICY 8202:

Air Transport Provider Representative  
11-Brian Harrison

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- Jennifer Antonucci

County Fire Chiefs' Non-Transport BLS Provider  
9- Vacant

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

Eisenhower Health  
1-Mandeep Daliwhal, MD (Ibanez)  
4-Thomas Wofford

EMT / EMT-P Training Programs  
6-Maggie Robles

EMT-at-Large  
13 - Vacant

Paramedic-at-Large  
14-Patrick Anderson

Hemet Valley Medical Center  
1-Todd Hanna, MD  
4-Trish Rita-Rita

Idyllwild Fire Protection District  
5-Mark Lamont

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

JFK Memorial Hospital  
1-Timothy Rupp, MD  
4- Evelin Millsap

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

**This Meeting of PMAC is on:**  
**Monday, November 22, 2021**  
**9:00 AM to 11:00 AM**  
**Virtual Session via Microsoft TEAMS**

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)**  
August 23, 2021 Minutes— Seth Dukes, MD (Attachment A)
4. **STANDING REPORTS**
  - 4.1. Trauma System—Shanna Kissel (Attachment B)
  - 4.2. STEMI System— Leslie Duke (Attachment C)
  - 4.3. Stroke System— Leslie Duke (Attachment D)
5. **Other Reports**
  - 5.1. EMCC Report – Dan Bates
6. **DISCUSSION ITEMS, UNFINISHED & NEW BUSINESS**
  - 6.1. Unfinished Business –
    - 6.1.1. PMAC Representation
      - 6.1.1.1. RCFCA Non-Transport BLS provider position
      - 6.1.1.2. EMT-at-Large position
      - 6.1.1.3. EMT / EMT-P Training Program position
    - 6.2. CQI Update – Lisa Madrid (Attachment E)
    - 6.3. Education / Policy Update – Dustin Rascon (Attachment F)
    - 6.4. Leave Behind Narcan – William Downes, MD
    - 6.5. Supraglottic Airway i-Gel – Alayna Prest, MD
    - 6.6. Epi-drip - Ryan Holtkamp
    - 6.7. OG Tube – Dustin Rascon (Attachment G)
    - 6.7. COVID Update – Misty Plumley
    - 6.8. 2022 Meeting Dates (Attachment H)
    - 6.9. 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-Matt Johnson

Kaiser Permanente Moreno Valley

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

Palo Verde Hospital

1-David Sincavage, MD  
4-Nena Foreman

Parkview Community Hospital

1-Chad Clark, MD  
4-Allan Patwaran

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- Richard Harvey  
8-Jeff Stout

Riverside County Police Association

7-Sean Hadden

Riverside University Health System Med. Center

1-Michael Mesisca, DO (Vice Chair)  
4-Lori Maddox

San Geronio Memorial Medical Center

1-Richard Preci, MD  
4-Angie Brady

Temecula Valley Hospital

1-Pranav Kachhi, MD  
4-Jacquelyn Ramirez

Trauma Audit Comm. & Trauma Program Managers

2- Vacant  
3-Brandon Woodward

Ex-officio Members:

1-Cameron Kaiser, MD, Public Health Officer  
2-Reza Vaezazizi, MD, REMSA Medical Director  
3-Trevor Douville, 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)**

—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
<b>1. CALL TO ORDER</b>	PMAC Chair Dr. Seth Dukes called the meeting to order at 9:02 a.m.	
<b>2. Virtual Attendance</b>	Attendance taken based on participant list on Microsoft TEAMS.	
<b>3. Approval of Minutes</b>		The May 17, 2021 PMAC meeting minutes were approved with no changes.
<b>4. STANDING REPORTS</b>		
<b>4.1 Trauma System Updates</b>	<p>Trauma Audit Committee is discussing guidelines for a Level IV Trauma Center.</p> <p>Riverside University Health System – Medical Center was designated as a Level I Trauma Center in June 2021. This does not change field criteria or destination.</p> <p>Trauma System Plan update to be submitted to EMSA in October 2021.</p>	Information only.
<b>4.2 STEMI System Updates</b>	<p>The STEMI dashboard posted on Rivcoems.org was updated to reflect quarter 1 2021 data related to the ImageTrend Patient Registry. Expansion of data presented on the dashboard continues to be developed; along with performance metric reports for tracking and guidance for CQI Initiatives.</p> <p>No changes to STEMI treatment or administrative policies in Fall PUC.</p> <p>STEMI-specific education is finalized and has been sent to providers for the 2021 Fall PUC.</p> <p>A STEMI specific orientation handbook has been developed for new STEMI managers onboarding process.</p> <p>The next Regional STEMI Committee meeting is scheduled for October 12<sup>th</sup>, 2021.</p>	Information only.
<b>4.3 Stroke System Updates</b>	<p>The Stroke dashboard posted on Rivcoems.org was updated to reflect quarter 1 2021 data related to the ImageTrend Patient Registry. Expansion of data presented on the dashboard continues to be developed; along with performance metric reports for tracking and guidance for CQI initiatives.</p> <p>No changes to stroke treatment or administrative policies in Fall PUC.</p> <p>Stroke-specific education is finalized and has been sent to providers for the 2021 Fall PUC.</p> <p>A stroke specific orientation handbook has been developed for new stroke managers onboarding process.</p> <p>The next Regional Stroke Committee meeting is scheduled for November 16<sup>th</sup>, 2021.</p>	Information only.
<b>5. OTHER REPORTS</b>		
<b>5.1 EMCC Report</b>	<p>EMCC update</p> <ul style="list-style-type: none"> <li>• Nominations are open for a new Chair and Vice Chair</li> </ul>	Information only.

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	<ul style="list-style-type: none"> <li>• COVID-19 update</li> <li>• RODA Grant update</li> <li>• Alternative destinations for 5150s</li> <li>• In partnership with RUHS-Behavioral Health, working on a new policy to include clinical therapists on non-emergency vehicles to accompany 5150s. Once the language is finalized, it will be brought forward for approval and implementation.</li> </ul>	
<p><b>6. DISCUSSION ITEMS, UNFINISHED &amp; NEW BUSINESS</b></p>		
<p><b>6.1 Unfinished Business</b></p>	<p>Unfinished business</p>	
<p><b>6.1.1 PMAC Representation</b></p> <p><b>6.1.1.1 RCFA Non-Transport BLS Provider position</b></p> <p><b>6.1.1.2 EMT-at-Large position</b></p> <p><b>6.1.2 EMS Physician on Scene Proposal</b></p>	<p>PMAC Representation for RCFA Non-Transport BLS Provider position is open for nomination. No nominations were brought forth at the meeting.</p> <p>PMAC Representation for EMT-at-Large position is open for nomination. No nominations were brought forth as the meeting.</p> <p>PMAC continued conversation regarding the EMS Physician on Scene Proposal that was discussed at the last meeting. A new and updated proposal was reviewed. The intent of the policy is to allow a licensed physician who is participating in an accredited postgraduate EMS Fellowship training program to assist paramedic personnel in advance life support procedures according to REMSA policies and protocols and/or to serve as direct medical control when at the scene of an incident. The EMS fellow on scene will have the authority to provide on-scene medical direction for procedures and/or medications that are designated as Base Hospital Orders (BHOs) in all REMSA treatment protocols. EMS Field personnel may receive and carry out BHOs from the EMS Fellow so long as they fall within their scope of practice and what is currently permitted per the appropriate REMSA treatment protocol.</p> <p>Dr. Stephen Patterson, RCH motioned to move the Administrative policy proposal forward to allow EMS Fellow on scene to behave as a Base Station Physician in treating the patient on scene. Dr. Michael Mesisca, RUHS seconded the motion.</p> <p>There were 0 opposed and 0 abstained from the motion. PMAC gave a unanimous approval to move the EMS Physician on Scene Proposal forward.</p> <p>Following implementation of the proposal and before assisting in the field, the EMS Physician will be required to complete the acknowledgement application, to be added as an additional</p>	<p>PMAC unanimously approved the EMS Physician on Scene Proposal.</p>

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	<p>crew member on scene and fulfill any training requirements to complete the credentialing process.</p>	
<p><b>6.2 Recognitions</b></p>	<p>Recognizing outstanding performance from our providers, REMSA and PMAC congratulated and thanked first responders and their team for exceptional service in patient care from an incident in August. This incident highlights exceptional coordination and collaborative efforts among all agencies and facilities.</p> <p>Awards of Excellence were given to the recipients below:</p> <p><b>Riverside County Sheriff's Office</b>  Sgt. J. Fitzgerald  Sgt. D. Goetz  Deputy M. Chappell  Deputy N. Sandoval  Deputy J. Glass  Deputy B. Bowdry</p> <p><b>Riverside County Fire</b>  David Rodriguez, Battalion Chief  Christopher Dyer, Paramedic  Nicholas Araiza, Paramedic  Bob Taylor, Paramedic  Christopher Pruckler, Paramedic  Jeffrey Logan, Paramedic  Steven Murray, Paramedic Engineer  Donald Norton, Fire Captain  Ryan Johnston, Fire Captain  Jimmy Barraza, Paramedic  Doug Kishi, Engineer</p> <p><b>AMR</b>  Austen Ward, Paramedic  Brooke Van Winkle, EMT  Jonathan James, Paramedic  Matthew Zuvia, EMT  Daniel Heredia, Paramedic  Michelle Latarreur, EMT  Jacob Chavez, Paramedic  Robert Pegler, EMT  Brandon Lima, Paramedic  Justin Holst, EMT</p> <p><b>Mercy Air</b>  Hannah Green, RN  Aaron Klienschmidt, Paramedic  James Carmichael, Pilot  Paige Estrada, RN  Robert Lynch, Paramedic  Michael Tepper, Pilot</p>	

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	<p>Mikhail Reyes, RN Victor Bedolla, Paramedic James Cammissa, Pilot <b>ED Staff from Riverside University Health System</b> <b>ED Staff from Arrowhead Regional Medical Center</b></p>	
<b>6.3 CQI Update</b>	<p>CQI Medical Cardiac Arrest and Traumatic Cardiac Arrest Summary reports were reviewed. A summary of the cardiac arrest reports can also be access at Rivcoems.org under the SCOPE dashboard. For a more detailed look at the data, please join the CQILT meetings for further discussion.</p> <p>Base Hospital audits for May and June are complete. All of the Base Hospitals did outstanding. The only identified gap found, was a Base Hospital Physician Group is non-existent and would like to see one formed.</p> <p>EMSA published the 2020 CORE Measure Manual in late July. It is due mid-September. REMSA has significantly reduced the amount of CORE Measures we have. EMSA took out the measures that were not working, to make it much easier to gather the data. The goal with EMSA is to run reports on data elements and pull them automatically, like they do with CEMIS. REMSA needs to focus on better aspirin documentation for STEMI. Once our report is complete in September, at the next CQILT meeting, the group will go over the CORE Measures, share our reports and make sure our documentation is aligned with EMSA.</p>	Information only.
<b>6.4 Education/Policy Update</b>	<p>2021 Fall PUC includes training videos on:</p> <ul style="list-style-type: none"> <li>• CQI Program and Continuing Education</li> <li>• STEMI-specific education</li> <li>• Stroke-specific education</li> <li>• +EMS SAFR Project</li> <li>• Policy 4602 Behavioral Emergencies</li> </ul> <p>Train to trainer materials for Fall PUC will be sent out by close of business today. REMSA will hold a Q&amp;A session on Thursday from 1300-1600 regarding the training materials via Microsoft TEAMS. A knowledge check quiz will also be provided to the trainers along with the answer key. 2-hours of CE credits can be given for this PUC training.</p> <p>The Guide for Continuing Education Providers was created to clarify the process and establish procedures which allows for the program approval of prehospital continuing education providers in Riverside County; to assist those providers so that they meet the standards and requirements for CE providers according to Title 22 regulations.</p>	Information only.
<b>6.5 Supraglottic Airways Presentation</b>	<p>Alayna Prest, MD, EMS Fellow at Loma Linda University, presented her recommendation to create an implementation plan for the supraglottic airway (SGA), i-gel into practice for</p>	PMAC unanimously agreed to move forward with the

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	<p>ICEMA and REMSA for adult patients. She discussed literature supporting evidence that the SGA is useful, beneficial, and readily available airway tool to the pre-hospital providers. A comparison between Air-Q, i-gel and LMA Supreme was reviewed. In conclusion, i-gel appears to be favored over the other alternative SGA. PMAC commented that having another tool when intubation is needed could be beneficial, but also emphasized the importance of BVM and ET tubes as still the primary and preferred source of airway devices.</p> <p>PMAC unanimously agreed to move forward with Dr. Prest’s recommendation to create an implementation plan for the supraglottic airway, i-gel.</p> <p>REMSA will work with Dr. Prest in identifying a protocol to be included with this recommendation and will review with PMAC before training and implementation is complete. Data will also be collected on this new device after implementation.</p>	<p>recommendation to create an implementation plan for the supraglottic airway, i-gel into practice at REMSA for adult patients.</p>
<p><b>6.6 RODA Grant Update</b></p>	<p>RODA Grant update reviewed surveillance statistics from January to July 2021. Overdoses in Riverside County decreased 11% from 2020, and the fatality rate also decreased 25%. Fentanyl usage has gone up significantly in the County.</p> <p>Policy implementation and programs in development: Working on creating an education package regarding trauma from care.</p> <p>Leave behind naloxone program is free for any providers who apply, to get free naloxone. Providers do not need to have a licensed medical professional to distribute naloxone.</p> <p>REMSA is working with ICEMA to align policies and procedures on this program to move forward with implementation.</p>	<p>Information only.</p>
<p><b>6.7 +EMS Project</b></p>	<p>+EMS Project is a joint grant funded project that started 14-months ago with participants in 8 counties, 3 HIOs, 6 LEMSAs, 14 EMS providers, 21 Hospitals and 6 ePCR vendors, Riverside County included.</p> <p>The project was used to connect our systems through the SAFR model, for health information exchange (HIE).</p> <ul style="list-style-type: none"> <li>• (S)earch <ul style="list-style-type: none"> <li>○ First-responders will be able to access patient information to enhance clinical decision-making during emergency cases</li> </ul> </li> <li>• (A)lert <ul style="list-style-type: none"> <li>○ EDs will receive real-time patient information to improve clinical decision support and preparation</li> </ul> </li> <li>• (F)ile <ul style="list-style-type: none"> <li>○ Pre-hospital care records will be integrated into the HER to support comprehensive record and seamless transitions of care</li> </ul> </li> <li>• (R)econcile</li> </ul>	<p>Information only.</p>

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	<ul style="list-style-type: none"> <li>○ Patient outcome data will be returned to first responders for quality and system improvement</li> </ul> <p>Riverside County works with ImageTrend Elite and Manifest Medex to get data into the HIE Patient Repository. The grant is set to run to the end of October 2021. There is not an identified funding source now that would extend past the grant expiration. It may be continued in a different grant cycle, but there is no confirmation now.</p>	
<b>6.8 COVID-19 Update</b>	<ul style="list-style-type: none"> <li>● Riverside County has seen a steady increase in COVID-19 cases</li> <li>● The FDA has approved the Pfizer vaccine for ages 16+</li> <li>● Booster shots will likely come in the Fall</li> <li>● Healthcare workers vaccination requirement currently does not include EMS providers</li> <li>● For the upcoming Flu season, facilities are looking towards co-locating Flu and COVID-19 vaccines</li> </ul>	Information only.
<b>6.9 Action Item Review</b>	No action items to review.	
<b>7. Request for Discussions</b>	<p>Follow up on the progress of the HEMS Unified Scope of Practice. The preliminary parts are complete along with the application, REMSA is working on lining up the remaining pieces before submitting it to the State.</p> <p>Thoughts on broadening the EMT Scope of Practice to include naloxone in regards to the RODA Program.</p>	Discussion.
<b>8. Announcements</b>	RODA program is working with Public Health for a combined presentation to present at the California Paramedics Foundation on an opioid land project sponsored by CVS health in the next month or two.	Information only.
<b>9. NEXT MEETING/ADJOURNMENT</b>	<p>Monday, November 22, 2021 (9:00 – 11:00 a.m.)</p> <p>Virtual Platform – Microsoft TEAMS</p>	Information only.





**FOR CONSIDERATION BY PMAC**

DATE: November 8, 2021

TO: PMAC

FROM: Shanna Kissel, RN, Assistant Nurse Manager

SUBJECT: Trauma System

1. JFK Memorial Hospital was designated as the first county Level IV trauma center. This designation level does not affect field triage for critical trauma patients. Policy 5301 was updated with changes to contact a Level I or II trauma Base hospital for critical patients.
2. Desert Regional Medical Center will have their American College of Surgeons Level II verification visit in December.
3. Trauma System Plan update submission to EMSA has be postponed until Q.2, 2022 and will be submit with the other specialty care plans and the EMS plan.

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

**FOR CONSIDERATION BY PMAC**

Date: November 22, 2021

TO: PMAC

FROM: Leslie Duke, Specialty Care Coordinator, RN

SUBJECT: STEMI System

1. STEMI System Plan update submission to EMSA has be postponed until Q2, 2022 and will be submit with the other specialty care plans and the EMS plan
2. The STEMI dashboard posted on Rivcoems.org was updated to reflect Q2 2021 data related to the Image Trend STEMI patient registry.
3. STEMI-specific education was completed by providers for the Fall 2021 Policy Update Course.
4. Policies: No changes to STEMI treatment or administrative policies in Fall PUC.
5. Performance metric reports continue to be developed related to the E2B project with STEMI managers to identify areas of opportunity in decreasing time and CQI initiatives for both EMS and hospital processes.
6. Image Trend STEMI Patient Registry data for PCI volume has been validated with each facility for accuracy of data entry. Areas of opportunities have been identified and rectified.

Next STEMI Committee meeting is on January 11th, 2022 via video conference

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

**FOR CONSIDERATION BY PMAC**

Date: November 22, 2021

TO: PMAC

FROM: Leslie Duke, Specialty Care Coordinator, RN

SUBJECT: Stroke System

1. Stroke System Plan update submission to EMSA has be postponed until Q2, 2022 and will be submit with the other specialty care plans and the EMS plan.
2. The Stroke dashboard posted on Rivcoems.org was updated to reflect Q2 2021 data related to the Image Trend Stroke patient registry.
3. Stroke-specific education was completed by providers for the Fall 2021 Policy Update Course.
4. Policies: No changes to stroke treatment or administrative policies in Fall PUC.
5. Expansion of data presented on the dashboard continues to be developed related to thrombectomy volumes and Door to TPA times.

Next Stroke Committee meeting is on February 15<sup>th</sup>, 2022 via video conference

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

## Riverside County EMS Agency

### California Core Quality Measures Data - Calendar Year 2020

Measure ID #	Measure Name	Numerator Value (Subpopulation)	Denominator Value (Population)	Reporting Value (%)	Notes and Comments
TRA-2	Transport of Trauma Patients to a Trauma Center	3095	5364	58%	Data is based on Patient level using incident date/hour, name, age, gender. Strong recommendation that criteria account for transporting responses only (eDisposition.12 = Treated, Transported by this Unit). Patients not transported (ie AMA, dead on scene) substantially inflate denominator with the current criteria. When eDispo.12 accounted for transported only, REMSA's % increased to 66% consistent with 2019. However, REMSA also detected an internal documentation issue with eDisposition.23 not correctly identifying trauma centers. When accounting for both of these, REMSA's actual % on this metric was < 91%. Therefore, REMSA is also in the process of working with education and ePCR system to fix the eDispo.23 issue.
HYP-1	Treatment Administered for Hypoglycemia	1559	3205	49%	Data is based on Patient level using incident date/hour name, age, gender. If based on all responses, Numerator = 1767, Denominator=3982 and reporting value would be 44.4%. In 2019 REMSA was at 82%. REMSA does not currently have eProcedure.03 as an option which is being corrected and should substantially improve metric.
STR-1	Prehospital Screening for Suspected Stroke Patients	5251	5280	99%	Data is based on Patient level using incident date/hour name, age, gender. If based on all responses, Numerator= 6197, Denominator=6113 and the reporting value would still be 99%. (Current value is an improvement from 2019 @ 87% likely due to stroke education efforts)
PED-3	Respiratory Assessment for Pediatric Patients	575	668	86%	Data is based on Patient level using incident date/hour, name, age, gender. If patient level was not assessed and data was provided at the response level, then denominator = 1217; numerator = 841, and metric would be @ 69%. Current outcome is consistent with 2019 @ 85%.
RST-4	911 Requests for Services That Included a Lights and/or Sirens Response	348090	394001	88%	Response level only. No patient level modifications made so all responses could be accounted for (Fire and Ambulance). In 2019 calendar year, REMSA used vehicle ID (unit number) to filter only 9-1-1 response units for a more valid count, but based on consistent % calculations (2019 = 89%), current EMSA criteria is sufficient.
RST-5	911 Requests for Services That Included a Lights and/or Sirens Transport	11525	152881	8%	No modifications or patient level needed as criteria already includes eResponse.07="Ground Transport"; and eDisposition12= "Treated, Transported by this EMS Unit" which accounts predominantly for patient level.

#### Links to the SCOPE Dashboards:

<https://rivcoems.org/Data>

<https://datastudio.google.com/reporting/0BykHNCGE-ixib29ZUGI3TGc3V2s/page/VgD>

## Public Safety Personnel Draft Document

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### Policy #101 - REMSA Approved Definitions:

\*\*\*NEW DEFINITION\*\*\*

#### Public Safety Personnel (EMSA Scope of Practice Document):

Any individual who has received the minimum training standards for EMS personnel, which includes first aid, CPR and AED operation, and who also respond to tactical casualty care situations.

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### Policy #3309 – Intranasal Naloxone Use by Public Safety Personnel (PSPs)

#### PURPOSE

(current) To establish the process and procedures to allow for approved **law enforcement agencies and appropriately trained law enforcement** personnel to provide intranasal naloxone to patients with suspected acute narcotic overdose.

(proposed) To establish the processes and procedures to allow for approved **public safety personnel** to provide intranasal naloxone to patients with suspected acute narcotic overdose.

#### Training Standards

1. (current) **Law Enforcement** agencies in Riverside County seeking to utilize naloxone to manage patients with suspected narcotic overdose shall be authorized and approved by REMSA in accordance with state laws, regulations and REMSA policies. Authorized agencies shall administer naloxone in accordance with this policy.
1. (proposed) Agencies **that employ PSPs** in Riverside County seeking to utilize naloxone to manage patients with suspected narcotic overdose shall be authorized and approved by REMSA in accordance with state laws, regulations and REMSA policies. Authorized agencies shall administer naloxone in accordance with this policy.
2. (current) **Law enforcement** personnel must be trained to the Public Safety Personnel First Aid and CPR standard as outlined in Title 22, Division 9, Chapter 1.5, Section and maintain ongoing competencies and proficiencies as outlined by Section 100022
2. (proposed) **PSPs** must be trained to the Public Safety Personnel First Aid and CPR standard as outlined in Title 22, Division 9, Chapter 1.5, Section and maintain ongoing competencies and proficiencies as outlined by Section 100022
4. (current) Each authorized **law enforcement** agency requesting authorization will submit:
4. (proposed) Each authorized agency **that employs PSPs** requesting authorization will submit:

#### Performance Standards

1. (current) **Law enforcement personnel** working for agencies authorized to administer intranasal naloxone by REMSA may provide 4 mg intranasal naloxone following procedure outlined in this policy and in REMSA approved training.
  1. (proposed) **PSPs** working for agencies authorized to administer intranasal naloxone by REMSA may provide 4 mg intranasal naloxone following procedure outlined in this policy and in REMSA approved training.
  3. (current) Responding EMS providers shall document the intranasal naloxone use as “prior to arrival” and assign the administration to the administering **law enforcement** agency.
  3. (proposed) Responding EMS providers shall document the intranasal naloxone use as “prior to arrival” and assign the administration to the administering **public safety** agency.
  4. (current) Participating **law enforcement** agencies will report all cases of naloxone administration to REMSA via the Naloxone use for Public Safety Personnel form
  4. (proposed) Participating **public safety** agencies will report all cases of naloxone administration to REMSA via the Naloxone use for Public Safety Personnel form
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**Policy #4104 – Skills List**

Skill: INTRANASAL NALOXONE (IN) ADMINISTRATION BY PUBLIC SAFETY PERSONNEL

(current) **Law enforcement personnel** working for agencies that are REMSA authorized to administer intranasal naloxone may provide 4 mg IN following procedures outlined in policy #3309 and in REMSA approved training

(proposed) **PSPs** working for agencies that are REMSA authorized to administer intranasal naloxone may provide 4 mg IN following procedures outlined in policy #3309 and in REMSA approved training

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**Policy #4601 – Overdose / Adverse Reaction**

BLS Patient Management (current)

BLS Patient Management (*proposed*)

**\*\*REMSA Authorized Public Safety Personnel Only\*\***

- **For respiratory depression / respiratory arrest with suspected narcotic overdose**  
Naloxone **IN ONLY. MAY REPEAT ONCE.** Use REMSA approved administration device with REMSA approved pre-loaded dose

**\*\*REMSA authorized Public Safety Personnel OR provider agencies with LOSOP approval\*\***

- **For respiratory depression / respiratory arrest with suspected narcotic overdose**  
Naloxone **IN ONLY. MAY REPEAT ONCE.** Use REMSA approved administration device with REMSA approved pre-loaded dose

**\*\*Provider agencies with LOSOP approval only\*\***

- **For respiratory depression / respiratory arrest with suspected narcotic overdose**  
Adults: Naloxone 0.5 mg (0.5 mL) **IN ONLY. MAY REPEAT PRN. TITRATE TO IMPROVEMENT OF RESPIRATORY DEPRESSION, NOT RESOLUTION OF AMS**

Pediatrics: See REMSA Policy #4102 (Calculation Chart) for patient specific dosage and volume. **MAY REPEAT PRN.**

<b>Diphenhydramine — 50 mg / 1 mL Vial, or Carpuject®</b>	X	X	1	X	X	X	1	X	X	1	1
<b>Epi. 1:1,000 — 1 mg / 1 mL Ampule</b>	X	1	1	X	X	1	1	X	1	1	1
<i>or</i> Epi. 1:1,000 — 30 mg / 30 mL Vial	X	1	1	X	X	1	1	X	1	1	1
<i>or</i> "EpiPen" / Auto-Injector. — 0.3 mg / 0.3 mL	0	0	0	0	0	0	0	0	0	0	0
<b>Epi. 1:10,000 — 1 mg / 10 mL Prefilled Syringe</b>	X	X	2	X	X	X	3	X	X	3	3
<i>or</i> Epi. 1:1,000 — 1 mg / 1 mL Ampule	X	X	2	X	X	X	3	X	X	3	3
<i>or</i> Epi. 1:1,000 — 30 mg / 30 mL Vial	X	X	1	X	X	X	1	X	X	1	1
<b>Glucagon — 1 mg / 1 mL Vial of Powder + Vial of Diluent</b>	X	1	1	X	X	1	1	X	1	1	1
<b>Glucose Gel — 1 Container</b>	1	1	1	X	1	1	1	1	1	1	0
<b>Ipratropium Br.— 0.5 mg / 2.5 mL Vial</b>	X	X	0	X	X	X	1	X	X	1	1
<b>Lidocaine 2% — 100 mg / 5 mL Prefilled Syringe</b>	X	X	0	X	X	X	1	X	X	1	1
<i>or</i> Lidocaine 2% — 400 mg / 20 mL Vial	X	X	0	X	X	X	1	X	X	1	1
<b>Magnesium Sulfate — 5 g / 10 mL Prefilled Syringe or Vial</b>	X	X	0	X	X	X	1	X	X	1	1
<i>or</i> Magnesium Sulfate — 1 g / 2 mL Vial	X	X	0	X	X	X	5	X	X	5	5
<i>or</i> Magnesium Sulfate - 4 g / 100 mL IV Bag	X	X	0	X	X	X	1	X	X	1	1
<b>Naloxone — 2 mg / 2 mL Prefilled Syringe or Vial</b>	X	1	1	X	X	4	4	X	4	4	1
<i>or</i> Naloxone — 4 mg / 10 mL Vial	X	1	1	X	X	2	2	X	2	2	1
<i>or</i> Naloxone — 0.4 mg / 1 mL Prefilled Syringe, Vial or Carpuject®	X	5	5	X	X	20	20	X	20	20	5
<b>Nitroglycerin — 0.4 mg / 1 Dose Multi-dose Spray or Bottle of Tab.</b>	X	1	1	X	X	1	1	X	1	1	1
<b>Nitro. Paste 2% — 1 g / 1 Inch Packet with Paper Applicators</b>	X	X	0	X	X	X	2	X	X	2	0
<i>or</i> Nitro. Paste 2% — 30 g / 1 Tube with Paper Applicators	X	X	0	X	X	X	1	X	X	1	0
<i>or</i> Nitro. Paste 2% — 60 g / 1 Tube with Paper Applicators	X	X	0	X	X	X	1	X	X	1	0
<b>Normal Saline 0.9% — 1000 mL IV Bag</b>	X	1	1	X	X	2	2	X	2	2	2
<i>or</i> Normal Saline 0.9% — 500 mL IV Bag	X	2	2	X	X	4	4	X	4	4	4
<i>or</i> Normal Saline 0.9% — 250 mL IV Bag	X	4	4	X	X	8	8	X	8	8	8
<b>Normal Saline 0.9% — 50 mL IV Bag</b>	X	X	0	X	X	X	1	X	X	1	1





<b>Administrative Policy</b>		<b>3308</b>
<b>Effective</b> <b>April 1, 2021</b>	<b>Expires</b> <b>March 31, 2022</b>	
Policy: <b>ALS to BLS Downgrade</b>	Approval: Medical Director <b>Reza Vaezazizi, MD</b>	Signature 
Applies To: <b>First Responder and Transport Services</b>	Approval: REMSA Administrator <b>Trevor Douville</b>	Signature 

**PURPOSE**

To establish criteria for downgrading from an advanced life support (ALS) level of care to a basic life support (BLS) level of care in the pre-hospital setting when responding to Riverside County EMS Agency (REMSA) approved Emergency Medical Dispatch (EMD) response determinant calls.

**AUTHORITY**

[California Health and Safety Code - Division 2.5: Emergency Medical Services \[1797.2\]](#)  
[California Health and Safety Code - Division 2.5: Emergency Medical Services \[1797.2\]](#)



Previous text: "Riverside County Emergency Command Center Emergency Medical Dispatch (EMD) response determinant calls"

**Downgrade Procedures**

The following procedures must be completed prior to transferring the patient from an ALS to a BLS level of care:

1. The ALS first response service provider must be dispatched by a REMSA authorized EMD center **AND** the response level must be Omega or Alpha.
2. A complete paramedic assessment must be performed and documented on an electronic patient care report (ePCR).
3. No ALS intervention is warranted or has been initiated.
4. Paramedic judgement indicates that the patient does not require an ALS level of care.
5. If the patient's condition deteriorates during transport, the BLS resource shall transport the patient to the closest most appropriate receiving center and make appropriate notifications.



<b>Administrative Policy</b>		<b>3310</b>
<b>Effective</b> <b>May 1, 2021</b>	<b>Expires</b> <b>March 31, 2022</b>	
Policy: <b>“LEAVE BEHIND NALOXONE” KIT DISTRIBUTION BY EMS PROVIDERS</b>	Approval: Medical Director <b>Reza Vaezazizi, MD</b>	Signed 
Applies To: <b>EMR, EMT, AEMT, PM, EMS System</b>	Approval: EMS Administrator <b>Trevor Douville</b>	Signed 

**PURPOSE**

To authorize and describe procedures for EMS personnel to distribute “Leave Behind Naloxone” kits to individuals who are at risk for experiencing an opioid overdose. “Leave Behind Naloxone” kits may also be distributed to individuals who may come in contact with individuals who are at risk for experiencing an opioid overdose.

**AUTHORITY**

[California Health and Safety Code - Division 2.5: Emergency Medical Services \[1797. - 1799.207.\]](#)  
[California Code of Regulations, Title 22. Social Security, Division 9. Prehospital Emergency Medical Services](#)  
[California Civil Code Section 1714.22](#)

**BACKGROUND**

The Naloxone Distribution Project (NDP) is a federally funded “Leave Behind Naloxone” initiative administered by the Department of Health Care Services (DHCS) in California to combat opioid overdose-related deaths through the free distribution of Naloxone to qualifying entities for the purpose of distribution to persons at risk for opioid overdose and those in a position to assist those persons at risk. EMS agencies in California are qualified entities to participate in this program. The NDP program is currently active in Riverside County through other community-based organizations; this program will now be extended to include distribution by EMS personnel who come in contact with high-risk individuals through the EMS system.

**RESOURCES**

[https://www.dhcs.ca.gov/individuals/Pages/Naloxone\\_Distribution\\_Project.aspx](https://www.dhcs.ca.gov/individuals/Pages/Naloxone_Distribution_Project.aspx)  
<https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/Pages/Naloxone-Standing-Order.aspx>

**REQUIREMENTS**

- All patients treated for an opioid overdose shall be assessed and managed in accordance with REMSA Policy #4601 (Overdose / Adverse Reaction).
- All patients treated for an opioid overdose who refuse transport shall be managed in accordance with REMSA Policy #4107 (Refusal of Treatment and / or Transport).
- This policy applies only to “Leave Behind Naloxone” kits intended for laypersons’ use.
- This policy does not refer to any Naloxone in the responding units’ required medication inventory, as outlined in REMSA Policy #3303 (Drug and Equipment List).
- EMS personnel shall document distribution of “Leave Behind Naloxone” kits in compliance with local and state reporting as required.



<b>Operational Policy</b>		<b>5202d</b>
<b>Effective</b> <b>April 1, 2021</b>	<b>Expires</b> <b>March 31, 2022</b>	
Policy: <b>Drug and Equipment List - HEMS</b>	Approval: Medical Director <b>Reza Vaezazizi, MD</b>	Signature DRAFT
Applies To: <b>Air Ambulance Services, EMS System</b>	Approval: REMSA Administrator <b>Trevor Douville</b>	Signature DRAFT

**APPLICATION**

This policy applies specifically to public safety personnel (PSP), emergency medical technicians (EMTs), advanced emergency medical technician (AEMTs), paramedics (EMT-Ps), and critical care paramedic (CCPs) that respond to incidents within Riverside county by helicopter.

**PURPOSE**

The purpose of this policy is to set equipment and medication requirements for Riverside County EMS Agency (REMSA) authorized PSP, EMT, AEMT, EMT-P, or CCP staffed air transport operations.

**Drug and Equipment List**

This policy lists the required equipment and minimum quantities to be carried by each paramedic staffed EMS air transport provider in Riverside County. Included are required and optional items, with minimum quantities indicated by the highest level of staffing. Operational needs must be met by carrying more than the minimum quantities. Any omitted equipment is not authorized except as required by law. Equipment trials must be authorized by REMSA.

Equipment:

- Optional equipment is identified by an "O".
  - Any agency desiring to carry and / or utilize mechanical CPR device with associated supplies must submit the "Optional Equipment Authorization Application" ([Found here](#)) and receive approval by REMSA prior to purchase
- Unauthorized equipment is identified by an "X".
- Equipment acquired from a field provider (first response or ground transport) is identified by a "P."

Medications:

- Alternative medications and / or concentrations are identified by an "A".

**All equipment and medications listed are per unit, unless otherwise noted.**

**Personal Documents**

Personal documents are listed per staff person. These documents must be current and valid; and carried as originals, photocopies, or as digital reproductions.

Personal Documents	BLS Air Transport	ALS Air Transport
First Responder / PSP Certificate		0
CA EMT Certificate		0
CA AEMT Certificate		0
CA EMT-P License		1
CPR for the "Professional Rescuer" or "Healthcare Provider" Card		1



# Operational Policy

# 5802

<b>Effective</b> <b>October 1, 2021</b>	<b>Expires</b> <b>September 30, 2023</b>
Approval: Medical Director <b>Reza Vaezazizi, MD</b>	Signature 
Approval: REMSA Administrator <b>Trevor Douville</b>	Signature 

Policy:  
**Community Assessment and Transport Team (CATT) Pilot Program**

Applies To:  
**PSP, EMT, AEMT, EMT-P, MICN, BHP, EMS System**

### PURPOSE

To establish a program to refer individuals who are experiencing a crisis to approved destinations and resources through the use of a Community Assessment and Transport Team (CATT).

### AUTHORITY

- [California Health and Safety Code - Division 2.5: Emergency Medical Services \[1797. - 1799.207.\]](#)
- [California Code of Regulations, Title 22. Social Security, Division 9. Prehospital Emergency Medical Services](#)
- [California Welfare and Institutions Code, Division 5. Community Mental Health Services](#)

## Initial Requirements

### Personnel

- Emergency Medical Technicians: will meet all training, license, and certification requirements per REMSA policy
- Behavioral Health Specialist or Clinical Therapist: will meet all training, license, and certification requirements per Riverside University Health System – Behavioral Health (RUHS – BH) policy
- All CATT personnel will receive at least eighty (80) hours of training on:
  - EMS Specific Curriculum
    - CPR, AED, naloxone administration, basic first aid and bleeding control
  - Crisis intervention curriculum:
    - De-escalation techniques, crisis health assessments, community resources and client navigation
  - All other training as required by RUHS - BH and / or REMSA

### Vehicles

All vehicles will be agreed upon by REMSA and Ambulance Contractor prior to use in this program. These vehicles will conform to the highest standards for crash safety ratings and passenger safety systems. An interior partition or barrier will be installed in the vehicle to provide separation between the driver and passenger compartments for vehicle occupant safety. All vehicle exterior colors, lettering, graphics, and markings will be approved by REMSA.

### Equipment

Vehicles utilized by CATT personnel will be considered Light Response for the purposes of determining the appropriate standard equipment and minimum quantities that must be carried. Refer to REMSA policy #3303 (*Drug and Equipment List*).

Additional equipment for CATT personnel will include: naloxone, a glucometer, and a pulse oximeter.

## Continuous Requirements

In addition to the maintenance of personnel, vehicle and equipment criteria listed above, Contractor will ensure the following criteria are also continuously met:

### Documentation

A REMSA electronic patient care report (ePCR) will be completed for every incident as outlined in Policy #7701 (*Patient Care Records*).

## CQI

1. Provide targeted continuing education activities to further the knowledge base of the field personnel who provide care as part of this program.
2. Develop criteria for evaluation of field personnel who provide care as part of this program, to include, but not be limited to:
  - a. Timely audits for 100% of ePCRs for CATT unit.
  - b. Direct observation, as needed.
  - c. Routine quarterly and annual performance evaluations.
  - d. Design of corrective action plans for individual deficiencies.
3. Develop a process for identifying trends in the quality of field care by:
  - a. Submitting reports as specified by REMSA
  - b. Designing and participating in educational offerings based on problem identification and trend analysis.
  - c. Making approved changes in internal policies and procedures to comply with REMSA policies.
  - d. Track and report all requests for and utilization of CATT unit

## Procedure for Requesting CATT Unit Response

For an individual in crisis, law enforcement or EMS personnel on scene will determine, if the individual would benefit from a response by CATT team, and will contact Ambulance Contractor Dispatch Center directly to request CATT unit response.

Ambulance Contractor will manage all requests for, and aspects of, CATT unit deployment. CATT Unit Response Time should be less than thirty (30) minutes from the time the available unit is notified by dispatch (eTimes.03) to the time the unit arrives on scene (eTimes.06). Exceptions on the time requirement are made due to circumstances limiting availability of the CATT unit (e.g. already deployed on another call, after hours request, or remote location).

**Before placing an individual on a WIC 5150 or 5585 hold, attempts should be made by law enforcement to request a CATT unit response.**

## Procedures for CATT Personnel

### Change in patient condition or recognition of a life-threatening illness or injury

An ALS Ambulance will be requested immediately if at any time during the patient encounter, a life-threatening illness or injury is recognized or if there is a change in patient condition.

If an individual is experiencing respiratory depression with a rate less than 12 or are in complete respiratory arrest as a result of a suspected opioid overdose, an ALS ambulance will be requested immediately and CATT personnel will administer naloxone using the following treatment algorithm:

Adults: Naloxone 0.5 mg (0.5 mL) IN ONLY. MAY REPEAT PRN. TITRATE TO IMPROVEMENT OF RESPIRATORY DEPRESSION, NOT RESOLUTION OF AMS.

Total naloxone administration may not exceed 10 mg.

### All other patients

1. On arrival at the scene, a crisis assessment and health screening will be performed by CATT personnel. This screening will include, but not be limited to:
  - a. A crisis assessment and triage by a licensed clinician
  - b. A review of the individual's past medical history, allergies, and current medications
  - c. Obtaining baseline vital signs to include, but not be limited to: heart rate, respiratory rate, blood pressure, SpO<sub>2</sub> level, blood glucose and pain severity level
2. Based on assessment findings, a determination will be made that the individual is either appropriate, or inappropriate, for transport by CATT unit.

### **Individuals That May Be Appropriate for Transport by CATT Unit**

The following individuals may be eligible for transport by CATT unit if they meet all (**ALL**) criteria listed below:

1. 18 years old or older
2. Have current capacity to make medical decisions
3. Are cooperative, compliant, not requiring restraints, and able to ambulate without assistance
4. Are negative for any signs / symptoms of life-threatening illness or injury
5. Are negative for any signs / symptoms of infectious disease (COVID-19, influenza, TB, etc.)
6. Have a heart rate between 60 and 100 bpm
7. Have a systolic blood pressure between 100 and 160 mmHg
8. Have a respiratory rate between 12 and 20 per minute
9. Have an SpO<sub>2</sub> between 92 and 100% on room air or on oxygen if chronically oxygen dependent
10. Have a blood glucose between 80 - 250 mg/dL

If an individual is found to meet all (**ALL**) of the above criteria, they may be appropriate for transport by CATT unit; however, they must still be evaluated by a licensed clinician.

### **Approved Destinations**

As determined by the results of the crisis assessment and health screening, an appropriate destination will be chosen by the Clinical Therapist based on bed availability, patient coverage and patient preferences if any. If the individual has no preference, the destination will be the closest appropriate facility. All destinations must be approved by Riverside County Mental Health Crisis Services and Riverside County EMS Agency. Examples of possible destinations include, but are not limited to, Psychiatric Emergency Services, Crisis Residential Treatment Facility, sobering center, shelters, and emergency departments.

#### 24/7 Mental Health Urgent Care Centers (MHUC)

1. MHUC Riverside: 9980 County Farm Rd, Bldg. 2, Riverside 92503  
Phone: (951) 509-2499
2. MHUC Perris: 85 Ramona Expressway, Ste. 1-3, Perris 92571  
Phone: (951) 349-4195
3. MHUC Palm Springs: 2500 N. Palm Canyon Dr., Ste. A4, Palm Springs 92571  
Phone: (442) 268-7000



<b>Administrative Policy</b>		<b>6301d</b>
<b>Effective</b> <b>April 1, 2021</b>	<b>Expires</b> <b>March 31, 2022</b>	
Policy: <b>Specialty Care Center Designation</b>	Approval: Medical Director <b>Reza Vaezazizi, MD</b>	Signature <b>DRAFT</b>
Applies To: <b>PRC, BH, EMS System</b>	Approval: REMSA Administrator <b>Trevor Douville</b>	Signature <b>DRAFT</b>

**PURPOSE**

To establish standards for the designation, re-designation, and de-designation, of specialty care centers (Trauma, STEMI, and Stroke) in Riverside county.

**AUTHORITY**

- [California Health and Safety Code - Division 2.5, Chapter 6: Facilities \[1798.100 - 1798.183.\]](#)
- [California Code of Regulations, Title 22, Division 9, Chapter 7: Trauma Care Systems](#)
- [California Code of Regulations, Title 22, Division 9, Chapter 7.1: ST-Elevation Myocardial Infarction Critical Care System](#)
- [California Code of Regulations, Title 22, Division 9, Chapter 7.2: Stroke Critical Care Systems](#)

**SPECIALTY CARE SYSTEM ASSESSMENT**

The need for additional specialty care centers in Riverside county, regardless of type, shall be assessed by the Riverside County EMS Agency (REMSA). This assessment will include, but not be limited to:

- Geographic location(s) of the proposed specialty care center(s) which will include, at a minimum, appropriateness based on projected population growth
- Prehospital transport time(s)
- Projected patient volume
- Projected impact on existing designated center(s)
- Hospital services available for specialty care

**INITIAL DESIGNATION / HIGHER LEVEL CENTER DESIGNATION PROCEDURES**

Prior to receiving an application for specialty care designation, the requesting hospital must submit a letter of intent to REMSA. Once reviewed, a specialty care system assessment will be performed within ninety (90) days of the date of the received request.

- Applicants requesting consideration to be designated as a Trauma receiving center in Riverside county must refer to policy #5304 (Trauma Center Standards) for more information regarding designation requirements.
- Applicants requesting consideration to be designated as a STEMI receiving center in Riverside county must refer to policy #5401 (STEMI Center Standards) for more information regarding designation requirements.
- Applicants requesting consideration to be designated as a Stroke receiving center in Riverside county must refer to policy #5701 (Stroke Center Standards) for more information regarding designation requirements.

REMSA approved accreditation/ certification/ verifying programs:

<u>STEMI</u>  American College of Cardiology (ACC)	<u>Stroke</u> Joint Commission (TJC) <b>OR</b> Det Norske Veritas-Germanischer Lloyd (DNV-GL) <b>OR</b> Healthcare Facilities Accreditation Program (HFAP)	<u>Trauma</u>  American College of Surgeons (ACS) *Level IV trauma centers must remain in compliance with current ACS standards
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If it is determined that the addition of a new or higher level of specialty care service would fill a recognized service gap in that geographical area, the requesting hospital must present a proposal of their program to the appropriate committee (Trauma, STEMI, or Stroke), which will include all relevant data that validates how their program will fill that gap.

1. Following the committee meeting, a recommendation will be made to the REMSA Medical Director.
2. If the requesting hospital's proposal establishes that they are able to satisfy the needs of the system, they will receive an application for their specialty care program.

Once submitted to REMSA, the application review process will be completed within ninety (90) days. Specialty care center designation may be granted only after the following criteria have been met:

- A system assessment of program gaps
- Recommendation to the REMSA Medical Director from the appropriate specialty care committee(s)
- A satisfactory review of a completed application
- REMSA participation in initial accreditation / certification / verification survey(s)
- Supporting written documentation and
- An initial, and satisfactory, site survey by REMSA personnel

### **RE-DESIGNATION PROCEDURES**

To achieve re-designation as a specialty care center in Riverside county, each specialty care center must:

1. Meet all applicable regulations listed in Title 22, Division 9, for the specific requested program, and the standards and requirements listed in all applicable REMSA policies
2. Successfully pass an audit performed by REMSA
3. Achieve re-accreditation / recertification / reverification by one (1) of the below organizations:

<u>STEMI</u>	<u>Stroke</u>	<u>Trauma</u>
American College of Cardiology (ACC)	Joint Commission (TJC) <b>OR</b> Det Norske Veritas-Germanischer Lloyd (DNV-GL) <b>OR</b> Healthcare Facilities Accreditation Program (HFAP)	American College of Surgeons (ACS) <small>*Level IV trauma centers must remain in compliance with current ACS standards</small>

REMSA staff will attend and perform audits during the entirety of all accreditation, certification, or verification surveys. A copy of the renewal certificate will be provided to REMSA no less than thirty (30) days prior to current expiration.

### **DESIGNATION TERMINATION / SUSPENSION PROCEDURES**

#### **Termination for Cause**

REMSA may terminate its specialty care center designation agreement with any designated specialty care center if it is determined that they have:

1. Failed to comply with current regulations as outlined in Title 22, Division 9
2. Failed to comply with current REMSA policy as outlined in policies 5304, 5401 and / or 5701
3. Had their license to operate as a PRC revoked or suspended

#### **Suspension of Designation**

REMSA may immediately suspend its specialty care center designation agreement with any designated specialty care center upon written notice if it is determined that they:

1. Have failed to cooperate with quality assurance procedures, audit findings and / or recommendations provided by REMSA.
2. Are in gross default of material obligation as specified in their agreement with REMSA.

Failure to remedy the issues identified in #1 and / or #2 above ("Suspension of Designation") within the time specified by REMSA will result in termination of the agreement for specialty care designation.

#### **Voluntary De-Designation**

Any specialty care center may voluntarily terminate their agreement for specialty care services upon thirty (30) days written notice to REMSA.





<b>Skill Verification Form</b>	
<b>Effective</b> <b>XX/XX, 2022</b>	<b>Expires</b> <b>XX/XX, 2023</b>
Category I Skill – Low Frequency/High Risk: <b>Orogastric (OG) Tube</b>	Approval: Medical Director <b>Reza Vaezazizi, MD</b>  Signed <b>DRAFT</b>
Applies To: <b>EMT-P, MICN, BHP, EMS System</b>	Approval: EMS Administrator <b>Trevor Douville</b>  Signed <b>DRAFT</b>

**Terminal Performance Objective**

To facilitate passive gastric decompression after orotracheal intubation (OTI) or insertion of an i-gel airway device.

**Before placing an OG tube, paramedics must:**

1. Determine successful placement of either the ETT or the i-gel using all appropriate steps prior to OG tube placement
2. Recognize relative contraindications:
  - a. History of esophageal strictures, varices and / other esophageal diseases
  - b. History of bleeding disorders
  - c. Caustic ingestions

DRAFT

## Orogastric (OG) Tube Placement Validation

**PERFORMANCE CRITERIA:** 100% accuracy required on all items with an \*

**Before placing an OG tube, the paramedic must:**

Points	Score	Performance Steps	Additional Information
1		Take or verbalize body substance isolation*	Selection: gloves, goggles, mask, gown, booties, N95 PRN
1		Recognize and indicate the need for OG tube placement*	
1		Use appropriate measuring technique to ensure proper placement*	VERBALIZE: Combined distance from the corner of the mouth to the ear lobe then to the xiphoid process
1		Mark the appropriate termination location on the OG tube with a piece of tape	

**While placing an OG tube, the paramedic must:**

1		Continuously monitor the oral cavity for secretions and suction as needed	
1		Insert the tube into the oral cavity and pass it along the floor, advancing it until the pre-measured portion of the tube meets the corner of the mouth*	
1		If resistance is met during insertion, stop advancement, and adjust direction slightly before reattempting	

**Immediately after placing an OG tube, the paramedic must:**

1		Confirm proper placement*	<ol style="list-style-type: none"> <li>Aspirate gastric contents</li> <li>Inject 30 - 60ml of air into the large lumen and auscultate over the stomach. If a "swooshing" sound is heard, placement is appropriate. If placement cannot be confirmed, the OG tube must be removed immediately</li> </ol>
1		Secure the tube*	Secure the tube to the side of the patient's face using tape
1		Reassess placement as needed	
1		Document procedure appropriately	<ul style="list-style-type: none"> <li>Size of OG tube</li> <li>Number of attempts</li> <li>Any encountered complications</li> </ul>

### Critical Failure Criteria

- \_\_\_ Failure to take or verbalize BSI prior to performing the skill
- \_\_\_ Failure to recognize and indicate the need for OG tube placement
- \_\_\_ Failure to insert the tube in the appropriate manner
- \_\_\_ Failure to confirm proper placement
- \_\_\_ Failure to appropriately secure the tube

2022

# PMAC MEETING SCHEDULE



	DATE	TIME	LOCATION
PMAC	02/28/2022	9am – 11am	Virtual Session
PMAC	05/23/2022	9am – 11am	Virtual Session
PMAC	08/22/2022	9am – 11am	Virtual Session
PMAC	11/28/2022	9am – 11am	Virtual Session