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 Provic
10- Jennifer Antonucci

County Fire Chiefs' Non-Transport BLS Provic
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, August 22, 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)**
   May 23, 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. Ultrasound 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
   6.4. Education / Policy Update – Dustin Rascon (Attachment E)
   6.5. Policy Review and Cycle Changes – Trevor Douville (Attachment F)
   6.6. Policy 3308 – ALS to BLS Downgrade
   6.7. HEMS – Shanna Kissel
   6.8. CARES Update – Catherine Farrokhi, PHD
   6.9. Training/EMT Programs/ AEMT– Bob Fontaine
   6.10. Festivals Update – Dr. Dukes
   6.11. COVID and Monkeypox Update – Misty Plumley
   6.12. 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 Gorgonio 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-Brian Savino, 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
May 23, 2022

TOPIC	DISCUSSION	ACTION
1. CALL TO ORDER	PMAC Chair Dr. Seth Dukes called the meeting to order at 9:04 a.m.	
2. Virtual Attendance	Attendance taken based on participant list on Microsoft TEAMS.	
3. Approval of Minutes		The February 28, 2022 PMAC meeting minutes were approved with no changes.
4. STANDING REPORTS		
4.1. Trauma System Updates	TAC will continue to discuss policy 5302 Trauma Continuation of Care to include all pre-hospital receiving centers and pediatrics. TAC will also be discussing the new Field Triage standards from the American College of Surgeons to determine if REMSA policy 5301 needs to be updated. Desert Regional Medical Center received their American College of Surgeons Level II verification. Trauma System Plan update submission to EMSA is still pending.	Information only.
4.2. STEMI System Updates	STEMI System Plan update submission to EMSA is still pending. The STEMI dashboard posted on rivcoems.org was updated to reflect data from quarter 4, 2021. STEMI Continuation of Care policy was updated to clarify verbiage for ease of understanding the purpose, use, along with role and responsibilities of the referral hospital, receiving center, and transporting provider. STEMI E2B Project is ongoing, the goal is to decrease the overall E2B <90 minutes as a County. REMSA audits have been completed for all six STEMI designated receiving centers.	Information only.
4.3. Stroke System Updates	Stroke System Plan update submission to EMSA is still pending. The Stroke dashboard posted on rivcoems.org was updated to reflect data from quarter 4, 2021. Stroke Continuation of Care policy was updated to clarify verbiage for ease of understanding the purpose, use, along with role and responsibilities of the referral hospital, receiving center, and transporting provider. Stroke HIFT (Hospital Interfacility Transport) project, education is being developed with the assistance of the stroke program managers.	Information only.
5. OTHER REPORTS		
5.1. EMCC Report	EMCC met in March 2022 and discussed standing reports from different divisions. The next EMCC meeting will be held on June 29th, 2022 in-person.	Information only.

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5.2. EMD Update	The EMD Committee meets quarterly to share ideas, review policies, and resolve any issues regarding Emergency Medical Dispatch. There are currently four EMD centers involved in the County, with an additional two joining soon.	
5.3. Ultrasound Trial Study	Dr. Patterson discussed the ongoing ultrasound trial study that has been introduced in both Riverside and San Bernardino County. The trial study focuses on the development and use of ultrasound in the field. They are working on creating a curriculum for training and equipment use. As the study progresses forward, the plan is to present a proposal to EMSA.	
6. DISCUSSION ITEMS, UNFINISHED & NEW BUSINESS		
6.1 Unfinished Business	Unfinished business	
6.1.1 PMAC Representation **6.1.1.1 EMT-at-Large position**	No current nominations for EMT-at-Large position. Please contact Shanna Kissel or REMSA for any nominations to be brought forth to the next meeting.	
6.2 Recognitions	Recognizing outstanding performance from our providers, REMSA and PMAC congratulated and thanked first responders and their team for exceptional service in patient care from three separate incidents that involved a cardiac arrest patient, food poisoning MCI, and a pediatric drowning. Awards of Excellence were given to the recipients below: Temecula Valley Hospital • Jack McGowan, ER Tech AMR • Sherry Drake • Jessie Jennings-Ernst Cal Fire • Engines: M255, E70, E32, E93, and M55 • Josh Scott, FAE/PM Desert Regional Medical Center • Mike Muela, MICN Cal Fire • Christopher Tirnetta, Paramedic • Xzavier Avalos	
6.3 CQI Update	CQI standing reports for Medical Cardiac Arrest and Traumatic Cardiac arrest was reviewed. No significant changes were seen in either report. CORE Measures report was condensed down to six measures. Any measures that had time values were removed.	Information only.

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	The six measures include: • Transport of trauma patients to trauma center • Treatment administered for hypoglycemia • Prehospital screening for suspected stroke patients • Respiratory assessment for pediatric patients • 911 request for services that included a lights and/or sirens response • 911 request for services that included a lights and/or sirens transport EMSA website has the manual that we follow for CORE measures criteria if anyone would like to access for references. This is important since EMSA plans to use CEMSIS to auto-export data, and we want to ensure that our data is good and accurate. BLS to 911 downgrade provisional policy was discussed. Data from January to March 2022 was reviewed. For inappropriate downgrades, education was provided to the providers. After the findings were presented, REMSA asked the group if continuation of the policy is needed, since it expires today. In discussion, providers concluded that they would like to extend the policy, seeing that it is beneficial to them as they are still using it, and ending it now would cause confusion. Michael Mesisca, MD, RUHS motioned to extend the provisional policy for another 90 days, until the next PMAC meeting in August, so further discussion can be had on whether to keep the policy or not. Bob Fontaine, MVC and Zeke Foster, MD, seconded the motion. PMAC voted: 0 opposed, 0 abstained, motion pass unanimously. REMSA clinical team will work on the potential final policy in the meantime. Dr Downes, EMS fellow reviewed a CQI module for hypoglycemia and the treatment of it. PCRs were pulled that did not have the proper treatment/documentation or action put in and were flagged for review. The findings showed the importance of proper documentation of glucose and the possibility of re-education may be needed.	PMAC approved to extend the provisional policy 3308: ALS to BLS Downgrade until the next PMAC meeting in August 2022 to discuss further continuation.
6.4 Education/Policy Update	Medication waiver policy (3301) was discussed at CQILT and realigned to follow along the appropriate path. Currently it is an Operational policy and REMSA requested PMAC to change the policy to an Administrative policy so that it can be updated as needed. Dr. Dukes, AMR motioned to move Policy 3301 – Medication Waiver to an Administrative policy. Dr. Patterson, RCH seconded the motion. PMAC voted: 0 opposed, 0 abstained, motion passed unanimously.	PMAC approved to change Policy 3301 – Medication Waiver Policy to an Administrative Policy.

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	Skill Verification Form: i-gel Supraglottic Airway Device and Orogastric (OG) tube • Ready to move this forward, finalizing the training and education, will be included in the next PUC • Reformatted the policy document (attached to the agenda) • Synchronized with ICEMA REMSA was approached by an agency looking to implement an advanced AEMT program. Looked at all of the skills that exist in our policy and compared it to the California list to make appropriate updates to the skills list. Will be working with EMS training programs and provider agencies to make sure a good curriculum is built for this as we move forward.	
6.5 Policy Review and Cycle Changes		
6.6 2023 PUC Calendar	To align with our annual reports and promote efficiency, REMSA proposed to change the PUC training cycles from twice a year in the Spring and Fall to now once a year starting 2023. Timeline of the new cycle will start as follows: • January CQILT is where new policies are brought up. An opportunity for agencies to bring forth anything they want changed or done in a public platform. It will require a second agency to motion the change. After CQILT will be public comment period • February PMAC, changes requested will be discussed at PMAC for transparency, and motioned to move forward and approve • After PMAC, REMSA will work on the training material needed for the approved changes • April CQILT, train to trainer materials will be available • May through June, agencies will have the opportunity to train their staff • July 1st, all applicable policies and protocols become effective PMAC discussed their concerns with the new schedule, and overall, did not support the new schedule. REMSA will revisit the cycle changes and bring forth a new proposal.	
6.7 CARES Data	Tabled to next meeting.	Information only.
6.8 Calcium Chloride	Dr Downes, EMS fellow presented a request for protocol update regarding medication calcium chloride for adult, end state renal disease patient on dialysis with suspected hyperkalemia and hemodynamic instability. The protocol includes If paramedics obtain EKG with patient, who display sinus bradycardia, high-grade AV block (3rd degree block) with slow junctional and ventricular escape rhythm, slow atrial fibrillation, conduction blocks, they would be able to call base	Information only.

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	hospitals for calcium chloride administration in this scenario. PMAC discussed further and concluded that a protocol manual change requires further evaluation through CQILT first, then to bring a formal proposal back to PMAC for voting. No further action needed today.	
6.9 Festivals Update	Tabled to next meeting.	
6.10 COVID Update	• Continuing to track covid positivity rates • Mobile teams to support vaccination and testing • Working through COVID treatments, and the impacts of long covid, to help our patients in the County • Offering first boosters for ages 5+ • Second boosters are reserved for individuals who are 50+ or immunocompromised	
6.11 Action Item Review		
7. Request for Discussions	Moreno Valley College requested to add, paramedic schools and preceptors to the next agenda	
8. Announcements	• Moreno Valley College, starting a second cohort of paramedic program. Also looking at sponsoring paramedic students	
9. NEXT MEETING/ADJOURNMENT	Monday, August 22, 2022 (9:00 – 11:00 a.m.) Virtual Platform – Microsoft TEAMS	Information only.

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PMAC Attendance:

Shanna Kissel, REMSA	Zeke Foster, MD, IVMC
Loren Bartlett,	Brian Harrison, Air Methods
Richard Blumel, AMR	Trevor Douville, REMSA
Julius Ibanez, MD, EH	Sherry Drake, Guest, AMR
Dan Bates, REMSA	Kristin Butler, LLUMC
Esita Harper, REMSA	Leslie Duke, REMSA
Seth Dukes, MD, AMR	Evelin Millsap, JFK
Wayne Ennis, AMR	Richard Harvey, Cal Fire
Catherine Farrokhi, REMSA	Robert Fontaine, MVC Edu
Stephani Harrington, REMSA	Jesse Ernst, Guest, AMR
Kathy Cash, EH	Sarah Lassiter, AMR
Ken Cardin, Morongo Fire	Christopher Lowder, Cal Fire
Alayna Prest, MD, LLUMC	Lisa Higuchi, AMR
Jennifer Antonucci, Murrieta Fire	Lauren Lee, Cal Fire
Sudha Mahesh, REMSA	Bryan Hanley, REMSA
James Lee, REMSA	John Connolly, City of Calimesa
Michael Downes, MD LLUMC	Suzee Kolodzik, AMR
Ryan Holtkamp, AMR	Evelyn Pham, REMSA
Jack McGowan, Guest, TVH	Melissa Schmidt, Hemet Fire
Joel Stillings, DO, DRMC	Dan Sitar, IVMC
Dustin Rascon, REMSA	Henry Olson, REMSA
Jeff Stout, Cal Fire	Sabrina Yamashiro, RCH
J Ludo Bartlett,	Stephen Patterson, MD, RCH
Christopher Linke, AMR	Thomas Wofford, EH
Noelle Toering, Riverside City Fire	Mike Macalinao, Guest, Murrieta Fire
Reza Vaezazizi, MD, REMSA	Nick Ritchey, REMSA
Lisa Mackie, RUHS	Shawn Fellabaum, JFK
Stan Hall, DRMC	Lisa Madrid, REMSA
Mattie Medina, Murrieta	Michael Mesisca, MD, RUHS
Amanda Walstrom, TVH	

FOR CONSIDERATION BY PMAC

DATE: August 8, 2022

TO: PMAC

FROM: Shanna Kissel, RN, Assistant Nurse Manager

SUBJECT: Trauma System

1. TAC will continue to discuss the new Field triage standards from the American College of Surgeons to determine if REMSA policy # 5301 needs to be updated. Will have an update after TAC on August 17th.
2. TAC approved changes to policy # 5302 Trauma continuation of care to include all pre-hospital receiving centers (including lower- level trauma centers) and Pediatrics.
3. TAC is updating Policy # 5304- Trauma Center standards to include Level III trauma centers.
4. Riverside Community Hospital and Inland Valley Medical Center will be having their ACS site verifications in October and November.
5. Trauma System Plan update was submitted to EMSA in June, pending approval.
6. 4 of the 5 trauma centers are on ImageTrend Trauma patient registry which allows the outcomes of trauma patients to feed back to the EMS crews.

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

FOR CONSIDERATION BY PMAC

Date: August 22, 2022

TO: PMAC

FROM: Leslie Duke, Specialty Care Coordinator, RN

SUBJECT: STEMI System

1. STEMI System Plan update submitted to EMSA.
2. The STEMI dashboard posted on Rivcoems.org was updated to reflect Q1 2022 data related to the Image Trend STEMI patient registry.
3. STEMI E2B project (ongoing): Performance metrics for Feb-May 2022 related to EMS on scene to hospital door time intervals was reviewed. Outcomes will be shared at the next STEMI Committee in October.
4. STEMI Data: Agency level EMS performance measures has been distributed to the corresponding agency for feedback.
5. Contracts: All 6 STEMI designated receiving center contracts have been renewed.

Next STEMI Committee meeting is on October 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: August 22, 2022

TO: PMAC

FROM: Leslie Duke, Specialty Care Coordinator, RN

SUBJECT: Stroke System

1. Stroke System Plan update submitted to EMSA.

2. The Stroke dashboard posted on Rivcoems.org was updated to reflect Q1 2022 data related to the Image Trend Stroke patient registry.

3. Project (ongoing): Stroke Hospital Interfacility Transport (HIFT) Education is continuing to be developed with the assistance of stroke managers and moving to the next steps.

4. Stroke Data: Agency level EMS performance measures has been distributed to the corresponding agency for feedback.

Next Stroke Committee meeting is on November 3rd, 2022 via video conference

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

Riverside County Policy Manual – Fall 2022 Updates / Change Log

Greetings all,

Below, you will find brief descriptions of the policy and protocol updates and changes that will become effective on October 1, 2022.

Additionally, on page 17 of this document, you will find the revised version of REMSA Policy #8301 (Policy Review Process), which becomes effective on January 1, 2023. Please take a moment to review it and familiarize yourself with the updated schedule as well as the means in which prospective protocol updates will be introduced, reviewed, and adopted by the EMS system in the future.

Policy	Current Language	Updated Language
3303 – Drug and Equipment List, pg. 8.	No requirement for supraglottic airway devices or NG / OG tubes	Par levels established for i-gel supraglottic airway devices and NG / OG tubes.
3303 – Drug and Equipment List, pg. 18	Ketamine 500 mg / 10 mL, par 2 for First Response, Ground Transport and HEMS providers.	Ketamine 500 mg / 10 mL, par 1 for First Response, Ground Transport and HEMS providers.
REASON – NG / OG: The addition of two (2) new devices required changes to the D/E List to ensure all provider agencies stock, and maintain, an appropriate amount of equipment on their apparatus' and / or response vehicles to maintain compliance with REMSA medical direction. **REASON – Ketamine: Multiple provider agencies requested a decrease in Ketamine par from two (2) to one (1) due to limited space in their narcotics boxes. Additionally, they stated that Fentanyl is still the preferred analgesic for pain control, further decreasing the need for more than one (1) vial.**		

Policy	Current Language	Updated Language
4104 – Skills List	NOT PERMITTED IN RIVERSIDE COUNTY: Supraglottic airway devices and OG tube insertion	Addition of new skills: i-gel and OG tube insertions*
REASON: The addition of two new skills required changes to the Skills List to reflect the indications, contraindications and expectations associated with them, as well as the provider level(s) that are permitted to perform them. ***In addition to the skills list, the i-gel supraglottic airway device and OG tube skill verification forms have been added to the complete ALS SCV packet.**		

Policy	Current Language	Updated Language
4105 – Atropine Sulfate (Drug Index) 4404 – Symptomatic Bradycardia	Symptomatic bradycardia with pulses: Adults: 0.5 mg (5 mL) IV/IO. **MAY REPEAT EVERY 3-5 MINUTES TO A MAX OF 3 MG (30 mL)**.	Symptomatic bradycardia with pulses: Adults: 1 mg (10 mL) IV/IO. **MAY REPEAT EVERY 3-5 MINUTES TO A MAX OF 3 MG (30 mL)**.
REASON: In the latest 2020 AHA update, the recommended single dose administration of Atropine for symptomatic bradycardia was increased from 0.5 mg to 1 mg based on data suggesting that at low doses, unintentional paradoxical bradycardia may occur.		

Policy	Current ID number	Updated ID number
5501 – Interfacility Transfer	Interfacility Transfer Policy	Tactical EMS Operations
REASON: to create consistency and better alignment in the policy manual, the IFT policy was moved out of the "*Programs and Systems*" series and into a more appropriate one, "*Hospitals*." The new Tactical EMS Operations policy was put in its place, taking both its location in the manual as well as its policy ID number.		

Policy	Current ID number	Updated ID number
6401 - NEW	N/A	Interfacility Transfer
REASON: as stated above, consistency and better alignment were needed after the Tactical EMS Operations policy was published. No content within the IFT policy was changed, only its location in the policy manual and its policy ID number.		

8 mm Cuffed Endotracheal Tube	X	X	O	X	X	X	2 EMSC	X	X	2 EMSC	2
8.5 mm Cuffed Endotracheal Tube	X	X	O	X	X	X	O	X	X	O	O
9 mm Cuffed Endotracheal Tube	X	X	O	X	X	X	O	X	X	O	O
Size 3 - i-gel Supraglottic Airway Device	X	X	1	X	X	X	1	X	X	1	1
Size 4 - i-gel Supraglottic Airway Device	X	X	1	X	X	X	1	X	X	1	1
Size 5 - i-gel Supraglottic Airway Device	X	X	1	X	X	X	1	X	X	1	1
Size 10 - Nasogastric / Orogastric Tube	X	X	O	X	X	X	O	X	X	O	O
Size 12 - Nasogastric / Orogastric Tube	X	X	1	X	X	X	1	X	X	1	1
Size 14 - Nasogastric / Orogastric Tube	X	X	1	X	X	X	1	X	X	1	1
Size 16 - Nasogastric / Orogastric Tube	X	X	O	X	X	X	O	X	X	O	O
Size 18 - Nasogastric / Orogastric Tube	X	X	1	X	X	X	1	X	X	1	1
Adult Endotracheal Intubation Stylet	X	X	1	X	X	X	1 EMSC	X	X	1 EMSC	1
Endotracheal Tube Introducer Stylet (Bougie)	X	X	O	X	X	X	1	X	X	1	1
Commercial Endotracheal Tube Securing Device	X	X	1	X	X	X	1	X	X	1	1

Ventilation

Ventilation equipment is listed per unit or vehicle. PSP equipment requirements apply to REMSA authorized providers.

Ventilation	Light Response			First Response				Ground Transport			Air
	EMT	AEMT	EMT-P	PSP	EMT	AEMT	EMT-P	EMT	AEMT	EMT-P	EMT-P
Neonate Resuscitator Mask	O	O	O	1 EMSC	1 EMSC	1 EMSC	1 EMSC	1 EMSC	1 EMSC	1 EMSC	1
Infant Resuscitator Mask	O	O	O	1 EMSC	1 EMSC	1 EMSC	1 EMSC	1 CHP	1 CHP	1 CHP	1
Pediatric Bag Valve Mask (BVM) Resuscitator Mask O_2 Reservoir	O	O	O	1 EMSC	1 EMSC	1 EMSC	1 EMSC	1 CHP	1 CHP	1 CHP	1
Adult Bag Valve Mask (BVM) Resuscitator Mask O_2 Reservoir	1	1	1	1 EMSC	1 EMSC	1 EMSC	1 EMSC	1 CHP	1 CHP	1 CHP	1
Manometer for BVM	1	1	1	O	2	2	2	2	2	2	2
Pedi. Colorimetric CO_2 Detector	O	O	O	O	O	1 EMSC	1 EMSC	0	1 EMSC	1 EMSC	1
Adult Colorimetric CO_2 Detector	O	1	1	O	O	1 EMSC	1 EMSC	O	1 EMSC	1 EMSC	1
O2-RESQ™ CPAP Device Flow Generator and Circuit Medium Bi-Trac ED Mask Head Strap	X	X	O	X	X	X	1	X	X	1	1

Controlled Substances

Controlled substances are listed per unit or vehicle. Of the authorized options, the preferred medication is in **bold** print. Minimum par levels required at all times:

Controlled Substances	Light Response			First Response				Ground Transport			Air
	EMT	AEMT	EMT-P	PSP	EMT	AEMT	EMT-P	EMT	AEMT	EMT-P	EMT-P
Fentanyl — 100 mcg / 2 mL Ampule, Vial, or Carpuject©	X	X	1	X	X	X	1	X	X	1	1
Fentanyl — 100 mcg / 5 mL Ampule, Vial, or Carpuject©	X	X									
Fentanyl — 100 mcg / 10 mL Ampule, Vial, or Carpuject©	X	X									
Ketamine – 500 mg / 10 mL Ampule, Vial or Carpuject©	X	X	O	X	X	X	2	X	X	2	2

CURRENT LANGUAGE

Controlled Substances

Controlled substances are listed per unit or vehicle. Of the authorized options, the preferred medication is in **bold** print. Minimum par levels required at all times:

Controlled Substances	Light Response			First Response				Ground Transport			Air
	EMT	AEMT	EMT-P	PSP	EMT	AEMT	EMT-P	EMT	AEMT	EMT-P	EMT-P
Fentanyl — 100 mcg / 2 mL Ampule, Vial, or Carpuject©	X	X	1	X	X	X	1	X	X	1	1
Fentanyl — 100 mcg / 5 mL Ampule, Vial, or Carpuject©	X	X	O	X							
Fentanyl — 100 mcg / 10 mL Ampule, Vial, or Carpuject©	X	X	O	X							
Ketamine – 500 mg / 10 mL Ampule, Vial or Carpuject©	X	X	O	X	X	X	1	X	X	1	1

NEW LANGUAGE

ALS Skills Competency Verification Form

1a. Name as shown on paramedic license / MICN authorization	1b. Certificate / license number
1c. Signature of person demonstrating competency	1d. Certifying authority REMSA

Airway Skills	Verification of competency	
1. BLS airway adjuncts	Affiliation	Date
Signature of person verifying competency	Printed name	Cert / License / Authorization number
2. Continuous Positive Airway Pressure (CPAP)	Affiliation	Date
Signature of person verifying competency	Printed name	Cert / License / Authorization number
3. i-gel Supraglottic Airway Device	Affiliation	Date
Signature of person verifying competency	Printed name	Cert / License / Authorization number
4. Laryngoscopy and Magill Forceps	Affiliation	Date
Signature of person verifying competency	Printed name	Cert / License / Authorization number
5. Orogastric (OG) Tube	Affiliation	Date
Signature of person verifying competency	Printed name	Cert / License / Authorization number
6. Orotracheal Intubation (OTI)	Affiliation	Date
Signature of person verifying competency	Printed name	Cert / License / Authorization number
7. Post OTI Confirmation & Monitoring	Affiliation	Date
Signature of person verifying competency	Printed name	Cert / License / Authorization number
8. Positive Pressure Ventilation	Affiliation	Date
Signature of person verifying competency	Printed name	Cert / License / Authorization number

SKILL	INDICATION(S)	PSP	EMT	AEMT	EMT-P	CONTRAINDICATIONS	EXPECTATIONS
		BLS Patient Management		ALS Patient Management			
PERILARYNGEAL AIRWAY ADJUNCT / SUPRAGLOTTIC AIRWAY (RESCUE AIRWAY) **CURRENT LANGUAGE**	• When airway management is required for a patient that is apneic in whom less invasive techniques (BLS airway management) - **and OTI** - have failed or are not likely to be successful	NOT PERMITTED IN RIVERSIDE COUNTY					
i-gel / SUPRAGLOTTIC AIRWAY DEVICE **NEW LANGUAGE**	• When airway management is required for a patient that is apneic in whom less invasive techniques (BLS airway management) - **and OTI** - have failed or are not likely to be successful <u>Patients must meet ALL of the following criteria</u>: 1. Apnea or inadequate respirations (usually less than eight (8) breaths per minute) 2. Unresponsive to verbal and / or tactile stimuli 3. Absence of a gag reflex 4. Airway management is unsuccessful using BLS maneuvers (BVM with oral / nasal adjuncts) 5. Airway management is unsuccessful after oral endotracheal intubation (OTI) 6. An appropriately sized airway is available					<u>Introduction of the i-gel supraglottic airway device is contraindicated if **ANY** of the criteria below exist</u>: • 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)	Determine appropriately sized i-gel device based on the patient's estimated weight Apply appropriate, clinically required technique to manually position the head and mandible of the unconscious patient to open the upper airway Insert the i-gel supraglottic airway device into the patient's mouth, directing it towards the hard palate. The cuff outlet should be facing the patient's chin Advance the i-gel supraglottic airway device with gentle but continuous pressure until definitive resistance is felt. The integral bite block should rest at the incisors.

SKILL	INDICATION(S)	PSP	EMT	AEMT	EMT-P	CONTRAINDICATIONS	EXPECTATIONS
		BLS Patient Management		ALS Patient Management			
NASOGASTRIC / OROGASTRIC TUBE PLACEMENT **CURRENT LANGUAGE**	• To facilitate passive gastric decompression	NOT PERMITTED IN RIVERSIDE COUNTY					
OROGASTRIC (OG) TUBE PLACEMENT **NEW LANGUAGE**	• To facilitate passive gastric decompression after orotracheal intubation (OTI) or the insertion of an i-gel supraglottic airway device.					• The patient's airway is NOT being managed with an ETT or i-gel supraglottic airway device	Appropriate OG tube diameter size will be selected based on: 1. The size available (16fr or 18fr), post OTI **OR** 2. The corresponding diameter based on the size i-gel supraglottic airway device that was inserted The appropriate measuring technique will be utilized to ensure proper placement. Confirmation of proper placement will occur, followed by securing the OG tube to the patients face.

Skill Verification Form

	Effective	Expires
Category I Skill – Low Frequency/High Risk: **i-gel Supraglottic Airway Device**	**October 1, 2022**	**March 31, 2023**
Applies To: **EMT-P, MICN, BHP, EMS System**	Approval: Medical Director **Reza Vaezazizi, MD**	Signed DRAFT
	Approval: EMS Administrator **Trevor Douville**	Signed DRAFT

Terminal Performance Objective

Ensure the secure placement of the i-gel supraglottic airway device 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	OG Tube Size
Yellow	**65 – 130 lbs / 30 – 60 kg**	**3**	**12**
Green	**110 – 200 lbs / 50 – 90 kg**	**4**	**12**
Orange	**200+ lbs / 90+ kg**	**5**	**14**

Contraindications for Use

Introduction of the i-gel supraglottic airway device is contraindicated if **ANY** of the criteria below exist:

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

1. 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
2. Two (2) UNSUCCESSFUL attempts have been made to manage the patient's airway using OTI
   - An OTI attempt is defined as the laryngoscope blade insertion into the oral cavity to assist with visualization of the laryngopharynx.

ePCR Documentation

Minimum documentation elements:

- Size of the i-gel supraglottic airway device
- Number of placement attempts and whether the placement was successful
- Lung sounds
- Change of colorimetric device
- Continuous SpO_2 and $EtCO_2$ 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:

<table>
<tr><th>Points</th><th>Score</th><th>Performance Steps</th><th>Additional Information</th></tr>
<tr><td>1</td><td></td><td>Take or verbalize body substance isolation. *</td><td>Selection: gloves, goggles, mask, gown, booties, N95 PRN</td></tr>
<tr><td>1</td><td></td><td>Methodically complete an assessment of the airway and breathing, identifying inadequate ventilation and / or signs of hypoxia within the first 30 seconds. *</td><td>Inadequate ventilation and / or signs of hypoxia include, but are not limited to:
• Pale / cyanotic / diaphoretic skins
• Altered level of consciousness
• Increased work of breathing or apnea
• Poor chest rise and fall</td></tr>
<tr><td>1</td><td></td><td>Verbalize the need to perform insertion of the i-gel supraglottic airway device. *</td><td>Reasons should include:
1. Recognition of 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
2. Two (2) UNSUCCESSFUL attempts have been made to manage the patient's airway using OTI</td></tr>
<tr><td>1</td><td></td><td>Verbalize the need for continued airway management utilizing BLS techniques, in addition to high flow oxygen administration and SpO_2 monitoring, while the i-gel supraglottic airway device is being prepared for insertion. *</td><td></td></tr>
<tr><td>1</td><td></td><td>Determine the appropriately sized i-gel supraglottic airway device and OG tube size based on the patient's estimated weight. *</td><td>
<table>
<tr><th>Color</th><th>Patient Weight</th><th>i-gel Size</th><th>OG Size</th></tr>
<tr><td>Yellow</td><td>65 – 130 lbs / 30 – 60 kg</td><td>3</td><td>12</td></tr>
<tr><td>Green</td><td>110 – 200 lbs / 50 – 90 kg</td><td>4</td><td>12</td></tr>
<tr><td>Orange</td><td>200+ lbs / 90+ kg</td><td>5</td><td>14</td></tr>
</table>
</td></tr>
<tr><td>1</td><td></td><td>Open the i-gel supraglottic airway device package, then apply a small layer of water-based lubricant to the back, sides, and front of the cuff. Place the i-gel supraglottic airway device back into the protective cradle. *</td><td></td></tr>
<tr><td>1</td><td></td><td>Confirm that the patient has been adequately pre-ventilated prior to an insertion attempt. *</td><td></td></tr>
<tr><td>1</td><td></td><td>Confirm that $EtCO_2$, and suction, are readily available for post-insertion monitoring and care. *</td><td></td></tr>
<tr><td>1</td><td></td><td>Demonstrate and / or verbalize removal of BLS airway adjuncts. *</td><td></td></tr>
<tr><td>1</td><td></td><td>Apply appropriate, clinically required technique to manually position the head and mandible of the patient to open the upper airway. *</td><td>• Medical – Head tilt / chin lift
• Trauma – Jaw thrust or modified chin lift</td></tr>
</table>

1		Grasp the i-gel supraglottic airway 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 i-gel supraglottic airway device into the patient's mouth, directing it towards the hard palate.	The cuff outlet should be facing the patient's chin.
1		Advance the i-gel supraglottic airway device with gentle but continuous pressure until definitive resistance is felt.	The integral bite block should rest at the incisors (front teeth) with the optimal position noted by the horizontal guideline present just below the i-gel supraglottic airway device size identifier.

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

1		Attach $EtCO_2$ to the BVM, then the BVM to the i-gel supraglottic airway device, then begin ventilations. *	
1		Assess and ensure: *	• Bilateral breath sounds • Equal rise and fall of the chest • $EtCO_2$ measurements are appropriate • SpO_2 is adequate
1		Secure the i-gel supraglottic airway device using the support strap (if included) or tape. *	Taping from maxilla to maxilla is recommended when the support strap is unavailable.
1		Verbalize reassessment of respiratory status: *	1. When the patient's condition changes 2. Every time the patient is moved
1		Verbalize documentation of the following: *	• Lung sounds • Continuous SpO_2 and $EtCO_2$ monitoring • Patient response to intervention
1		Verbalize the following troubleshooting solutions: 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…	1. Consideration should be made that the placement of the i-gel supraglottic airway device 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 (1) size larger.

Critical Failure Criteria

____Failure to take or verbalize BSI before performing the skill
____Failure to recognize the need for i-gel supraglottic airway device insertion
____Failure to verbalize the indications for i-gel supraglottic airway device
____Failure to determine the appropriate size i-gel supraglottic airway device **AND** OG tube
____Failure to use the appropriate i-gel supraglottic airway device insertion technique
____Failure to use $EtCO_2$ immediately after i-gel supraglottic airway device insertion
____Failure to verbalize when i-gel supraglottic airway device reassessments should occur
____Failure to verbalize how to appropriately troubleshoot issues after i-gel supraglottic airway device insertion

	Skill Verification Form - DRAFT	
	Effective **October 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 an i-gel supraglottic airway device.

Indications for Use

- After successful placement of an ETT or i-gel supraglottic airway device.

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 supraglottic airway device.

Orogastric (OG) Tube Placement Validation

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

Before placing an OG tube, the paramedic must:

<table>
<tr><th>Points</th><th>Score</th><th>Performance Steps</th><th>Additional Information</th></tr>
<tr><td>1</td><td></td><td>Take or verbalize body substance isolation. *</td><td>Selection: gloves, goggles, mask, gown, booties, N95 PRN</td></tr>
<tr><td>1</td><td></td><td>Recognize and indicate the need for OG tube placement. *</td><td></td></tr>
<tr><td>1</td><td></td><td>Select and / or verbalize how to choose an appropriate OG tube size. *</td><td>i-gel:
<table><tr><th>Color</th><th>Patient Weight</th><th>i-gel Size</th><th>OG Size</th></tr><tr><td>Yellow</td><td>65 – 130 lbs / 30 – 60 kg</td><td>3</td><td>12</td></tr><tr><td>Green</td><td>110 – 200 lbs / 50 – 90 kg</td><td>4</td><td>12</td></tr><tr><td>Orange</td><td>200+ lbs / 90+ kg</td><td>5</td><td>14</td></tr></table>
OTI: 16fr or 18fr, whichever size is readily available</td></tr>
<tr><td>1</td><td></td><td>Demonstrate and / or verbalize the appropriate measuring technique to ensure proper placement. *</td><td>Combined distance between the corner of the mouth to the ear lobe to the xiphoid process</td></tr>
<tr><td>1</td><td></td><td>Demonstrate and / or verbalize where to mark the appropriate termination location on the OG tube using a piece of tape. *</td><td></td></tr>
<tr><td>1</td><td></td><td>Demonstrate and / or verbalize how to lubricate the OG tube using an appropriate technique prior to insertion. *</td><td>i-gel: place a small bolus of lubricant directly over the gastric port then insert the tube a short distance. Move the tube in and out, without completely withdrawing it from the port, multiple times to ensure maximum lubrication has been applied prior to completely inserting it into the stomach.

OTI: lubricate the distal third of the gastric tube.</td></tr>
</table>

While placing an OG tube, the paramedic must:

<table>
<tr><td>1</td><td></td><td>Continuously monitor the oral cavity for secretions and suction as needed.</td><td></td></tr>
<tr><td>1</td><td></td><td>FOR USE WITH THE i-gel SUPRAGLOTTIC AIRWAY DEVICE: Insert the tube into the integrated gastric port adjacent to the ventilation tube, advancing it until the premeasured (“taped off”) portion of the tube meets the top of the i-gel supraglottic airway device. *

*FOR USE WITH OTI: Insert the tube into the oral cavity and pass it along the floor, advancing it until the pre-measured (“taped off”) portion meets the corner of the mouth. *</td><td></td></tr>
</table>

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. *	VERBALIZE: to confirm placement is correct - • 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 • Gastric contents may erupt from the tube
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.	• Size of OG tube • Placement (orally or in the i-gel supraglottic airway device 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 select the appropriate OG tube size
____Failure to measure the OG tube using the appropriate technique(s)
____Failure to mark the appropriate termination location on the OG tube
____Failure to lubricate the OG tube using the appropriate technique(s)
____Failure to insert the OG tube in the appropriate manner
____Failure to confirm proper placement
____Failure to appropriately secure the tube
____Failure to verbalize that reassessment would occur as needed

ATROPINE SULFATE

CLASS:

- Anticholinergic

ACTION:

- Competes with acetylcholine for receptor sites blocking the PNS response at SA & AV nodes.
- Increases heart rate by increasing electrical conduction through the heart.
- Inhibits secretions by decreasing PNS effect on bronchial, salivary, sweat and GI glands.
- ONSET = 2-4 minutes
- DURATION = 2-6 hours

INDICATIONS	DOSAGE/ROUTE
Symptomatic bradycardia with pulses (4404)	Adults: 0.5 mg (5 mL) IV/IO. **MAY REPEAT EVERY 3-5 MINUTES TO A MAX OF 3 MG (30 mL).** **INITIAL AND REPEAT PEDIATRIC ADMINISTRATION REQUIRES A BASE HOSPITAL ORDER (BHO)**. See REMSA Policy #4102 (Calculation Chart) for patient specific dosage and volume

INDICATIONS	DOSAGE/ROUTE
New dosing -> Symptomatic bradycardia with pulses (4404)	Adults: 1 mg (10 mL) IV/IO. **MAY REPEAT EVERY 3-5 MINUTES TO A MAX OF 3 MG (30 mL).** **INITIAL AND REPEAT PEDIATRIC ADMINISTRATION REQUIRES A BASE HOSPITAL ORDER (BHO)**. See REMSA Policy #4102 (Calculation Chart) for patient specific dosage and volume

ALS Patient Management	ALS Patient Management
• Establish, maintain, and ensure peripheral IV and / or IO access for emergency stabilization, and / or as clinically indicated, in adult and pediatric patients Consider the need for additional sites as clinically indicated	• Establish, maintain, and ensure peripheral IV and / or IO access for emergency stabilization, and / or as clinically indicated, in adult and pediatric patients Consider the need for additional sites as clinically indicated
• Interpret and continuously monitor ECG and vital signs Perform, interpret and transmit 12-lead ECG(s), as clinically indicated, when: o A STEMI is suspected o A STEMI is ECG-monitor identified or o If the patient's cardiac rhythm is atypical or difficult to interpret	• Interpret and continuously monitor ECG and vital signs Perform, interpret and transmit 12-lead ECG(s), as clinically indicated, when: o A STEMI is suspected o A STEMI is ECG-monitor identified or o If the patient's cardiac rhythm is atypical or difficult to interpret
• **For symptomatic bradycardia with pulses** Adults: Atropine 0.5 mg (5 mL) IV/IO. **MAY REPEAT EVERY 3-5 MINUTES TO A MAX OF 3 MG (30 mL).**	• **For symptomatic bradycardia with pulses** Adults: Atropine 1 mg (10 mL) IV/IO. **MAY REPEAT EVERY 3-5 MINUTES TO A MAX OF 3 MG (30 mL).**

Standard Medications		Grey 3–5 kg	Pink 6-7 kg	Red 8-9 kg	Purple 10-11 kg	Yellow 12-14 kg	White 15-18 kg	Blue 19-23 kg	Orange 24-29 kg	Green 30-36 kg	Adult
Atropine		IV	IV								IV
1 mg	0.5 mg	0.08 mg	0.13 mg								0.5 mg
10 mL	5 mL	0.8 mL	1.3 mL								5 mL
Atropine		IV	IV	IV	I						IV
1 mg	0.5 mg	0.08 mg	0.13 mg	0.17 mg	0.2						1 mg
10 mL	5 mL	0.8 mL	1.3 mL	1.7 mL	2						10 mL

CURRENT LANGUAGE

NEW LANGUAGE

RIVERSIDE COUNTY EMS AGENCY	Administrative Policy	5501
	Effective XX/XX, 2022	Expires XX/XX, 2023
Policy: Tactical EMS Operations	Approval: Medical Director Reza Vaezazizi, MD	Signature
Applies To: All participating agencies and providers	Approval: REMSA Administrator Trevor Douville	Signature

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RIVERSIDE COUNTY EMS AGENCY	Administrative Policy	5501
	Effective April 1, 2022	Expires March 31, 20
Policy: Interfacility Transfer	Approval: Medical Director Reza Vaezazizi, MD	Signature
Applies To: Acute Care Facilities, EMS System	Approval: EMS Administrator Trevor Douville	Signature

RIVERSIDE COUNTY EMS AGENCY	Administrative Policy	6401
	Effective April 1, 2022	Expires March 31, 2023
Policy: Interfacility Transfer	Approval: Medical Director Reza Vaezazizi, MD	Signature
Applies To: Acute Care Facilities, EMS System	Approval: EMS Administrator Trevor Douville	Signature

	Administrative Policy	8301d
	Last revised **January 1, 2023**	Last reviewed **January 1, 2023**
Policy: **Policy Review Process**	Approval: Medical Director **Reza Vaezazizi, MD**	Signature
Applies To: **EMS System**	Approval: REMSA Administrator **Trevor Douville**	Signature

PURPOSE

To describe the Riverside County EMS Agency's (REMSA) policy review process.

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
2013 Strategic Continuous Quality Improvement Plan (SCQIP)

Policy Categories

Administrative

These policies inform the EMS system of REMSA-specific rules and procedures that cover a wide array of internal tasks and functions.

- Their intent is to serve as a guide for REMSA operations.
- They are rarely revised, with modifications occurring to ensure alignment with changes to federal, state, or local law.
- System input is not required, and is usually not obtained, when these policies are modified.

Operational

These policies describe the rules and expectations that REMSA has for all EMS system participants, which cover a wide array of day-to-day tasks and functions.

- Their intent is to provide direction and guidance to agencies and individual personnel to ensure compliance with federal, state, and local laws.
- They are revised infrequently, sometimes only once (1x) per calendar year.
- System input is required through participant comments at the CQILT and, ultimately, adoption through the PMAC; however, REMSA may modify any of these policies without system input if an immediate need is recognized. In this event, REMSA will notify the system of the change as soon as possible through the use of a System Advisory.

Provisional

These policies are created as a result of an immediately identified system need when sufficient time to obtain public comment and stakeholder input does not exist.

- Their intent is to provide immediate direction and guidance to agencies and individual personnel that addresses the identified system need.
- Unlike other policies, their effective periods usually last only a few weeks to a few months before they either expire or are renewed for another specific, finite period of time.
- REMSA will notify the system of provisional policy implementation as soon as possible through the use of a System Advisory.

Treatment Protocols

These policies constitute medical control by the REMSA Medical Director, as specified in Section 1798 of the California Health and Safety Code and describe the REMSA approved scope of practice for public safety personnel, EMTs and paramedics in Riverside County.

- Their intent is to detail the approved treatments and procedures that may be utilized based on a thorough assessment of the patient's complaint as well as their clinical presentation.
- They are revised infrequently, sometimes only once (1x) per calendar year.

- System input is required through participant comments at the CQILT and, ultimately, adoption through the PMAC; however, REMSA may modify any of these policies without system input if an immediate need is recognized. In this event, REMSA will notify the system of the change as soon as possible through the use of a System Advisory.

REMSA has a responsibility to the public as well as the EMS system as a whole, to improve the delivery of prehospital care services through the monitoring, review, and evaluation of system activities and performance. Policies and / or protocols, including any of the types described above, may require modification based on an immediately identified system-wide, operational need and EMS system stakeholder input may not be obtained. In this event, REMSA will notify the system of the change as soon as possible through the use of a System Advisory.

Policy Review Process

REMSA's policy review process is facilitated through the Continuous Quality Improvement Leadership Team (CQILT) and the Prehospital Medical Advisory Committee (PMAC), with additional advisory group input from the Trauma Audit Committee (TAC), the STEMI system committee, the Stroke system committee and / or others, as needed and as appropriate.

Annual Policy Review Schedule

Beginning January 1, 2023, REMSA will initiate the policy and protocol review process as follows:

- **January CQILT**: In addition to all standing agenda items, individual CQILT participants, on behalf of the agency that they represent, may propose any policy or protocol for modification. In addition to the request for modification, REMSA recommends a brief presentation consisting of objective, empirical data to validate the request. A Committee level discussion will occur to decide if the issue justifies policy and / or protocol change through the PMAC in February.

  A motion and second are required in order for the proposal to move to consideration during the public comment period and at the PMAC. Due to this review schedule, items that are not carried into the public comment period will not have the opportunity to be addressed again until the next January CQILT meeting.

  The public comment acceptance period will open the day after CQILT and remain open until the Monday before the February PMAC.

- **February PMAC:** In addition to all standing agenda items, all public comment submissions that were received during the open public comment period will be addressed at large. After further discussion, a motion and second are required in order for any / all recommendations to be formally adopted. Due to this review schedule, items that are addressed at this PMAC meeting, but not formally adopted, will need to be re-addressed at the next January CQILT meeting if the agency that brought the issue to attention believes that it still remains.

  Immediately after this PMAC meeting, REMSA will begin producing the necessary educational content for distribution to the system.

- **April CQILT:** In addition to all standing agenda items, REMSA will present all educational content and provide a question-and-answer session to provide any necessary clarification(s). Agencies that do not participate in this meeting will not receive the mandatory education package.

- **May through June:** Agency / department level training occurs.

- **July 1:** All applicable policies and protocols become effective.

All other required education, as identified through the CQILT and PMAC outside of the schedule noted above, will be delivered using REMSA's online Learning Management Platform.

Policy and Protocol Effective and Expiration Dates

Beginning July 1, 2023, all REMSA policies and protocols will go into effect, and remain in effect, unless and until there is an identified need to modify their content utilizing the steps outlined above (Annual Policy Review Schedule) or, the triennial review period begins (below).

Triennial Policy Review Schedule

Beginning January 1, 2026, and continuing on a triennial bases (every three (3) years thereafter), REMSA will review all policies and protocols contained in the REMSA Policy and Procedure manual to ensure that the content remains accurate and meaningful.

REMSA requests that all agencies, departments, and organizations take time to review each policy and provide public comments after the January CQILT occurring during the triennial review period, for review and adoption at the February PMAC.

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**