



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- Anthony Gonzales

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- Robert Fontaine

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, May 23, 2022
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)**
February 28, 2022 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
 - 5.2.** EMD Update – Mattie Medina/ James Lee
 - 5.3.** U.S. Trial Study – Dr. Patterson
 - 6. DISCUSSION ITEMS, UNFINISHED & NEW BUSINESS**
 - 6.1.** Unfinished Business –
 - 6.1.1.** PMAC Representation
 - 6.1.1.1.** EMT-at-Large position
 - 6.2.** Recognitions
 - 6.3.** CQI Update – Lisa Madrid (Attachment E – Reports)
 - 6.4.** Education / Policy Update – Dustin Rascon
 - 6.5.** Policy Review and Cycle Changes (Attachment F)
 - 6.6.** 2023 PUC Calendar (Attachment G)
 - 6.7.** CARES Data – Catherine Farrokhi, PHD
 - 6.8.** Calcium Chloride - Adult (ALS) – Dr. Downes, EMS Fellow
 - 6.9.** Festivals Update – Dr. Dukes
 - 6.10.** COVID Update – Misty Plumley
 - 6.11.** 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. Meeting minutes are audio recorded to facilitate dictation for minutes.

PMAC Draft Minutes
February 28, 2022

TOPIC	DISCUSSION	ACTION
1. CALL TO ORDER	PMAC Chair Dr. Seth Dukes called the meeting to order at 9:03 a.m.	
2. Virtual Attendance	Attendance taken based on participant list on Microsoft TEAMS.	
3. Approval of Minutes		The November 22, 2021 PMAC meeting minutes were approved with no changes.
4. STANDING REPORTS		
4.1 Trauma System Updates	<p>JFK Memorial Hospital and REMSA are performing QI on trauma patients presenting to the facility. TAC will be discussing policy 5302 Trauma continuation of care for process improvement to include Level IV trauma centers.</p> <p>Desert Regional Medical Center had their ACS Survey in December. Outcome for verification is pending.</p> <p>Trauma System Plan Update submission to EMSA has been postponed until quarter 2, 2022. It will be submitted with the other specialty care plans and the EMS plan.</p> <p>REMSA will begin looking at blunt traumatic arrest and transport to the facilities as a QI project. ICEMA will also be looking at their numbers as well.</p>	Information only.
4.2 STEMI System Updates	<p>STEMI System Plan update submission to EMSA has been postponed until quarter 2, 2022 and will be submitted with the other specialty care plans and the EMS plan.</p> <p>STEMI dashboard has been updated with quarter 3, 2021 data and posted on rivcoems.org.</p> <p>STEMI-specific education was completed and sent out to providers for Spring 2022 Policy Update Course.</p> <p>No changes to STEMI treatment or administrative policies in Spring PUC.</p> <p>STEMI E2B project with ICEMA: Performance metrics and reports continue to be developed related to the E2B project to identify areas of opportunity in decreasing EMS to hospital door time interval and CQI initiatives for both EMS and hospital processes.</p>	Information only.
4.3 Stroke System Updates	<p>Stroke System Plan update submission to EMSA has been postponed to quarter 2, 2022 and will be submitted with the other specialty care plans and the EMS plan.</p> <p>Stroke dashboard has been updated with quarter 3, 2021 data and posted on rivcoems.org. Expansion of data presented on the stroke dashboard was related to additional breakdown of discharge disposition categories.</p> <p>Stroke-specific education was completed and sent out to providers for Spring 2022 Policy Update Course.</p> <p>No changes to stroke treatment policies for Spring PUC.</p> <p>Update made to the stroke administration policy was related to</p>	Information only.

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	<p>DNV-GL branding to reflect DNV & HFAP to reflect ACHC after merger of the companies and change in branding.</p> <p>A Stroke regional project called HIFT (Hospital Interfacility Transport) is currently in the early stages. This project consists of education on the care for the ischemic and hemorrhagic stroke patient during interfacility transport by a paramedic from a primary to a higher level of care stroke center and hand-off report between the hospital nurse and paramedic transporting the patient. The project will also develop ways to track measurable outcomes.</p>	
5. OTHER REPORTS		
5.1 EMCC Report	No EMCC update. The December EMCC meeting was cancelled and will meet again in March 2022.	Information only.
6. DISCUSSION ITEMS, UNFINISHED & NEW BUSINESS		
6.1 Unfinished Business	Unfinished business	
<p>6.1.1 PMAC Representation</p> <p>6.1.1.1 RCFA Non-Transport BLS Provider position</p> <p>6.1.1.2 EMT-at-Large position</p> <p>6.1.1.3 EMT/EMT-P Training Program position</p>	<p>There are 3 open positions for PMAC representation.</p> <p>RCFA Non-Transport BLS provider nominated Anthony Gonzales, Engineer from Calimesa Fire to fill the vacant position. PMAC voted unanimously for Anthony Gonzales.</p> <p>No current nominations for EMT-at-Large position. Please contact Shanna Kissel for any nominations to be brought forth to the next meeting.</p> <p>EMT/EMT-P Training program nominated Robert Fontaine, Moreno Valley College Program Director to fill the position. PMAC voted unanimously for Robert Fontaine.</p>	<p>Anthony Gonzales, Calimesa Fire was approved as the RCFA Non-Transport BLS Provider position.</p> <p>Robert Fontaine, Moreno Valley College was approved as the EMT/EMT-P Training Program position.</p>
6.2 Recognitions	<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 involving a cardiac arrest patient.</p> <p>Awards of Excellence were given to the recipients below:</p> <p>Riverside City Police Department Officer Jeff Southard</p> <p>Riverside City Fire Captain Greg White Kevin Whitaker, Engineer/Paramedic Rafael Llamas, Paramedic/Firefighter Dean Felch, Firefighter Noelle Toering, EMS Coordinator</p>	

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	<p>AMR Juan Vergara, Paramedic Breanne Hardgrave, EMT</p>	
6.3 CQI Update	<p>CQI standing reports for Medical Cardiac Arrest and Traumatic Cardiac arrest was reviewed. Policy 7101 has been updated to require annual submissions for CQI Plans. They are due on December 31st. REMSA is working on elevating the CQI process.</p>	Information only.
6.4 Education/Policy Update	<p>An updated CE provider guide will be released in the next couple of days. Medication waiver policy will also be updated shortly and will also be done on Microsoft Forms online exclusively, moving away from paper forms. EPI administration form that is required for at any point of dilution, will also be released soon.</p>	Information only.
6.5 PUC Calendar	<p>REMSA proposed to change the public comment period. Currently, policies are taken to CQILT to review, then to PMAC for review then public comment period opens. After REMSA reviews, updated policies are developed in training with a plan to push out in January and July. What REMSA has noticed with changing over from PowerPoint training to video trainings, the schedule does not accommodate enough time for training videos to be complete. The new proposed schedule will push the public comment period to start before PMAC, so that at the PMAC meeting, REMSA can bring stakeholders comments to review at PMAC for transparency. Then after discussion as PMAC, REMSA will take all of the comments and changes to develop into education and stay on track to release for training. A preview of the calendar was sent out, and PMAC approved this change. The change will be effective for Fall PUC 2022.</p>	New public comment period was approved.
6.6 Atropine dosing in Bradycardia	<p>Mirroring AHA's recent changes in guideline for Atropine dosing in Bradycardia, changing the dose recommendation increase from .5 mg to 1mg IV every 3-5 minutes with a max dose of 3 mg. Stephen Patterson, MD, RCH motioned to support the move to change the dosing to 1 mg. Patrick Anderson, Riverside City Fire and Zeke Foster, MD, seconded the motion. PMAC voted: 0 – opposed, 0 – abstained, passed unanimously. This change will be reflected in the Fall 2022 policy update.</p>	PMAC approved Atropine dosing to change from .5 mg to 1 mg.
6.7 Medication error disclosure to patient	<p>REMSA CQI staff has been working through cases where medication errors have occurred and noticed an increase trend in these cases. Either the wrong medication was given, or the dose was significantly outside of protocol. A vast majority of these cases had no significant bad outcome to patients; however, discussion was had regarding creating a process on how to inform the patient regarding the error. After continued discussion, PMAC agreed that notifying the patient would be</p>	Information only.

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	beneficial, however the process to do so was a challenge. Suggestions of having a standardized form or written process was brought up. It was concluded that devoting a group of CQI staff and educators into a taskforce to dive deeper into this would be the best approach. Lisa Higuchi, AMR, Stephanie Dvorak, Cal Fire and Lauren Lee, Cal Fire volunteered to participate in the taskforce.	
6.8 EMS personnel working with expired credentials	Informational item to remind provider agencies that they are responsible for ensuring their EMS personnel are up to date with renewing their credentials in a timely manner. Failure to do so means that the EMS personnel should immediately stop working. It is also in every provider CQI plans to ensure that licensure it up to date for their staff.	Information only.
6.9 COVID-19 Update	Tabled to next meeting.	
6.10 Action Item Review		
7. Request for Discussions	REMSA reminded everyone to review the BLS to 911 downgrade policy.	
8. Announcements		
9. NEXT MEETING/ADJOURNMENT	Monday, May 23, 2022 (9:00 – 11:00 a.m.) Virtual Platform – Microsoft TEAMS	Information only.

FOR CONSIDERATION BY PMAC

DATE: May 9, 2022

TO: PMAC

FROM: Shanna Kissel, RN, Assistant Nurse Manager

SUBJECT: Trauma System

1. TAC will continue to discuss policy 5302 Trauma continuation of care to include all pre-hospital receiving centers and Pediatrics.
2. TAC will be discussing the new Field triage standards from the American College of Surgeons to determine if REMSA policy 5301 needs to be updated.
3. Desert Regional Medical Center received their American College of Surgeons Level II verification.
4. Trauma System Plan update submission to EMSA still pending.

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

FOR CONSIDERATION BY PMAC

Date: May 23, 2022

TO: PMAC

FROM: Leslie Duke, Specialty Care Coordinator, RN

SUBJECT: STEMI System

1. STEMI System Plan update pending submission to EMSA.
2. The STEMI dashboard posted on Rivcoems.org was updated to reflect Q4 2021 data related to the Image Trend STEMI patient registry.
3. Policies: STEMI Continuation of Care administrative policy was updated to clarify verbiage for ease of understand the purpose, use, along with role and responsibilities of the referral hospital, receiving center, and transporting provider.
4. STEMI E2B project (ongoing): Performance metrics for January 2022 related to EMS on scene to hospital door time intervals were reviewed at the April STEMI Committee meeting. Auditing will continue for a two-quarter timeframe looking at identifying areas of opportunity in decreasing EMS to hospital door time intervals and CQI initiatives for EMS. Next steps: Hospital performance metrics will be developed, validated, and reviewed at the July STEMI managers/committee meeting to identify areas of opportunities to decrease time intervals between processes with the goal of decreasing overall E2B <90 minutes as a County.
5. REMSA audits have been completed for all 6 STEMI designated receiving centers.

Next STEMI Committee meeting is on July 12th, 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: May 23, 2022

TO: PMAC

FROM: Leslie Duke, Specialty Care Coordinator, RN

SUBJECT: Stroke System

1. Stroke System Plan update pending submission to EMSA.
2. The Stroke dashboard posted on Rivcoems.org was updated to reflect Q4 2021 data related to the Image Trend Stroke patient registry.
3. Policies: Stroke Continuation of Care administrative policy was updated to clarify verbiage for ease of understand the purpose, use, along with role and responsibilities of the referral hospital, receiving center, and transporting provider.
4. Stroke HIFT (hospital interfacility transport) project: Education is being developed with the assistance of stroke managers.

Next Stroke Committee meeting is on August 4th, 2022 via video conference

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

Medical Cardiac Arrest- 1/1/2021-03/31/2022

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

	2021								2022		Average		
	Qtr1		Qtr2		Qtr3		Qtr4		Qtr1				
Total Incidents	2030		1491		1598		1774		1911		1761		
Total Approx., Patients	1447		1089		1173		1281		1400		1278		
By Age group	Children (<=12)	14	1%	14	1%	19	2%	16	1%	20	1%	17	1%
	Adolescents (13-17)	8	0.6%	5	0.5%	10	0.9%	4	0.3%	7	0.5%	7	1%
	Young Adults (18-35)	100	7%	122	11%	104	9%	101	8%	99	7%	105	8%
	Adults(36-64)	484	33%	395	36%	450	38%	460	36%	471	34%	452	35%
	Adults(65-79)	492	34%	339	31%	348	30%	399	31%	471	34%	410	32%
	Older Adults (>=80)	349	24%	214	20%	242	21%	300	23%	332	24%	287	22%
ROSC	Yes	227	16%	150	14%	157	13%	193	15%	199	14%	185	14%
	No	1220	84%	939	86%	1016	87%	1088	85%	1201	86%	1093	86%
Cardiac Arrest during EMS event	Yes, Prior to EMS Arrival	1339	92.5%	1029	94.5%	1096	93.4%	1179	92.0%	1292	92.3%	1187	92.9%
	Yes, After EMS Arrival	107	7.4%	60	5.5%	77	6.6%	102	8.0%	104	7.4%	90	7.0%
	No	1	0.1%		0.0%		0.0%		0.0%	4	0.3%	3	0.2%
Disposition	Treated and Transported	325	22%	223	20%	258	22%	277	22%	299	21%	276	22%
	Pronounced in Field	1122	78%	866	80%	915	78%	1004	78%	1099	79%	1001	78%

	2021								2022		Average	
	Qtr1		Qtr2		Qtr3		Qtr4		Qtr1			
Total Transports	325		223		258		277		299		276	
STEMI center	185	57%	136	61%	156	60%	176	64%	201	67%	171	62%
Riverside Community Hospital	64	35%	50	37%	51	33%	67	38%	74	37%	61	36%
Desert Regional Medical Center	22	12%	24	18%	20	13%	29	16%	35	17%	26	15%
Loma Linda University Medical Center, Murrieta	47	25%	27	20%	39	25%	37	21%	37	18%	37	22%
Eisenhower Medical Center	23	12%	14	10%	20	13%	23	13%	23	11%	21	12%
JFK - John F Kennedy Memorial Hospital	19	10%	15	11%	19	12%	8	5%	8	4%	14	8%
Temecula Valley Hospital	6	3%	4	3%	7	4%	8	5%	8	4%	7	4%
*Loma Linda University Medical Center	4	2%	2	1%	0	0%	4	2%	4	2%	3	2%
Non-STEMI Center	137	42%	86	39%	94	36%	97	35%	98	33%	102	37%
Hemet Valley Medical Center	30	22%	20	23%	25	27%	23	24%	20	20%	24	23%
Riverside University Health System Medical Center	32	23%	22	26%	24	26%	16	16%	23	23%	23	23%
Corona Regional Medical Center	19	14%	10	12%	12	13%	14	14%	12	12%	13	13%
San Geronio Memorial Hospital	11	8%	5	6%	3	3%	9	9%	7	7%	7	7%
Inland Valley Medical Center	8	6%	5	6%	6	6%	9	9%	7	7%	7	7%
Parkview Community Hospital Medical Center	10	7%	7	8%	13	14%	5	5%	8	8%	9	8%
Kaiser Permanente, Riverside	10	7%	7	8%	2	2%	6	6%	6	6%	6	6%
Menifee Valley Medical Center	5	4%	2	2%	2	2%	3	3%	1	1%	3	3%
Kaiser Permanente, Ontario	5	4%	3	3%	1	1%	3	3%	2	2%	3	3%
Palo Verde Hospital	1	1%	4	5%	0	0%	0	0%	2	2%	1	1%
Rancho Springs Medical Center	2	1%	1	1%	2	2%	2	2%	9	9%	3	3%
Kaiser Permanente, Moreno Valley	2	1%	0	0%	3	3%	4	4%	0	0%	2	2%
Kindred Hospital, Ontario	1	1%	0	0%	0	0%	3	3%	0	0%	1	1%
Kaiser Permanente, Fontana			0	0%	1	1%	1	1%	0	0%	1	0%
St. Bernardine Medical Center	1	1%	0	0%	0	0%	0	0%	0	0%	0	0%
Facility name not available	3	2%	1	1%	7	7%	4	4%	1	1%	3	3%

Median Time		2021				2022
		Qtr1	Qtr2	Qtr3	Qtr4	Qtr1
Patient contact time (etimes07-etimes03)	First Response	0:07:45	0:07:23	0:07:34	0:08:08	0:07:41
	Ground Transport	0:08:49	0:08:34	0:09:30	0:10:34	0:09:33
	Total	0:08:10	0:07:47	0:08:06	0:08:46	0:08:09
Scene time (etimes09-etimes07)	First Response	0:21:59	0:21:35	0:22:15	0:22:37	0:25:28
	Ground Transport	0:18:39	0:18:22	0:17:11	0:17:15	0:19:00
	Total	0:20:00	0:20:13	0:20:00	0:19:33	0:21:36
First CPR to Determination of Death (earrest15-earrest19) Disposition : "Resuscitation Attempted, Dead at Scene"	First Response	0:24:51	0:24:21	0:26:00	0:25:00	0:25:07
	Ground Transport	0:25:32	0:25:56	0:26:30	0:26:18	0:25:32
	Total	0:25:00	0:25:00	0:26:15	0:25:30	0:25:22
First CPR to Transport (etimes09-earrest19)	Ground Transport	0:24:08	0:35:32	0:25:29	0:24:14	0:24:52
Patient contact to transport time (etimes11-etimes07) Dispo= "Patient treated and transported by this unit"	Ground Transport	0:29:59	0:32:44	0:29:49	0:27:23	0:28:17
Patient contact to determination of death (earrest15-etimes07)	First Response					
	Dead at Scene, No Resuscitation, No Transport	0:00:46	0:00:25	0:00:46	0:00:23	0:00:28
	Resuscitation Attempted, Dead at Scene, No Transport	0:23:07	0:22:48	0:22:51	0:23:14	0:23:00
	Ground Transport					
	Dead at Scene, No Resuscitation, No Transport	0:01:06	0:01:00	0:01:00	0:01:00	0:01:28
	Resuscitation Attempted, Dead at Scene, No Transport	0:21:39	0:21:00	0:21:10	0:21:24	0:20:32

**Data is based on Incidents and documentation*

Traumatic Cardiac Arrest Summary Report- 2021-22

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

		2021								2022		Average	
		Qtr1		Qtr2		Qtr3		Qtr4		Qtr1			
Total Incidents		140		157		164		164		151		155	
Average Age		43		37		45		42		42		42	
Median Age		40		30		42		37		37		37	
By Age group	0-9	7	4%	11	7%	4	3%	7	5%	6	4%	7	5%
	10-14	4	2%	2	1%					1		2	2%
	15-24	20	12%	23	14%	21	14%	20	13%	17	11%	20	13%
	25-34	25	15%	51	31%	39	26%	36	24%	35	23%	38	24%
	35-44	21	13%	27	16%	21	14%	23	15%	36	24%	26	17%
	45-54	23	14%	12	7%	27	18%	19	13%	12	8%	19	12%
	55-64	9	5%	12	7%	17	11%	14	9%	10	7%	12	8%
	65-79	26	16%	8	5%	25	17%	19	13%	23	15%	21	13%
80+	5	3%	11	7%	10	7%	8	5%	11	7%	9	6%	
By Ambulance Zone	Northwest Zone	40	24%	49	30%	47	31%	38	25%	41	27%	44	29%
	Desert Zone	33	20%	40	24%	44	29%	29	19%	34	23%	38	24%
	Southwest Zone	26	16%	21	13%	29	19%	25	17%	33	22%	27	18%
	Central Zone	21	13%	16	10%	17	11%	21	14%	18	12%	18	12%
	San Jacinto Zone	11	7%	16	10%	21	14%	18	12%	13	9%	15	10%
	Pass Zone	5	3%	13	8%	3	2%	12	8%	6	4%	7	4%
	Mountain Plateau Zone	3	2%	1	1%	3	2%	2	1%	3	2%	3	2%
	Palo Verde Zone	1	1%	1	1%	0	0%	1	1%	1	1%	1	0%
Injury Mechanism	Blunt only	72	44%	93	57%	79	52%	84	56%	82	54%	82	53%
	Penetrating	24	15%	34	21%	36	24%	27	18%	32	21%	32	20%
	Blunt and penetrating	3	2%	2	1%	7	5%	6	4%	4	3%	4	3%
	Burn	2	1%	0	0%	1	1%	2	1%	0	0%	1	0%
	Blunt and Burn	2	1%	2	1%	1	1%	2	1%	0	0%	1	1%
	Drowning	27	16%	14	9%	11	7%	15	10%	20	13%	18	12%
	Other	4	2%	9	5%	16	11%	3	2%	3	2%	8	5%
	Not documented	4	2%	3	2%	13	9%	8	5%	10	7%	8	5%
Odomeater Reading	Total Incidents documented	23		29		17		27		17		22	
	Sum of Odometer Reading	220		181		156		259		85		161	
	Average of Odometer Reading	10		6		8		8		5		10	
	Max of Odometer Reading	27		27		48		26		11		28	

Traumatic Cardiac Arrest *Base Hospital Contact*

Base Hospital contact("Yes/No") (itdisposition.007)	2021								2022		Average	
By Agency	Qtr1		Qtr2		Qtr3		Qtr4		Qtr1			
	140		157		164		147		151		152	
Yes	21	15%	28	18%	40	24%	41	28%	35	23%	28	18%
First Response	11	8%	15	10%	21	13%	21	14%	20	13%	15	10%
Ground Transport	10	7%	13	8%	19	12%	20	14%	15	10%	13	8%
No	119	85%	129	82%	124	76%	106	72%	116	77%	99	65%
First Response	77	55%	90	57%	77	47%	78	53%	88	58%	68	45%
Ground Transport	42	30%	39	25%	47	29%	28	19%	24	16%	30	20%
By Disposition (edisposition.12)												
Yes	21	15%	28	18%	40	24%	41	28%	35	23%	28	25%
Patient Treated and Transported by this EMS Unit	8	38%	12	43%	13	33%	20	49%	14	40%	11	37%
Dead at scene	4	19%	7	25%	14	35%	3	7%	5	14%	6	29%
Patient Treated and Transported with this Crew in Another EMS Unit	9	43%	9	32%	11	28%	16	39%	16	46%	10	28%
Patient Treated and Care Transferred to Another EMS Unit					2	5%	2	5%	0	0%	1	4%
No	119	85%	129	82%	124	76%	106	72%	116	77%	99	75%
Dead at scene	90	76%	106	82%	118	95%	100	94%	111	96%	88	82%
Patient Treated and Transported by this EMS Unit	15	13%	13	10%	4	3%	3	3%	3	3%	6	11%
Patient Treated and Transported with this Crew in Another EMS Unit	12	10%	7	5%	11	9%	1	1%	1	1%	5	6%
Patient Treated and Care Transferred to Another EMS Unit	2	2%	3	2%		0%	2	2%	1	1%	2	1%

Traumatic Cardiac Arrest *Response Times*

Median Time		2021				2022
		Qtr1	Qtr2	Qtr3	Qtr4	Qtr1
Patient contact time (etimes07-etimes03)	First Response	0:07:37	0:07:55	0:08:26	0:08:01	0:09:19
	Ground Transport	0:08:20	0:09:57	0:08:30	0:09:15	0:09:13
	Total	0:07:52	0:08:14	0:08:28	0:08:22	0:09:13
Scene time (etimes09-etimes07)	First Response	0:13:00	0:07:59	0:10:39	0:21:00	0:13:49
	Ground Transport	0:10:55	0:06:22	0:10:06	0:08:09	0:11:39
	Total	0:12:48	0:07:07	0:10:28	0:12:19	0:13:12
First CPR to Determination of Death (earrest15-earrest19) Disposition :"Res., attempted, Dead at Scene"	First Response	0:21:35	0:18:24	0:26:00	N<10	N<10
	Ground Transport	N<10	N<10	N<10	N<10	N<10
	Total	0:22:00	0:20:00	0:24:30	N<10	N<10
First CPR to Transport (etimes09-earrest19)	Ground Transport	N<10	0:08:49	N<10	N<10	N<10
Patient contact to transport time (etimes11-etimes07) Dispo= "Patient treated and transported by this unit"	Ground Transport	0:27:45	0:15:02	0:20:59	0:25:37	0:22:00
Patient contact to determination of death (earrest15-etimes07)	First Response					
	Dead at Scene, No Resuscitation, No Transport	0:01:00	0:01:00	0:01:00	0:01:00	0:00:20
	Resuscitation Attempted, Dead at Scene, No Transport	0:20:00	0:18:58	0:22:03	0:16:00	0:19:22
	Ground Transport					
	Dead at Scene, No Resuscitation, No Transport	0:01:44	0:01:34	0:01:00	0:02:00	0:03:22
	Resuscitation Attempted, Dead at Scene, No Transport	0:19:20	0:17:30	0:21:14	0:15:57	0:19:50

* In Q3, 2020 12 responses by First Response agencies reported >20min scene time. These included 8 penetrating, 1 blunt, and 3 drowning incidents.

** In Q3, 2020 15 responses by First Response Agencies had time intervals greater than 20 minutes. Of these, 8 involved drowning incidents.

Number of Responses		2021				2022
		Qtr1	Qtr2	Qtr3	Qtr4	Qtr1
Patient contact time (etimes07-etimes03)	First Response	88	105	98	99	112
	Ground Transport	52	52	66	48	37
	Total	140	157	164	147	149
Scene time (etimes09-etimes07)	First Response	23	19	16	24	17
	Ground Transport	23	24	17	26	15
	Total	46	43	33	50	32
First CPR to Determination of Death (earrest15-earrest19) Disposition: "Res., attempted, Dead at Scene"	First Response	11	10	11	4	6
	Ground Transport	7	7	9	2	2
	Total	18	17	20	6	8
First CPR to Transport (etimes09-earrest19)	Ground Transport	9	13	5	5	3
Patient contact to transport time (etimes11-etimes07) Dispo= "Patient treated and transported by this unit"	Ground Transport	22	25	17	23	15
Patient contact to determination of death (earrest15-etimes07)	First Response	56	71	77	70	80
	Dead at Scene, No Resuscitation, No Transport	39	53	59	59	64
	Resuscitation Attempted, Dead at Scene, No Transport	17	18	18	11	16
	Ground Transport	27	25	40	22	21
	Dead at Scene, No Resuscitation, No Transport	16	14	23	15	12
	Resuscitation Attempted, Dead at Scene, No Transport	11	11	17	7	9
		83	96	117	92	101



Administrative Policy		3301
Effective	XX, XX, 2022	Expires
		XX, XX, 2023
Policy:	Approval: Medical Director	Signature
Medication Waiver Program	Reza Vaezazizi, MD	
Applies To:	Approval: REMSA Administrator	Signature
EMS System	Trevor Douville	

DEFINITION

Nationally recognized supply limitation:

Nationally recognized supply limitations are determined by the Food and Drug Administration (FDA) and the status of any applicable medication will be listed as “*Currently in Shortage*” in their electronic portal (found here: <https://www.accessdata.fda.gov/scripts/drugshortages/default.cfm>). Before submitting a waiver request, their website should be referenced; waivers to operate outside of REMSA policy will not be approved if the medication in question is not listed.

PURPOSE

To permit and regulate the use of alternative medications and / or concentrations when the REMSA authorized “Standard” medications and / or concentrations cannot be obtained due to nationally recognized supply limitations.

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](#)

Procedure

If REMSA authorized standard medications and / or concentrations cannot be obtained due to nationally recognized supply limitations and an alternative medication and / or concentration must be used, then:

1. REMSA must be notified by utilizing the REMSA Medication Waiver form, found here: <https://forms.office.com/g/ZRPuzthLhM>.
 - a. Reliance on the inventory of only one (1) vendor is not a legitimate reason for approval to operate outside of compliance. Live links must be included in the submitted waiver for verification purposes.
2. Once verified and approved, agencies / organizations may then obtain the needed medication(s) in an alternative concentration and / or volume, as outlined in the “Alternative Medications / Dosages” section of REMSA policy #4201 (Calculation Chart).
3. Should additional education regarding storage, handling, pre-administration mixing, proper administration techniques, side effects, medication disposal, etc. be required, it must be approved by the REMSA Medical Director prior to deployment.
4. As an additional safety measure, agencies / organizations should consider placing a high-visibility red sticker on each alternative medication vial and / or ampule.
5. Internal agency / organization policy must be followed for alternative medication distribution, notification of staff, and field calculation of volumes.
6. 100% continuous quality improvement (CQI) review of each use of an alternative medication is expected.
7. Notification of each use of an alternative medication must be reported to REMSA within seventy-two (72) hours, using the form found here: <https://forms.office.com/g/ACStXc1FnA>.
 - a. Epinephrine diluted and administered at the point of care must be reports using this form: <https://forms.office.com/g/2iYVT4Jf3Y>



Skill Verification Form

	Effective XX/XX/2022	Expires XX/XX/2023
Category I Skill – Low Frequency/High Risk: i-gel Supraglottic Airway Device	Approval: Medical Director Reza Vaezazizi, MD	Signed DRAFT
Applies To: EMT-P, MICN, BHP, EMS System	Approval: EMS Administrator Trevor Douville	Signed DRAFT

Terminal Performance Objective

Ensure the secure placement of a supraglottic airway device (i-gel) to facilitate positive pressure ventilation.

Indications for Use

Patients must meet **ALL** of the following criteria:

- Apnea or inadequate respirations (usually less than eight (8) breaths per minute)
- Unresponsive to verbal and/or tactile stimuli
- Absence of a gag reflex
- Airway management is unsuccessful using BLS maneuvers (BVM with oral/nasal adjuncts)
- Airway management is unsuccessful after oral endotracheal intubation (OTI)
- An appropriately sized airway is available

i-gel Size Chart

Color	Patient Weight	i-gel Size
Yellow	65 – 130 lbs / 30 – 60 kg	3
Green	110 – 200 lbs / 50 – 90 kg	4
Orange	200+ lbs / 90+ kg	5

Contraindications for Use

The introduction of the i-gel is contraindicated if **ANY** of the criteria below exist:

- The patient is conscious and has an intact gag reflex
- Known ingestion of caustic substances
- Unresolved upper foreign body airway obstruction (FBAO)
- Severe facial or esophageal trauma, bleeding or swelling of the airway, or an unstable jaw fracture
- The patient has a known esophageal disease or diseases (e.g., cancer, varices, surgery, etc.)
- The patient weighs less than 30 kg / 65 lbs.

The patient’s airway can be maintained using less invasive methods (i.e., BVM with oral/nasal adjuncts)

Evaluate the need to perform insertion of the i-gel by:

- Recognizing a difficult airway that precludes the direct visualization of the patient's glottic opening (e.g., airway edema, arthritis, scoliosis of the spine, significant overbite, small mandible, short neck, morbid obesity, cervical spine immobilization, face or neck trauma); and
- Three (3) UNSUCCESSFUL attempts have been made to manage the patient's airway using OTI
 - a. An OTI attempt is defined as the laryngoscope blade insertion into the oral cavity to assist with the visualization of the laryngopharynx.

ePCR Documentation

Minimum documentation elements:

- Size of the SGA
- Number of placement attempts and whether the placement was successful
- Lung sounds
- Change of colorimetric device
- Continuous SpO₂ and EtCO₂ monitoring results
- Patient response to intervention

i-gel Supraglottic Airway Device Validation

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

Before performing the i-gel Supraglottic Airway Device placement, 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		Methodically complete an assessment of the airway and breathing within 30 seconds. *	Follow respiratory assessment sequence.														
1		Identify inadequate ventilation and/or signs of hypoxia within the first 30 seconds. *	Pale/cyanotic, altered level of consciousness, diaphoresis, increased work of breathing or apnea, poor chest rise, and fall														
1		Determine appropriately sized SGA (i-gel) device based on the patient's estimated weight	<table border="1"> <thead> <tr> <th>Color</th> <th>Patient Weight</th> <th>i-gel Size</th> </tr> </thead> <tbody> <tr> <td>Yellow</td> <td>65 – 130 lbs / 30 – 60 kg</td> <td>3</td> </tr> <tr> <td>Green</td> <td>110 – 200 lbs / 50 – 90 kg</td> <td>4</td> </tr> <tr> <td>Orange</td> <td>200+ lbs / 90+ kg</td> <td>5</td> </tr> </tbody> </table>	Color	Patient Weight	i-gel Size	Yellow	65 – 130 lbs / 30 – 60 kg	3	Green	110 – 200 lbs / 50 – 90 kg	4	Orange	200+ lbs / 90+ kg	5		
Color	Patient Weight	i-gel Size															
Yellow	65 – 130 lbs / 30 – 60 kg	3															
Green	110 – 200 lbs / 50 – 90 kg	4															
Orange	200+ lbs / 90+ kg	5															
1		Apply appropriate, clinically required technique to manually position the head and mandible of the unconscious patient to open the upper airway. *	<ul style="list-style-type: none"> Medical – Head tilt/chin lift Trauma – Jaw thrust or modified chin lift 														
1		Ensure EtCO ₂ , and suction, are readily available	<ul style="list-style-type: none"> Orogastric tubes – 12F and 14F sizes to fit down the SGA (i-gel) suction port 														
1		Pre-oxygenate the patient with 100% oxygen via BVM															
1		Apply a small amount of water-based lubricant to the back, sides, and front of the cuff															
1		Grasp the SGA (i-gel) device at the integral bite block with the dominant hand, then gently open the patient's mouth with the other hand															

While performing i-gel Supraglottic Airway Device placement, the paramedic must:

1		Insert the SGA (i-gel) into the patient's mouth, directing it towards the hard palate	The cuff outlet should be facing the patient's chin		
1		Advance the device with gentle but continuous pressure until definitive resistance is felt	The integral bite block should rest at the incisors		

After performing i-gel Supraglottic Airway Device placement, the paramedic must:

1		Attach the BVM to the SGA (i-gel) device and begin ventilations			
1		Assess and ensure:	<ul style="list-style-type: none"> Bilateral breath sounds 		

			<ul style="list-style-type: none"> • Equal rise and fall of the chest • EtCO₂ measurements are appropriate • SPO₂ is adequate
1		Secure the SGA (i-gel) device using a Tube Tamer or tape	
1		Verbalize documentation of the following:	<ul style="list-style-type: none"> • Lung sounds • Continuous SpO₂ and EtCO₂ monitoring • Patient response to intervention
1		<p>Verbalize the following troubleshooting solutions:</p> <ol style="list-style-type: none"> 1. If excessive air leakage is encountered, then... 2. If the i-gel has been repositioned correctly, or reinserted entirely, and air is still leaking then... 	<ol style="list-style-type: none"> 1. Consideration should be made that the placement of the i-gel is either too high or too low and it needs to be repositioned or reinserted. 2. Consider reinserting an i-gel device that is one size larger.

Critical Failure Criteria

- ___ Failure to take or verbalize BSI appropriate to the skill before performing the skill
- ___ Failure to correctly identify an FBAO
- ___ Failure to attach oxygen to the BVM
- ___ Failure to appropriately position patient and open airway
- ___ Any procedure that would have harmed the patient



Skill Verification Form - DRAFT

	Effective April 1, 2022	Expires March 31, 2023
Category I Skill – Low Frequency/High Risk: Orogastric (OG) Tube	Approval: Medical Director Reza Vaezazizi, MD	Signed DRAFT
Applies To: EMT-P, MICN, BHP, EMS System	Approval: EMS Administrator Trevor Douville	Signed DRAFT

Terminal Performance Objective

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

Indications for Use

- After successful placement of an ETT or i-gel
- An appropriately sized OG tube is available:
 - Adult: 16 - 18fr
 - Pediatric 8 - 10fr
 - Infant 5 – 6fr
 - SGA igel insertion: 12F and 14F sizes to fit down the SGA (i-gel) suction port

Contraindications for Use

Introduction of the OG tube is contraindicated if **ANY** of the criteria below exist:

- The patient's airway is NOT being managed with an ETT or i-gel

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 an 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		<p>FOR USE WITH OTI: Insert the tube into the oral cavity and pass it along the floor, advancing it until the pre-measured portion of the OG tube meets the corner of the mouth*</p> <p>FOR USE WITH SGA(i-gel): Insert the tube into the integrated suction port adjacent to the ventilation tube, advancing it until the pre-measured portion of the OG tube meets the top of the SGA (i-gel)*</p>	<p>An appropriately sized OG tube is available:</p> <ul style="list-style-type: none"> ○ Adult: 16 - 18fr ○ Pediatric 8 - 10fr ○ Infant 5 – 6fr ○ SGA i-gel insertion: 12F and 14F sizes to fit down the SGA (i-gel) suction port
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*	<ul style="list-style-type: none"> - Gastric contents erupt from the tube - Introduce 30 - 60ml of air into the large OG tube lumen while auscultating over the stomach. If a “swooshing” sound is heard, placement is appropriate. If placement cannot be confirmed, the OG tube must be removed immediately
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"> ● Size of OG tube ● Placement (orally or in the SGA(i-gel) port) ● Number of attempts ● Any encountered complications

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

DRAFT



2023 PUC Matrix

Policy Updates

		Spring 2023
Specialty care policy review, CQILT (if needed)	Q4.2022 Committee meetings	
CQILT meeting review	Proposed policy review	January 2023
Public comment period	14- day public comment	Mid- January- Beginning of February
REMSA compiles comments for PMAC agenda		Public comment period ends 1 week before PMAC
PMAC Agenda out with provider comments by agency	Send agenda out 1 week before meeting	1 week before PMAC
PMAC	Discuss comments/ policy and protocol changes voted on at committee meeting.	End of February 2023
Policies/ Curriculum/ video recordings finalized	Immediately after PMAC- CQILT	February- April 2023
Train the trainer courses/ Education to providers/	PUC Education to be given at April CQILT	End of April 2023
Provider Agency/ MICN education		May and June, 2023
Policy manual effective		July 1, 2023