

PREHOSPITAL MEDICAL ADVISORY COMMITTEE MEETING AGENDA (PMAC)

PMAC MEMBERS PER POLICY 8202:

Air Transport Provider Representative 11- Brian Harrison

American Medical Response 5- Jeremy Shumaker Seth Dukes, MD

BLS Ambulance Service Representative 12- Lori Lopez

Cathedral City Fire Department 5- Justin Vondriska

Corona Regional Medical Center 1- Robert Steele, MD

4- Alecia Passow

County Fire Chiefs' Non-Transport ALS Provid 10- Jennifer Antonucci, Murrieta FD

<u>County Fire Chiefs' Non-Transport BLS Provic</u> 9- Anthony Gonzales, Calimesa FD

Desert Regional Medical Center 1- Joel Stillings, D.O 4- Michael Muela, PLN

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

EMT / EMT-P Training Programs 6- Robert Fontaine, Moreno Valley College

EMT-at-Large 13 - VACANT

Paramedic-at-Large 14- Patrick Anderson, Riverside City Fire

Hemet Valley Medical Center 1- Todd Hanna, MD 4- Cindy Blenkarn

Idyllwild Fire Protection District 5- Mark Lamont

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

JFK Memorial Hospital 1- Timothy Rupp, MD 4- Robin Boardman, PLN

Kaiser Permanente Riverside 1- Jonathan Dyreyes, MD 4- Barbara Coriell This Meeting of PMAC is on: Monday, February 6, 2023 9:00 AM to 11:00 AM Ben Clark Training Center- Auditorium

- 1. <u>CALL TO ORDER & HOUSEKEEPING (3 Minutes)</u> Andrew Pachon, MD (Chair)
- 2. <u>ATTENDANCE (taken based on participant sign in sheet)</u> Shanna Kissel (REMSA)
- 3. <u>APPROVAL OF MINUTES (3 Minutes)</u> November 28, 2022 Minutes— Andrew Pachon, 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. Tele- 911 Dan Bates/ Dr. Marc Eckstein
- 5.2. EMD Update –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
 - 6.1.1.2. EMT Student position
 - 6.1.1.3. Riverside County Police Association
- 6.2. Recognitions
- 6.3. CQI Update Lisa Madrid
- **6.4.** Education / Policy Update Dustin Rascon (Attachment E)
- 6.5. Policy 3308 ALS to BLS Downgrade (Attachment F)
- **6.6.** Action Item Review

7. <u>REQUEST FOR DISCUSSIONS</u>

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- Christopher Ward

Menifee Valley Medical Center 1- Todd Hanna, MD 4- Matt Johnson

Kaiser Permanente Moreno Valley 1- George Salameh, MD 4- Carol Fuste

Palo Verde Hospital 1- David Sincavage, MD 4- Katchya Currier

Parkview Community Hospital 1- Chad Clark, MD 4- Allan Patawaran

Rancho Springs Medical Center 1- Zeke Foster, MD 4- Janny Nelson

<u>Riverside Community Hospital</u> 1- Stephen Patterson, MD 4- Sabrina Yamashiro, PLN

Riverside County Fire Department 5- Richard Harvey 8- Jeff Stout

Riverside County Police Association 7- VACANT

Riverside University Health System Med. Center 1- Andrew Pachon (Chair)

4- Lori Maddox, PLN

San Gorgonio Memorial Medical Center 1- Richard Preci, MD 4- Angie Brady

Temecula Valley Hospital 1- Pranav Kachhi, MD 4- Amanda Walstrom

Trauma Audit Comm. & Trauma Program Managers 2- Stephen Kernop, TPD RUHS

3- Sara Edwards, TMD RUHS

Ex-officio Members:

1- Geoffrey Leung, MD, Public Health Officer

2- Reza Vaezazizi, MD, REMSA Medical Director

3- Bruce Barton, REMSA Director

4- Dan Bates, REMSA Program Chief II

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 Evelyn Pham at (951) 358-5029 / or email PMAC@rivco.org. PMAC Agendas with attachments are available at: <u>www.rivcoems.org</u>. Meeting minutes are audio recorded to facilitate dictation for minutes.

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)

- May 15, 2023- Location: In-person TBD

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 August 22, 2022 PMAC meeting minutes were approved with no changes.
4. STANDING REPORTS		
4.1. Trauma System Updates	 TAC will continue to discuss the new field triage standards from the ACS to determine if REMSA Policy #5301 needs to be updated. Changes include child unrestrained, active bleeding requiring a tourniquet, and suspicion of child abuse. REMSA Policy #5304 – Trauma Center Standards remain as is, not adding Level III standards at this time. RCH, IVMC, and DRMC had their ACS site verifications in October and November. Pending final outcome. Trauma System Plan update was submitted to EMSA in June, approval pending until 2021 EMS plan is submit. 5 of the 6 trauma centers are on ImageTrend patient registry platform which allows the outcomes of trauma patients to feed back to EMS crews. REMSA designated Eisenhower Health as a Level IV Trauma Center. 	Information only.
4.2. STEMI System Updates	 STEMI System Plan update submitted to EMSA, pending approval. STEMI dashboard was updated to reflect quarter 2, 2022 data related to the ImageTrend patient registry. STEMI E2B project (ongoing): moving into the next steps of hospital door to balloon times. STEMI Data: Agency level EMS performance measures Q3 has been distributed to the corresponding agency for auditing. STEMI Center Standards Policy #5401 has been updated with new verbiage surrounding diversion in the absence of internal disaster. STEMI designated hospitals have received a 2022 policy performance report. STEMI quarterly meeting will consist of 1 regional meeting with ICEMA in July. 	Information only.
4.3. Stroke System Updates	 1. Stroke System Plan update submitted to EMSA, pending approval with EMS plan submission. 2. Stroke dashboard was updated to reflect quarter 2, 2022 data related to the ImageTrend patient registry. 3. Project (ongoing): Stroke Hospital Interfacility Transport (HIFT) Education is continuing to be developed with the 	Information only.

	 assistance of stroke program managers and moving to the next steps. 4. Stroke data: agency level EMS performance measures Q3 is being prepared and will be distributed to the corresponding agency for auditing. 5. Stroke Center Standards Policy #5701 has been updated with new verbiage surrounding diversion in the absence of internal disaster. 6. Stroke designated hospitals have received a 2022 policy performance report. 7. Stroke quarterly meeting will consist of 1 regional meeting with ICEMA in May. 	
5. OTHER REPORTS		
5.1. EMCC Report	EMCC met in October to discuss standard reports from the clinical and data team. Next EMCC meeting is scheduled for December.	Information only.
5.2. EMD Update	 No current updates from EMD. The Committee will meet on November 30th, 2022. Discussed adding to the agenda tier response regarding alpha and omega calls 	Information only.
5.3. Ultrasound Trial Study	Currently still onboarding devices and getting providers trained. San Bernardino County joined in on the trail and should bring in more scans to review. The biggest hurdle is finding oversight for the ultrasound readings.	Information only.
6. DISCUSSION ITEMS, UNFINISHED & NEW BUSINESS		
6.1 Unfinished Business	Unfinished business	
6.1.1 PMAC	No current nominations for EMT-at-Large position. PMAC	
Representation 6.1.1.1 EMT-at-Large position	discussed the possibility of having an EMT student fill the position. After discussion, PMAC decided it would be best to keep this position as an active EMT field provider, but will add on the agenda for the next PMAC meeting to also add in a new student position to the PMAC representation.	
6.2 Recognitions	Tabled to next in-person meeting.	
6.3 CQI Update	REMSA reminded the agencies that CQI plans are due by December 31 st , 2022, and January 31 st , 2023 for the annual CQI update.	Information only.
6.4 Education/Policy Update	The new calculation chart will continue to be reviewed by a workgroup to update the dosing in the chart. REMSA is also seeking the guidance of a pharmacist to ensure dosing formulas are correct. Once the chart is updated, a final version of the	

 current format will be presented at the January CQLIT before final approval and implementation. Policy #1207 and #1208 (Paramedic Accreditation and Paramedic Reverification) Both policies will be combined into one (numbered #1207, still titled Paramedic Accreditation). Additionally, to align with administrative policies as well as ALS Agreements between municipalities and the County, beginning July 1⁴⁷, 2023, paramedics who are applying for initial accreditation, or reverification of accreditation, will be required to submit copies of their PALS and PHTLS cards along with all other required documentation. These certifications are already submitted at the employer level and are not newly expected courses that providers are required to take. A system advisory will also go out regarding this notice before the deadline in 2023. Policy #6103 – Ambulance Diversion REMSA is updating the language in this administrative policy to clarify what does – and does not - constitute an internal disaster. A name change away from "Internal Disaster" is being considered as well to prevent further confusion. After reviewing the data from the last couple of weeks, PMAC approved Policy #3308 ALS to BLS Downgrade and if it would be beneficial to continue and extend the provisional policy or let expire today. Providers expressed their concerns with rescinding the policy today will impact the alpha and omega calls and cause disruption to the current system. It seems that most of the inappropriate downgrades may be a documentation deficiency, and not due to an action deficiency. PMAC is open to extending it once again until fourther data sessesment is done, or until a potential new policy can be developed to replace it. Dr. Foster motioned to extend the policy until alpotential new policy can be developed to replace it. Dr. Foster motioned to extend the policy until apotential new policy can be developed to replace it. Dr. Foster motioned to extend the policy until he nex			
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out later today pointing to the changes in language for further		· · ·	
insight into the appropriate, and proper use and introduction to			
these devices. Additional resources will also be available on the			
website education page.			
	6.7 Policy Cycle Changes		Information only.
change requests will be reviewed at the January CQILT, starting			
2023, and then pushed to PMAC in February for approval. Once		2023, and then pushed to PMAC in February for approval. Once	

		1
	approved, implementation will start on July 1 st , 2023. Update cycle are for protocols only.	
	Education Platform	
	In quarter 1 or 2 of 2023, REMSA will officially launch its new	
	LMS platform to provide education and updates along with	
	licensing for all EMS and hospital providers. If anyone is	
	interested in a tour, or wishes to begin using the platform now, please contact Dustin Rascon.	
6.8 TIP (Trauma	Trauma Intervention Program (TIP) of Riverside County is	Information only.
Intervention Program)	looking for caring people willing to be part of a team of citizen	internation only.
,	volunteers trained to provide emotional and practical support	
	to the victims of traumatic events. A TIP volunteer will be	
	called to emergency scenes by local police, fire medical and	
	hospital personnel to comfort and support families during	
	traumatic events.	
6.9 Buprenorphine Admin	Vanessa Lara presented on behalf of Dr. Gene Hern regarding	Discussion.
by EMS for Opioid	integrating substance use disorder treatment into Emergency	
Withdrawal	Medical Services. The suggestion includes paramedic-initiated	
	Buprenorphine administration for opioid overdose or withdrawal. PMAC agrees with this suggestion, however to	
	follow the new guideline for changes, a formal proposal needs	
	to be presented at CQILT first and voted at the next PMAC	
	before moving forward to fill out a LOSOP application. If	
	approved, REMSA would like to see this as a system wide	
	implementation process.	
6.10 IO Location Selection	Dr. Dukes presented data from RHeaRT regarding the benefits	PMAC approved
Preferences	of IO location selection. The preference in the upper extremity	adding IO location
	over the lower extremity showed significant increase in ROSC	selection preference
	rates. PMAC discussed whether this would be more of an	to the upper extremity
	appropriate change for education versus policy. Dr. Dukes proposed to add in written protocol access be obtained	over the lower extremity in written
	preferentially to the upper extremity, if not possible, then the	protocol.
	later choice would be the lower extremity. Dr. Foster motioned	
	to move forth with Dr. Dukes proposal, Dr. Ibanez seconded the	
	motion.	
	PMAC voted: 0 opposed. Motion passed unanimously	
	REMSA reminded PMAC that all new protocol changes must	
	follow the new cycle change of going through a draft version at	
	CQILT first, then final changes will be approved at PMAC for	
	implementation on July 1 st , 2023.	
6.11 New Chair Election	Dr. Andrew Pachon, RUHS was nominated as chair for the 2023-	PMAC approved Dr.
	2024 term. PMAC voted: 0 opposed. Passed unanimously.	Pachon as the new chair for PMAC and Dr.
	Dr. Andrew McCague, JFK was nominated as vice chair for the	McCague as the vice
	2023-2024 term.	chair for the 2023-
	PMAC voted: 0 opposed. Passed unanimously.	2024 term.

6.12 2023 Meeting Dates 6.13. COVID/Monkeypox Update	 2023 REMSA Clinical meeting dates were presented. Some meetings will be held in-person, and some will stay virtual for the time being. Quarter 2 will resume in-person meetings at Riverwalk. REMSA will also attempt including a hybrid online version. PMAC requested to change the May PMAC date to May 15th instead due to scheduling conflicts with other events. PMAC approved the new 2023 meeting dates. COVID-19 State of Emergency expires in February 2023. So far hospitals have been seeing a greater impact from RSV and the Flu than COVID. Monkeypox vaccine is available. Cases have decreased throughout the County and State/Nation. 	PMAC approved the new 2023 meeting dates.
6.14. Action Item Review	None	
7. Request for Discussions	None	
8. Announcements	None	
9. NEXT	Monday, February 6, 2023 (9:00 – 11:00 a.m.)	Information only.
MEETING/ADJOURNMENT	Virtual Platform – Microsoft TEAMS	

PMAC Attendance:

Shanna Kissel, REMSA	Zeke Foster, MD, IVMC
Alexandra Jabr, Cal Fire	Andrew McCague, MD, JFK
Andrew Pachon, MD, RUHS	Kristie Hinz, Cal Fire
Julius Ibanez, MD, EH	Carla Bolowich, Cal FIre
Dan Bates, REMSA	Chris Douglas, Corona Fire
Christian Linneman, Cal Fire	Leslie Duke, REMSA
Seth Dukes, MD, AMR	Evelin Millsap, JFK
Sean Hakam, REMSA	Richard Harvey, Cal Fire
Catherine Farrokhi, REMSA	Robert Fontaine, MVC Edu
Stephani Harrington, REMSA	Joseph Christopher, EMD
Vanessa Hayflich, Air Methods	Sarah Lassiter, AMR
Ken Cardin, Morongo Fire	Dustin Rascon, REMSA
Cory Gorospe, Palm Springs Fire	Lisa Higuchi, AMR
Jennifer Antonucci, Murrieta Fire	Ryan Holtkamp, AMR
Sudha Mahesh, REMSA	Bryan Hanley, REMSA
James Lee, REMSA	Lori Maddox, RUHS
Kathy Cash, EH	Suzee Kolodzik, AMR
Christopher Lowder, Cal Fire	Evelyn Pham, REMSA
Noelle Toering, Riverside City Fire	Melissa Schmidt, Hemet Fire
Reza Vaezazizi, MD, REMSA	Dan Sitar, IVMC
Lisa Mackie, RUHS	Henry Olson, REMSA
Mattie Medina, Murrieta	Thomas Wofford, EH
Robin Boardman, JFK	Michael Muela, DRMC
Steven Wells, Corona Fire	Nick Ritchey, REMSA
Timothy Rupp, MD, JFK	Stephanie Zimmerman, AMR
Karleen Wade, REMSA	Richard Valenti, Cathedral City
Zak Saxton, Mercy Air	Sabrina Yamashiro, RCH
Christopher Ward, LLUMC-M	Stephen Kernop, RUHS
Tim Buckley, Soboba Fire	

FOR CONSIDERATION BY PMAC

DATE: January 20, 2023

TO: PMAC

FROM: Shanna Kissel, RN, Assistant Nurse Manager

SUBJECT: Trauma System

- 1. Changes to REMSA policy 5301 will be implemented July 1, 2023. Changes include: child unrestrained, active bleeding requiring a tourniquet, and suspicion of child abuse.
- 2. Trauma Audit Committee (TAC) will be discussing at the February TAC a Riverside county policy for the Hospital Emergency Response Team (HERT) similar to that in the ICEMA region.
- Riverside Community Hospital, Inland Valley Medical Center, and Desert Regional Medical Center had their ACS site verifications in October and November. All 3 facilities received verification.
- 4. Trauma System Plan update will be resubmitted to EMSA to include activities and system changes for CY 2020- 2022. This will be submitted to EMSA the end of January.
- 5. Effective January 1, 2023, all 6 trauma centers are on ImageTrend Trauma patient registry/ platform 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 Page 1 of 1

Date: February 6, 2023

TO: PMAC

FROM: Leslie Duke, Specialty Care Coordinator, RN

SUBJECT: STEMI System

- 1. STEMI System Plan update submitted to EMSA, pending approval.
- 2. The STEMI dashboard posted on Rivcoems.org was updated to reflect Q3 2022 data related to the Image Trend STEMI patient registry.
- 3. STEMI E2B project (ongoing): moving into the next steps of activation and pre-activation of incoming suspected STEMI patients.
- 4. STEMI Data: Agency level EMS performance measures Q4 was distributed to the corresponding agency for auditing.
- 5. Re-education of annual hospital requirements related to STEMI Center Administrative policies was completed during the first managers meeting of the year.
- 6. Quarterly STEMI Managers meeting has moved back to an in-person forum.

Next STEMI Committee meeting is on April 11th, 2023, via TEAMS conference

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

FOR CONSIDERATION BY PMAC Page 1 of 1

Date: February 6, 2022

TO: PMAC

FROM: Leslie Duke, Specialty Care Coordinator, RN

SUBJECT: Stroke System

- 1. Stroke System Plan update submitted to EMSA, pending approval with EMS plan submission.
- 2. The Stroke dashboard posted on Rivcoems.org was updated to reflect Q3 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 Q4 was distributed to the corresponding agency for auditing.
- 5. Re-education of annual hospital requirements related to Stroke Center Administrative policies was completed during the first managers meeting of the year.
- 6. Quarterly Stroke Managers meeting has moved back to an in-person forum.

Next Stroke Committee meeting is on May 4th, 2023, via TEAMS conference

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

View results

Respondent

3 Anonymous



1

Name and Title *

First and Last, Title within your agency / department

Lisa Higuchi, CES Manager

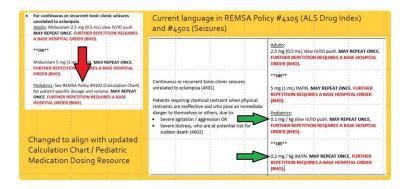
2

Agency / Department *

American Medical Response

Update: Pediatric Medication Administration Language

- REMOVAL: prescriptive language referring to REMSA Policy #4102 (Calculation Chart) for administration of medications to pediatric patients
- (RE)INTRODUCTION: specific dosing formulas (mg / kg, gm / kg, etc.) for administration of medications to pediatric patients
- **PURPOSE**: Providers in the field have grown accustomed to utilizing the Calculation Chart for dosing pediatric patients. Unfortunately, after review, the Chart has been found to contain many inaccuracies and inconsistencies in both dosing and volumes listed, as well as in the formulas used to get to those doses and volumes.
 - REMSA cannot knowingly publish a treatment protocol that directs providers to incorrectly dose patients when untoward patient outcomes could occur as a result.
 - Additionally, prescribing in protocol that providers must "See REMSA Policy #4102 (Calculation Chart) for patient specific dosage and volume" prohibits agencies that wish to use alternative pediatric treatment programs from being permitted to do so.
 - Identifying the PMDR explicitly as an educational / reference tool, along with the reintroduction of specific dosing calculations within each treatment protocol for pediatric patients, will help mitigate REMSA's liability while producing more accurate dosing for the pediatric population.



If the dosing calculation formula (such as mg/kg) is listed in the protocol, but a provider is using an "alternative pediatric treatment program", does that mean that paramedics from different agencies could potentially be utilizing different doses?

4

Medication Update: Activated Charcoal

REMOVAL: Activated Charcoal from -

- Drug and Equipment List
- ALS Drug Index
- Treatment Protocol Overdose / Adverse Reaction & Toxic Exposure, Inhalation, or Ingestion

PURPOSE:

- Difficulty procuring
- Low frequency / high risk medication
- Inappropriate / under- / unapproved utilization (given without BHO, for the wrong indication, or both)

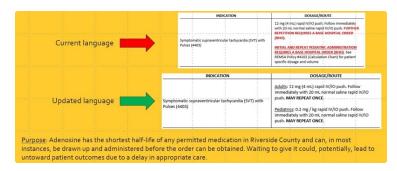
emoval of Activated Ch	narcoal from:	Overdose/Poisoning/Ingestion	Count of Admins (eMedication	540	340 62.96
		Overdose/Poisoning/Ingestion Behavioral / psychiatric disorder [Mental disorder]		115	.340 62.96
				115 .	. 67
Drug and Equipment List		Altered mental status		5	. 2
		General weakness		5	. 3
ALS Drug Index		No Medical Complaint		3	3
ALS Drug index		Rèspiratory distress - other		3	
		Pàin, non-traumatic body pain (acute)		2	: 2
Treatment Protocol:		T(aumatic Injury		2	2
		Cardiac anthythmia		2	
Overdose / Adverse Reac	tion	Abnormal uterine/vaginal bleeding		1	
		Respiratory distress - Acute bronchospasm		1	
Treatment Protocol:		Chest Pain - Suspected Cardiac		1	: 1
		Nausea		1	: 1
Toxic Exposure, Inhalatio	n, or	Dizziness/vertigo		1	1
Ingestion		Respiratory distress-Pulmonary edema/CHF · · · · ·			
		Abdominal Pain/Problems (GI/GU)		1	
		Upper GI bleed/(vomiting blood)		1	
		Headache non-traumatic		1	1
		Hyperglycemia (high blood sugar)		1	
		Grand Total		687	424 61.

5

Medication Update: Adenosine

REMOVAL: BHO requirement prior to initial and repeat administrations for adults and pediatrics

PURPOSE: Shortest half-life of any permitted medication in Riverside County and can, in most instances, be drawn up and administered before the order can be obtained. Waiting to give it could, potentially, lead to untoward patient outcomes due to a delay in appropriate care.



Medication Update: Calcium Chloride

CHANGE: Change in route of administration for pediatrics to align with adults

PURPOSE: CaCl2 can cause hypotension, syncope and significant venous irritation. Admin by IVPB is required for all patients with pulses. IV / IO administration is permitted in cardiac arrest scenarios only.





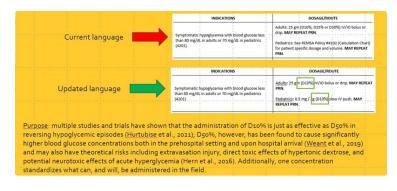
7

Medication Update: Dextrose

CHANGE: Removal of D25% and D50% as concentrations for admin to adults and pediatrics.

• D25% and D50% can still be carried; however, they must be diluted to D10% prior to administration.

PURPOSE: D10% is just as effective as D50% in reversing hypoglycemic episodes but has been shown to cause less frequent instances of reflex hyperglycemia, extravasation injury, direct toxic effects of hypertonic dextrose, and potential neurotoxic effects of acute hyperglycemia as D50% administration does. Additionally, one concentration standardizes what can, and will, be administered in the field.

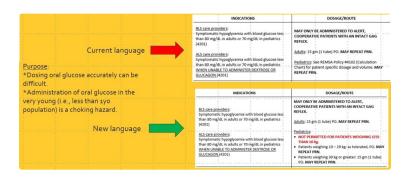


6

CHANGE: Administration to patients weighing less than 10 kg will change from "BHO" to "NOT PERMITTED."

PURPOSE:

- Dosing oral glucose accurately can be difficult.
- Administration of oral glucose in the very young (i.e., less than 1yo population) is a choking hazard.

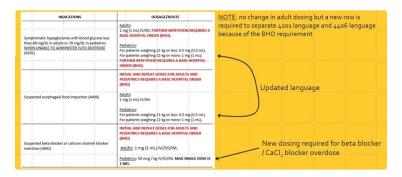


9

Medication Update: Glucagon

CHANGE: Dosing schedule modification for pediatrics only & new formula for beta blocker / CaCl2 blocker overdose

PURPOSE: to align with Rady Children's Glucagon admin protocol / pharmacist recommended dosing

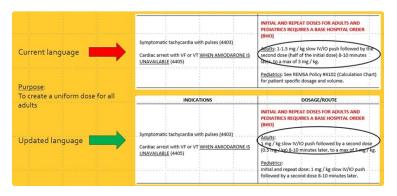


Medication Update: Lidocaine

CHANGE: Adult dosing

- FROM: 1-1.5 mg / kg with repeat at half the dose
- TO: 1 mg / kg with repeat at 0.5 mg / kg $\,$

PURPOSE: to create a uniform dose for all adults



11

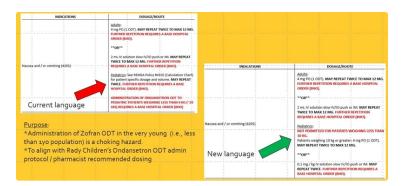
Medication Update: Ondansetron ODT

CHANGE: dosing schedule modification for pediatrics only

- FROM: 1-1.5 mg / kg with repeat at half the dose
- TO: 1 mg / kg with repeat at 0.5 mg / kg

PURPOSE:

- Administration of Zofran ODT in the very young (i.e., less than 1yo population) is a choking hazard.
- To align with Rady Children's Ondansetron ODT admin protocol / pharmacist recommended dosing



Update: REMSA Policy #1105 (Paramedic Internship)

Includes new definitions, eligibility criteria, paramedic student placement requirements and documentation requirements.

See email attachment (doc titled: "1105 v2.5")

Page 1 - under "Definitions and Descriptions", where the minimum requirements for being a paramedic preceptor have changed - unclear on the intent of the addition of the first bullet point, "Unrestricted paramedic license in California with a minimum of two (2) years of academic or clinical experience in emergency medicine within the last five (5) years." Who is this describing? And is there no requirement to be employed by a REMSA authorized ALS provider at any time, for this category? The current policy states 2 yrs as a paramedic with a REMSA ALS provider OR 5 years as a paramedic with one year with a REMSA ALS provider, which is reasonable and sufficient, so I am hoping we can discuss the rationale behind this proposed change.

Page 2, under "Paramedic Field Internship" - the bullet stating "Completing the comprehensive documentation of the patient contacts utilizing an EHR system under the preceptor's supervision." I think this should be clarified so that it's clear that the intern is NOT able to complete the the host agency's PCR.

Page 3, near the top: "The provider agency internship coordinator willact as the student's liaison offering support and advisement during the internship." What type of support and advisement is intended here, and how is this the same or different from the support / advisement of the EMS Training Program's field liaison?

Page 3, "Paramedic Training Programs based outside of Riverside County seeking to place a student intern with a Riverside County based provider agency must..." The current policy references the REMSA / ICEMA region rather than just Riverside County. AMR has provided the majority of preceptors for both the REMSA and ICEMA regions for a many years, and routinely utilizes preceptors from both Riverside and San Bernardino Counties to accomplish that. The number of available preceptors in any given operation / county changes constantly throughout the year depending on length of time for individual internship completion and hiring / training needs. Moving away from a REMSA / ICEMA regional approach will be needlessly cumbersome and cause delays in intern placement because we will no longer be able to use preceptors in either county without going through this additional process.

13

Update: REMSA Policy #3308 (ALS to BLS Downgrade)

Included new eligibility criteria based on:

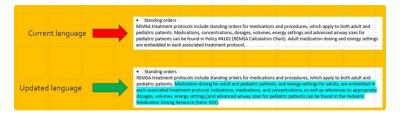
- Primary / Secondary impression
- Vitals Signs
- Pediatric Patients

See email attachment (doc titled: "3308d v3")

14

Update: REMSA Policy #4101 (Introduction to Treatment Protocols)

CHANGE: Update language to identify the Pediatric Medication Dosing Resource as an optional reference tool



Update: REMSA Policy #4405 (Cardiac Arrest)

• Change in Epi Drip inclusion criteria)

PROPOSAL:

- An emphasis should be placed on prepping an Epinephrine Infusion if the EtCo2 Value is above 20 mmHg at ANY time during the arrest so if ROSC is achieved and Hypotension exists, treatment can occur without delay.
- Hypotension be defined as SBP less than 90 mmHg and / or MAP less than 65 mmHg and the end goal to be MAP greater than 65 mmHg.

PURPOSE:

- Current available RHeaRT Data suggests that our average initial EtCO2 value in the patient subset where ROSC is obtained, for any length of time, is 27 mmHg during the onset of the arrest management. Yet, 48.70% of those patients (n= 347 at time of proposal) experience hypotension or re-arrest during the encounter.
- The relationship between MAP and CPP drives resuscitation guidelines to recommend maintaining a MAP greater than or equal to 65 mm Hg. Assuming a normal ICP, this threshold should guarantee a CPP of 55 to 60, the minimum needed to prevent cerebral ischemic injury.

WHEN PATIENT'S SYSTOLIC BP IS LESS THAN 90 MMHG AND EtCO2 IS GREATER THAN 20 MMHG;	WHEN PATIENT'S SYSTOLIC BP IS LESS THAN 90 MMHG
EPINEPHRINE DRIP	AND/OR MAP < 65 MMHG. IF EtCO2 IS > 20 MMHG DURING
	THE CARDIAC ARREST, AN EPINEPRHINE INFUSION SHOULD
Adults:	BE PREPARED IN CASE OF ROSC.
0.4 mg (0.4 ml, 1:1000) IVPB, infused in 100 ml normal	EPINEPHRINE DRIP
saline	Adults:
	0.4 mg (0.4 ml, 1:1000) IVPB, infused in 100 ml normal saline
OR	
	OR
0.2. mg (0.2 ml, 1:1000) IVPB, infused in 50 ml normal	
saline.	0.2. mg (0.2 ml, 1:1000) IVPB, infused in 50 ml normal saline.
RATE WILL BE CONTROLLED VIA DIAL-A-FLOW. INCREASE	RATE WILL BE CONTROLLED VIA DIAL-A-FLOW, INCREASE
DOSING EVERY 2-3 MINUTES, TO MAX 10 MCG/MIN, TO	DOSING EVERY 2-3 MINUTES, TO MAX 10 MCG/MIN, TO
ACHIEVE OR MAINTAIN SYSTOLIC BP OF 90 MMHG OR	ACHIEVE OR MAINTAIN SYSTOLIC BP OF 90 MMHG OR
GREATER.	GREATER.
 Begin infusion at 1 mg/min (15 ml/hr) then increase 	 Begin infusion at 1 mg/min (15 ml/hr) then increase to
to	 2 mcg/min (30 ml/hr) then increase to
2 mcg/min (30 ml/hr) then increase to	 4 mcg/min (60 ml/hr then increase to
4 mcg/min (60 ml/hr then increase to	 10 mcg/min (150 ml/hr)
10 mcg/min (150 ml/hr)	10 mcg/mm (150 m/m)
	IF MAX DOSING HAS BEEN REACHED AND A SYSTOLIC OF 90
F MAX DOSING HAS BEEN REACHED AND A SYSTOLIC OF	MMHG HAS NOT BEEN ACHIEVED, BEGIN ADMINSITERING
90 MMHG HAS NOT BEEN ACHIEVED, BEGIN	0.01 MG (1ml) 1:100.000 (PUSH DOSE EPINEPHRINE) PRN
ADMINSITERING 0.01 MG (1ml) 1:100,000 (PUSH DOSE	
	EVERY 1-5 MINUTES IN ADDITION TO THE DRIP UNTIL A
EPINEPHRINE) PRN EVERY 1-5 MINUTES IN ADDITION TO	SYSTOLIC OF 90 OR GREATER IS ATTAINED. NORMAL SALINE
	SYSTOLIC OF 90 OR GREATER IS ATTAINED. NORMAL SALINE SHOULD BE GIVEN CONCURRENTLY AS CLINICALLY INDICATED.

16

Update: REMSA Policy #4601 (Overdose / Adverse Reaction)

PROPOSAL:

 To permit REMSA-approved first response agency BLS personnel to carry and administer Naloxone utilizing AdaptPharma's pre-filled intranasal delivery device (4 mg / 0.1 mL).

PURPOSE:

• To increase the availability of Naloxone in the field in the event that no ALS apparatus or ambulance is readily available to respond to a medical air where Naloxone is needed and BLS personnel arrive on scene first.

View results

Respondent

1 Anonymous



1

Name and Title *

First and Last, Title within your agency / department

Cynthia Tait, RN, EMT-P, PHN, MPH

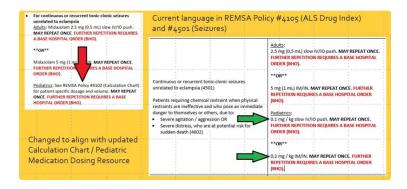
2

Agency / Department *

Center for Healthcare Education, Inc

Update: Pediatric Medication Administration Language

- REMOVAL: prescriptive language referring to REMSA Policy #4102 (Calculation Chart) for administration of medications to pediatric patients
- (RE)INTRODUCTION: specific dosing formulas (mg / kg, gm / kg, etc.) for administration of medications to pediatric patients
- **PURPOSE**: Providers in the field have grown accustomed to utilizing the Calculation Chart for dosing pediatric patients. Unfortunately, after review, the Chart has been found to contain many inaccuracies and inconsistencies in both dosing and volumes listed, as well as in the formulas used to get to those doses and volumes.
 - REMSA cannot knowingly publish a treatment protocol that directs providers to incorrectly dose patients when untoward patient outcomes could occur as a result.
 - Additionally, prescribing in protocol that providers must "See REMSA Policy #4102 (Calculation Chart) for patient specific dosage and volume" prohibits agencies that wish to use alternative pediatric treatment programs from being permitted to do so.
 - Identifying the PMDR explicitly as an educational / reference tool, along with the reintroduction of specific dosing calculations within each treatment protocol for pediatric patients, will help mitigate REMSA's liability while producing more accurate dosing for the pediatric population.



May repeat once in what time period? Suggest "maybe repeat once after XXX minutes if seizure is refractive to first dose.

4

Medication Update: Activated Charcoal

REMOVAL: Activated Charcoal from -

- Drug and Equipment List
- ALS Drug Index
- Treatment Protocol Overdose / Adverse Reaction & Toxic Exposure, Inhalation, or Ingestion

PURPOSE:

- Difficulty procuring
- · Low frequency / high risk medication
- Inappropriate / under- / unapproved utilization (given without BHO, for the wrong indication, or both)



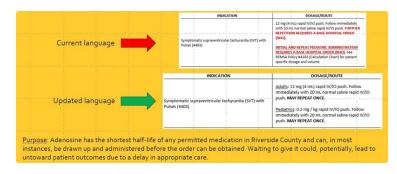
agree with removal

5

Medication Update: Adenosine

REMOVAL: BHO requirement prior to initial and repeat administrations for adults and pediatrics

PURPOSE: Shortest half-life of any permitted medication in Riverside County and can, in most instances, be drawn up and administered before the order can be obtained. Waiting to give it could, potentially, lead to untoward patient outcomes due to a delay in appropriate care.



May repeat once if SVT rhythm does not covert - no delay on repeating this medication

Medication Update: Calcium Chloride

CHANGE: Change in route of administration for pediatrics to align with adults

PURPOSE: CaCl2 can cause hypotension, syncope and significant venous irritation. Admin by IVPB is required for all patients with pulses. IV / IO administration is permitted in cardiac arrest scenarios only.



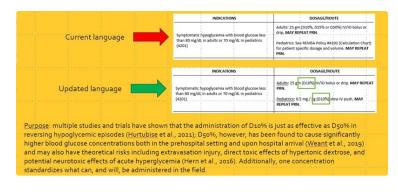
I have no expertise with this medication for pediatrics - no comment

Medication Update: Dextrose

CHANGE: Removal of D25% and D50% as concentrations for admin to adults and pediatrics.

• D25% and D50% can still be carried; however, they must be diluted to D10% prior to administration.

PURPOSE: D10% is just as effective as D50% in reversing hypoglycemic episodes but has been shown to cause less frequent instances of reflex hyperglycemia, extravasation injury, direct toxic effects of hypertonic dextrose, and potential neurotoxic effects of acute hyperglycemia as D50% administration does. Additionally, one concentration standardizes what can, and will, be administered in the field.



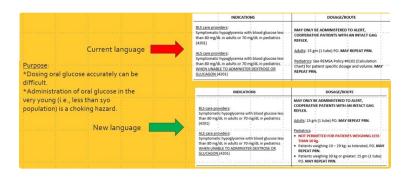
Concur with study on D10% AND UPDATED LANGUAGE

7

CHANGE: Administration to patients weighing less than 10 kg will change from "BHO" to "NOT PERMITTED."

PURPOSE:

- Dosing oral glucose accurately can be difficult.
- Administration of oral glucose in the very young (i.e., less than 1yo population) is a choking hazard.



70 mg/dl is not life threatening - why this high threshold for pediatrics?

9

Medication Update: Glucagon

CHANGE: Dosing schedule modification for pediatrics only & new formula for beta blocker / CaCl2 blocker overdose

INDICATIONS	DOSAGE/ROUTE	NOTE: no change in adult dosing but a new row is
Symptomatic hypoglycemia with blood glucose less than 80 mg/dL in adults or 70 mg/dL in pediatrics WHEN UNABLE TO ADMINISTER IV/IO DEXTROSE (4201)	Addits: 1 mg (1 mL) (v)/M. FORTHOR REPETITION REQURES A MAGE HOSPITAL ORDER (MHO). Pediatriss: For patients weighing 21 kg or less: 0.5 mg (0.5 mL). For patients weighing 22 kg or more: 1 mg (1 mL). For patients weighing 22 kg or more: 1 mg (1 mL).	required to separate 4201 language and 4406 language because of the BHO requirement
	ORDER (BHO).	
	INIȚIAL AND REPEAT DOSES FOR ADULTS AND PEDIATRICS REQUIREȘ A BASE HOSPITAL ORDER (BHO)	Updated language
Suspected esophageal food impaction (4406)	<u>Adults:</u> 1 mg (1 ml) IV/IM. <u>Pediatris:</u> For patients weighing 21 kg or less: 0.5 mg (0.5 ml). For patients weighing 22 kg or more: 1 mg (1 ml).	
Suspected beta blocker or calcium channel blocker overdose (4601)	INITIAL AND REPEAT DOSES FOR ADULTS AND PEOLATRICS REQUIRES A BASE HOSPITAL ORDER (BHO) <u>Adults:</u> 1 mg (1 mL) IV//IO/IM.	New dosing required for beta blocke /CaCl. blocker overdose
	Pediatrics: 50 mcg / kg IV/IO/IM. MAX SINGLE DOSE IS 1 MG.	

PURPOSE: to align with Rady Children's Glucagon admin protocol / pharmacist recommended dosing

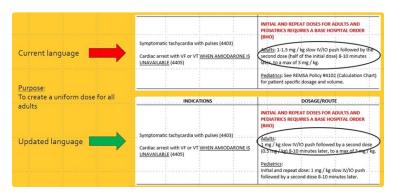
70 mg/dl is not life threatening - why this high threshold for pediatrics?

Medication Update: Lidocaine

CHANGE: Adult dosing

- FROM: 1-1.5 mg / kg with repeat at half the dose
- TO: 1 mg / kg with repeat at 0.5 mg / kg

PURPOSE: to create a uniform dose for all adults



Lidocaine should be 1 Mg/KG for all ages

11

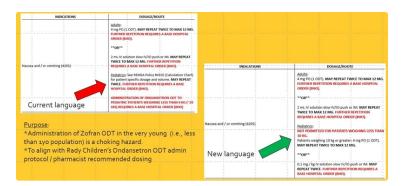
Medication Update: Ondansetron ODT

CHANGE: dosing schedule modification for pediatrics only

- FROM: 1-1.5 mg / kg with repeat at half the dose
- TO: 1 mg / kg with repeat at 0.5 mg / kg

PURPOSE:

- Administration of Zofran ODT in the very young (i.e., less than 1yo population) is a choking hazard.
- To align with Rady Children's Ondansetron ODT admin protocol / pharmacist recommended dosing



Update: REMSA Policy #1105 (Paramedic Internship)

Includes new definitions, eligibility criteria, paramedic student placement requirements and documentation requirements.

See email attachment (doc titled: "1105 v2.5")

13

Update: REMSA Policy #3308 (ALS to BLS Downgrade)

Included new eligibility criteria based on:

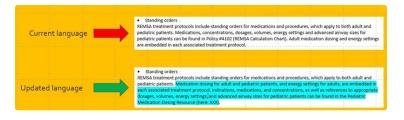
- Primary / Secondary impression
- Vitals Signs
- Pediatric Patients

See email attachment (doc titled: "3308d v3")

14

Update: REMSA Policy #4101 (Introduction to Treatment Protocols)

CHANGE: Update language to identify the Pediatric Medication Dosing Resource as an optional reference tool



Update: REMSA Policy #4405 (Cardiac Arrest)

• Change in Epi Drip inclusion criteria)

PROPOSAL:

- An emphasis should be placed on prepping an Epinephrine Infusion if the EtCo2 Value is above 20 mmHg at ANY time during the arrest so if ROSC is achieved and Hypotension exists, treatment can occur without delay.
- Hypotension be defined as SBP less than 90 mmHg and / or MAP less than 65 mmHg and the end goal to be MAP greater than 65 mmHg.

PURPOSE:

- Current available RHeaRT Data suggests that our average initial EtCO2 value in the patient subset where ROSC is obtained, for any length of time, is 27 mmHg during the onset of the arrest management. Yet, 48.70% of those patients (n= 347 at time of proposal) experience hypotension or re-arrest during the encounter.
- The relationship between MAP and CPP drives resuscitation guidelines to recommend maintaining a MAP greater than or equal to 65 mm Hg. Assuming a normal ICP, this threshold should guarantee a CPP of 55 to 60, the minimum needed to prevent cerebral ischemic injury.

WHEN PATIENT'S SYSTOLIC BP IS LESS THAN 90 MMHG AND EtCO2 IS GREATER THAN 20 MMHG;	WHEN PATIENT'S SYSTOLIC BP IS LESS THAN 90 MMHG
EPINEPHRINE DRIP	AND/OR MAP < 65 MMHG. IF EtCO2 IS > 20 MMHG DURING
Adults:	THE CARDIAC ARREST, AN EPINEPRHINE INFUSION SHOULD
0.4 mg (0.4 ml, 1:1000) IVPB, infused in 100 ml normal	BE PREPARED IN CASE OF ROSC.
saline	EPINEPHRINE DRIP
saine	Adults:
OB	0.4 mg (0.4 ml, 1:1000) IVPB, infused in 100 ml normal saline
08	
	OR
0.2. mg (0.2 ml, 1:1000) IVPB, infused in 50 ml normal	
saline.	0.2. mg (0.2 ml, 1:1000) IVPB, infused in 50 ml normal saline.
RATE WILL BE CONTROLLED VIA DIAL-A-FLOW. INCREASE	RATE WILL BE CONTROLLED VIA DIAL-A-FLOW, INCREASE
DOSING EVERY 2-3 MINUTES, TO MAX 10 MCG/MIN, TO	DOSING EVERY 2-3 MINUTES, TO MAX 10 MCG/MIN, TO
ACHIEVE OR MAINTAIN SYSTOLIC BP OF 90 MMHG OR	ACHIEVE OR MAINTAIN SYSTOLIC BP OF 90 MMHG OR
GREATER.	GREATER.
Begin infusion at 1 mg/min (15 ml/hr) then increase	 Begin infusion at 1 mg/min (15 ml/hr) then increase to
 Begin infusion at 1 mg/min (15 ml/hr) then increase to 	Begin infusion at 1 mg/min (15 ml/hr) then increase to 2 mcg/min (30 ml/hr) then increase to
to	 2 mcg/min (30 ml/hr) then increase to
to 2 mcg/min (30 ml/hr) then increase to	 2 mcg/min (30 m)/hr) then increase to 4 mcg/min (60 m)/hr then increase to
to 2 mcg/min (30 ml/hr) then increase to 4 mcg/min (60 ml/hr then increase to	 2 mcg/min (30 ml/hr) then increase to
to 2 mcg/min (30 ml/hr) then increase to	 2 mcg/min (30 ml/hr) then increase to 4 mcg/min (60 ml/hr then increase to 10 mcg/min (150 ml/hr)
to 2 mcg/min (30 ml/hr) then increase to 4 mcg/min (60 ml/hr then increase to 10 mcg/min (150 ml/hr)	2 mcg/min (30 ml/hr) then increase to 4 mcg/min (60 ml/hr then increase to 10 mcg/min (150 ml/hr) IF MAX DOSING HAS BEEN REACHED AND A SYSTOLIC OF 90
to 2 mcg/min (30 ml/hr) then increase to 4 mcg/min (60 ml/hr) then increase to 10 mcg/min (150 ml/hr) F MAX DOSING HAS BEEN REACHED AND A SYSTOLIC OF	2 mcg/min (30 ml/hr) then increase to 4 mcg/min (60 ml/hr then increase to 10 mcg/min (150 ml/hr) If MAX DOSING HAS BEEN REACHED AND A SYSTOLIC OF 90 MMH6 HAS NOT BEEN ACHIEVED, BEGIN ADMINISTERING
to 2 mcg/min (30 ml/hr) then increase to 4 mcg/min (60 ml/hr) then increase to 10 mcg/min (150 ml/hr) F MAX DOSING HAS BEEN REACHED AND A SYSTOLIC OF 10 MMHG HAS NOT BEEN ACHIEVED, BEGIN	2 mcg/min (30 ml/hr) then increase to 4 mcg/min (60 ml/hr then increase to 10 mcg/min (150 ml/hr) IF MAX DOSING HAS BEEN REACHED AND A SYSTOLIC OF 90 MMHG HAS NOT BEEN ACHIEVED, BEGIN ADMINSITERING 0.01 MG (1ml) 1:00,000 (PUSH DOSE EPINEPHRINE) PRN
to 2 mcg/min (30 ml/hr) then increase to 4 mcg/min (60 ml/hr) then increase to 10 mcg/min (150 ml/hr) F MAX DOSING HAS BEEN REACHED AND A SYSTOLIC OF 10 MMING HAS NOT BEEN ACHLEVED, BEGIN DMINISTERING 0.01 MG (1ml) 1:100,000 (PUSH DOSE	2 mcg/min (30 ml/hr) then increase to 4 mcg/min (60 ml/hr) then increase to 10 mcg/min (150 ml/hr) IF MAX DOSING HAS BEEN REACHED AND A SYSTOLIC OF 90 MMHG HAS NOT BEEN ACHIEVED, BEGIN ADMINSITERING 0.01 MG (1ml) 1:100,000 (PUSH DOSE EPINEPHRINE) PRN EVERY 1-5 MINUTES IN ADDITION TO THE DRIP UNTIL A
to 2 mcg/min (30 ml/hr) then increase to 4 mcg/min (60 ml/hr) then increase to 10 mcg/min (150 ml/hr) F MAX DOSING HAS BEEN REACHED AND A SYSTOLIC OF 30 MMHG HAS NOT BEEN ACHEVED, BEGIN ADMINSITERING 0.01 MG (1ml) 1:100,000 (PUSH DOSE EVINEPHRINE) PRN EVERY 1-5 MINUTES IN ADDITION TO	2 mcg/min (30 ml/hr) then increase to 4 mcg/min (60 ml/hr then increase to 10 mcg/min (150 ml/hr) IF MAX DOSING HAS BEEN REACHED AND A SYSTOLIC OF 90 MMHG HAS NOT BEEN ACHIEVED, BEGIN ADMINSITERING 0.01 MG (1ml) 1:00,000 (PUSH DOSE EPINEPHRINE) PRN
to 2 mcg/min (30 ml/hr) then increase to 4 mcg/min (60 ml/hr) then increase to 10 mcg/min (150 ml/hr) F MAX DOSING HAS BEEN REACHED AND A SYSTOLIC OF 80 MMHG HAS NOT BEEN ACHLEVED, BEGIN ADMINISTERING 0.01 MG (1ml) 1:100,000 (PUSH DOSE	2 mcg/min (30 ml/hr) then increase to 4 mcg/min (60 ml/hr) then increase to 10 mcg/min (150 ml/hr) IF MAX DOSING HAS BEEN REACHED AND A SYSTOLIC OF 90 MMHG HAS NOT BEEN ACHIEVED, BEGIN ADMINSITERING 0.01 MG (1ml) 1:100,000 (PUSH DOSE EPINEPHRINE) PRN EVERY 1-5 MINUTES IN ADDITION TO THE DRIP UNTIL A

Systolic BP of 90mmHg or greater is generic and invalid. What is the source of the MAP? Handheld BP which requires the provider to do a mathematical calculation or machine BP?

16

Update: REMSA Policy #4601 (Overdose / Adverse Reaction)

PROPOSAL:

• To permit REMSA-approved first response agency BLS personnel to carry and administer Naloxone utilizing AdaptPharma's pre-filled intranasal delivery device (4 mg / 0.1 mL).

PURPOSE:

• To increase the availability of Naloxone in the field in the event that no ALS apparatus or ambulance is readily available to respond to a medical air where Naloxone is needed and BLS personnel arrive on scene first.

View results

Respondent

2 Anonymous



1

Name and Title *

First and Last, Title within your agency / department

Holly Anderson- EMS Specialist, Riverside County Fire Dept.

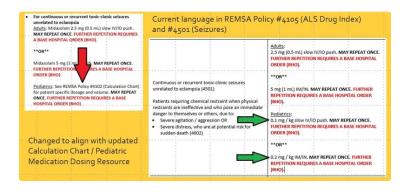
2

Agency / Department *

Riverside County Fire Dept.

Update: Pediatric Medication Administration Language

- REMOVAL: prescriptive language referring to REMSA Policy #4102 (Calculation Chart) for administration of medications to pediatric patients
- (RE)INTRODUCTION: specific dosing formulas (mg / kg, gm / kg, etc.) for administration of medications to pediatric patients
- **PURPOSE**: Providers in the field have grown accustomed to utilizing the Calculation Chart for dosing pediatric patients. Unfortunately, after review, the Chart has been found to contain many inaccuracies and inconsistencies in both dosing and volumes listed, as well as in the formulas used to get to those doses and volumes.
 - REMSA cannot knowingly publish a treatment protocol that directs providers to incorrectly dose patients when untoward patient outcomes could occur as a result.
 - Additionally, prescribing in protocol that providers must "See REMSA Policy #4102 (Calculation Chart) for patient specific dosage and volume" prohibits agencies that wish to use alternative pediatric treatment programs from being permitted to do so.
 - Identifying the PMDR explicitly as an educational / reference tool, along with the reintroduction of specific dosing calculations within each treatment protocol for pediatric patients, will help mitigate REMSA's liability while producing more accurate dosing for the pediatric population.



No comment

4

Medication Update: Activated Charcoal

REMOVAL: Activated Charcoal from -

- Drug and Equipment List
- ALS Drug Index
- Treatment Protocol Overdose / Adverse Reaction & Toxic Exposure, Inhalation, or Ingestion

PURPOSE:

- Difficulty procuring
- Low frequency / high risk medication
- Inappropriate / under- / unapproved utilization (given without BHO, for the wrong indication, or both)

arcoal from:			ins.03) Col	unt of BHCs (itDisposition	
	Overdose/Poisoning/Ingestion		540		340 62.96
	Behavioral / psychiatric disorder [Mental disorder]		115		67
Drug and Equipment List	Altered mental status				2
			5		3
			3		3
	Respiratory distress - other		3		
	Pain, non-traumatic body pain (acute)		2		: 2
	Traumatic Injury		2		2
	Cardiac anthythimia				1111
on	Abnormal uterine/vaginal bleeding		1		
	Respiratory distress - Acute bronchospasm		1		
	Chest Pain - Suspected Cardiac		1		1
	Nausea		1		1
or	Dizziness/vertigo		1		1
	Respiratory distress-Pulmonary edema/CHF · · · · ·		2		
	Abdominal Pain/Problems (GI/GU)		1		
	Upper GI bleed/(vomiting blood)		1		
	Headache non-traumatic		1		1
	Hyperglycemia (high blood sugar)		1		
	Grand Total		687		424 61.7
	on , or	or General variabless (of aneal evaluess in the second secon	orned usakes 5 5 No Modaic Comparis Response to by all factors Response to	General real-less 5 Ve Modial Comparing 3 Respector glutters - latter 3 Respector glutters - latter 3 Transmitter bryan latterite 2 OT Anormal contract bryan latterite 3 OC Anormal contract bryan latterite 1 OT Anormal contract bryan latterite 1 OL Anormal contract bryan latter 1 OL

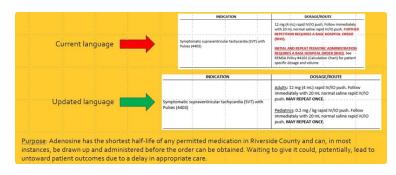
No comment

5

Medication Update: Adenosine

REMOVAL: BHO requirement prior to initial and repeat administrations for adults and pediatrics

PURPOSE: Shortest half-life of any permitted medication in Riverside County and can, in most instances, be drawn up and administered before the order can be obtained. Waiting to give it could, potentially, lead to untoward patient outcomes due to a delay in appropriate care.



No comment

Medication Update: Calcium Chloride

CHANGE: Change in route of administration for pediatrics to align with adults

PURPOSE: CaCl2 can cause hypotension, syncope and significant venous irritation. Admin by IVPB is required for all patients with pulses. IV / IO administration is permitted in cardiac arrest scenarios only.



No comment

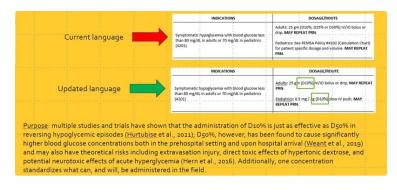
7

Medication Update: Dextrose

CHANGE: Removal of D25% and D50% as concentrations for admin to adults and pediatrics.

• D25% and D50% can still be carried; however, they must be diluted to D10% prior to administration.

PURPOSE: D10% is just as effective as D50% in reversing hypoglycemic episodes but has been shown to cause less frequent instances of reflex hyperglycemia, extravasation injury, direct toxic effects of hypertonic dextrose, and potential neurotoxic effects of acute hyperglycemia as D50% administration does. Additionally, one concentration standardizes what can, and will, be administered in the field.

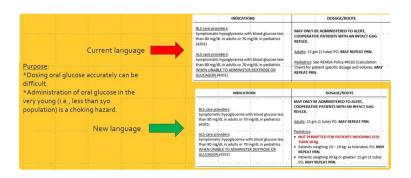


Medication Update: Oral Glucose

CHANGE: Administration to patients weighing less than 10 kg will change from "BHO" to "NOT PERMITTED."

PURPOSE:

- Dosing oral glucose accurately can be difficult.
- Administration of oral glucose in the very young (i.e., less than 1yo population) is a choking hazard.



No comment

9

Medication Update: Glucagon

CHANGE: Dosing schedule modification for pediatrics only & new formula for beta blocker / CaCl2 blocker overdose

PURPOSE: to align with Rady Children's Glucagon admin protocol / pharmacist recommended dosing

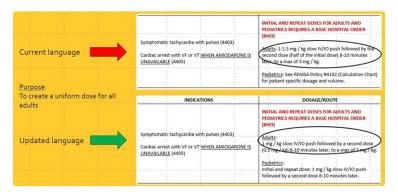
INDICATIONS	DOSAGE/ROUTE	NOTE: no change in adult dosing but a new row is
Symptomatic hypoglycemia with blood glucose less than 80 mg/dL in adult or 70 mg/dL in pediatrics WHEN UNABLE TO ADMINISTER IV/IO DEXTROSE (4201)	Adults: 1 mg (1 mg / 1 m//M. FURTHER REPETITION RECURRES A BASE HOSPITAL OBDAR (IHO). Pedatrics: For platents weighing 21 kg or less: 0.5 mg (0.5 mL). For platents weighing 22 kg or more: 1 mg (1 mL). FURTHER REPETITION RECURRES A BASE HOSPITAL- ORDER (IHO).	required to separate 4201 language and 4406 language because of the BHO requirement
	INITIAL AND REPEAT DOSES FOR ADULTS AND PEDIATRICS REQUIRES A BASE HOSPITAL ORDER (BHO) Adults:	Updated language
Suspected esophageal food impaction (4406)	Pediatrics: For patients weighing 21 kg or less: 0.5 mg (0.5 mL). For patients weighing 22 kg or more: 1 mg (1 mL).	$ \longrightarrow $
Susjected beta blocker or calcium channel blocker overdose (4601)	INITIAL AND REPEAT DOSES FOR ADULTS AND PEDIATRICS REQUIRES A BASE HOSPITAL ORDER (BHO) <u>Adults</u> : 1 mg (1 mL) IV//IO/IM.	New dosing required for beta blocke / CaCl, blocker overdose
	Pediatrics: 50 mcg / kg IV/IO/IM. MAX SINGLE DOSE IS 1 MG.	

Medication Update: Lidocaine

CHANGE: Adult dosing

- FROM: 1-1.5 mg / kg with repeat at half the dose
- TO: 1 mg / kg with repeat at 0.5 mg / kg $\,$

PURPOSE: to create a uniform dose for all adults



No comment

11

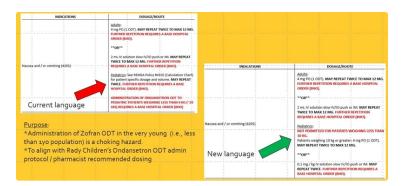
Medication Update: Ondansetron ODT

CHANGE: dosing schedule modification for pediatrics only

- FROM: 1-1.5 mg / kg with repeat at half the dose
- TO: 1 mg / kg with repeat at 0.5 mg / kg

PURPOSE:

- Administration of Zofran ODT in the very young (i.e., less than 1yo population) is a choking hazard.
- To align with Rady Children's Ondansetron ODT admin protocol / pharmacist recommended dosing



Update: REMSA Policy #1105 (Paramedic Internship)

Includes new definitions, eligibility criteria, paramedic student placement requirements and documentation requirements.

See email attachment (doc titled: "1105 v2.5")

No comment

13

Update: REMSA Policy #3308 (ALS to BLS Downgrade)

Included new eligibility criteria based on:

- Primary / Secondary impression
- Vitals Signs
- Pediatric Patients

See email attachment (doc titled: "3308d v3")

•Policy 3308-

(pg. 1) under ALS to BLS DOWNGRADE ELIGIBILITY- PRIMARY / SECONDARY IMPRESSION-#5. Hypoglycemia that persists after oral glucose administration- What is the time frame post administration of glucose is "persistent?" We would like to see a time listed here (i.e. 3-5 min).

#9. Seizure (active and or presenting as postictal)- This needs to be all seizures regardless of active or postictal. The likelihood of re-seizing is unknown there for the risk is too high. We would like to see this say, "Seizure(s)."

(pg. 1) under ALS to BLS DOWNGRADE ELIGIBILITY-VITAL SIGN ELEGIBILITY-

In the first paragraph, last sentence- "Trending vitals signs require A MINIMUM OF TWO SETS during the patient encounter." We would like a time to be associated with this to support what constitutes trending. Current protocol says vitals should be 5 min apart for critical patients and 15 for non-critical, so since this is a ALS to BLS downgrade we would like to see the initial and final set of vitals to be at least 5 min apart (how did you find the patient and how did you leave the patient). #1 & 2. Blood Glucose (BGL) is less than 60 or greater than 250- we would like to see some language that supports this patient being abnormal in some way based on the assessment findings to make the BGL an exclusion for downgrade.

(pg. 2) under ALS to BLS DOWNGRADE ELIGIBILITY-VITAL SIGN ELEGIBILITY-

8,9, & 10- What is the time frame for sustained? We would like this to have a time frame on it such as 5 min.

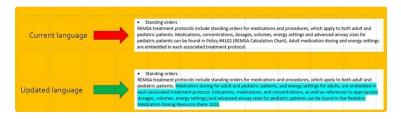
8,9, & 10- There needs to be adult and peds (ages 1-10) values listed here. The peds value needs to be based off of the high and low ranges using the following formulas-70+(age x 2) for the low and 90+(age x 2) for the high. Please state these formulas in this policy and we would like to see them in all policies that relate to peds blood pressures.

(pg. 2) under GENERAL CONSISERATION PRIOR TO DOWNGRADE-

Patients who have received ALS interventions, or those who would likely benefit from ALS interventions(s), cannot downgraded to a BLS level of care- we would like this to say "(see skills policy 4104 for all ALS skills)." The reason for this is that there is too much discrepancy with current medics thinking that a 12 lead is a diagnostic tool and not a skill. Policy 4104 clearly stats on pg. 2/21 that an ECG is a skill, pg. 3/21 that a 12 Lead is a skill, and so on.

Update: REMSA Policy #4101 (Introduction to Treatment Protocols)

CHANGE: Update language to identify the Pediatric Medication Dosing Resource as an optional reference tool



No comment

15

Update: REMSA Policy #4405 (Cardiac Arrest)

• Change in Epi Drip inclusion criteria)

PROPOSAL:

- An emphasis should be placed on prepping an Epinephrine Infusion if the EtCo2 Value is above 20 mmHg at ANY time during the arrest so if ROSC is achieved and Hypotension exists, treatment can occur without delay.
- Hypotension be defined as SBP less than 90 mmHg and / or MAP less than 65 mmHg and the end goal to be MAP greater than 65 mmHg.

PURPOSE:

- Current available RHeaRT Data suggests that our average initial EtCO2 value in the patient subset where ROSC is obtained, for any length of time, is 27 mmHg during the onset of the arrest management. Yet, 48.70% of those patients (n= 347 at time of proposal) experience hypotension or re-arrest during the encounter.
- The relationship between MAP and CPP drives resuscitation guidelines to recommend maintaining a MAP greater than or equal to 65 mm Hg. Assuming a normal ICP, this threshold should guarantee a CPP of 55 to 60, the minimum needed to prevent cerebral ischemic injury.

WHEN PATIENT'S SYSTOLIC BP IS LESS THAN 90 MMHG ADD E1CO21S GREATER THAN 20 MMHG; EPINEPHRINE DRIP Adults: 0.4 mg (0.4 ml, 1:1000) IVPB, infused in 100 ml normal saline **OR**	WHEN PATIENT'S SYSTOLIC BP IS LESS THAN 90 MMHG
	AND/OR MAP < 65 MMHG. IF EtCO2 IS > 20 MMHG DURING
	THE CARDIAC ARREST, AN EPINEPRHINE INFUSION SHOULD
	BE PREPARED IN CASE OF ROSC.
	EPINEPHRINE DRIP
	Adults:
	0.4 mg (0.4 ml, 1:1000) IVPB, infused in 100 ml normal saline
	OR
0.2. mg (0.2 ml, 1:1000) IVPB, infused in 50 ml normal	
saline.	0.2. mg (0.2 ml, 1:1000) IVPB, infused in 50 ml normal saline.
DOSING EVERY 2-3 MINUTES, TO MAX 10 MCG/MIN, TO ACHIEVE OR MAINTAIN SYSTOLIC BP OF 90 MMHG OR GREATER. • Begin infusion at 1 mg/min (15 ml/hr) then increase to • 2 mcg/min (30 ml/hr) then increase to • 4 mcg/min (60 ml/hr then increase to • 10 mcg/min (150 ml/hr)	 DOSING EVERY 2-3 MINUTES, TO MAX 10 MCG/MIN, TO ACHIEVE OR MAINTAIN SYSTOLIC BP OF 90 MMHG OR GREATER. Begin infusion at 1 mg/min (15 ml/hr) then increase to 2 mcg/min (30 ml/hr) then increase to 4 mcg/min (60 ml/hr) then increase to 10 mcg/min (150 ml/hr)
IF MAX DOSING HAS BEEN REACHED AND A SYSTOLIC OF 90 MMHG HAS NOT BEEN ACHIEVED, BEGIN ADMINSITERING 0.01 MG (1mi) 1:100,000 (PUSH DOSE EPINEPHRINE) PRN EVERY 1-5 MINUTES IN ADDITION TO	IF MAX DOSING HAS BEEN REACHED AND A SYSTOLIC OF 90 MMHG HAS NOT BEEN ACHIEVED, BEGIN ADMINISTERING 0.01 MG (1ml) 1:100,000 (PUSH DOSE EPINEPHRINE) PRN EVERY 1-5 MINUTES IN ADDITION TO THE DRIP UNTIL A SYSTOLIC OF 90 OR REARTER IS ATTAINED. NORMAL SALINE

Update: REMSA Policy #4601 (Overdose / Adverse Reaction)

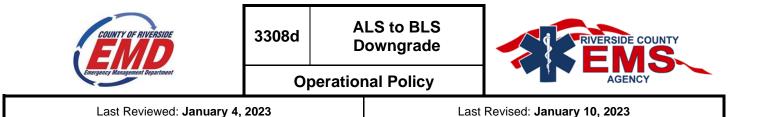
PROPOSAL:

 To permit REMSA-approved first response agency BLS personnel to carry and administer Naloxone utilizing AdaptPharma's pre-filled intranasal delivery device (4 mg / 0.1 mL).

PURPOSE:

• To increase the availability of Naloxone in the field in the event that no ALS apparatus or ambulance is readily available to respond to a medical air where Naloxone is needed and BLS personnel arrive on scene first.

No comment



PURPOSE

To establish criteria for downgrading from an advanced life support (ALS) level of care to a basic life support (BLS) level of care in the pre-hospital setting.

APPLICATION

The intent of this policy is to permit first response agencies to downgrade the level of care a patient will receive during transport so that the maximum number of ALS transport ambulances and / or ALS first response apparatus are able to remain in service, and available, to respond to other medical aid requests. If / when an ALS transport ambulance arrives on scene before a first response agency apparatus, and the ALS transport paramedic determines that additional ALS assistance is not required **AND** the patient's condition meets the criteria below, the patient should be transported by that ambulance. Excluding patients that have met Assess and Refer criteria related to behavioral health emergencies who have been referred out of the 911 system, it is not appropriate for an ALS transporting unit to wait at the scene for a BLS transporting unit when the paramedic is able to provide a BLS level of care.

AUTHORITY

California Health and Safety Code - Division 2.5: Emergency Medical Services [1797.204.] California Health and Safety Code - Division 2.5: Emergency Medical Services [1797.206.] California Code of Regulations, Title 22, Chapter 4, Article 8, and Section 100170

ALS to BLS DOWNGRADE ELIGIBILITY – PRIMARY / SECONDARY IMPRESSION

If at any point during the ALS assessment or in the presence of an ALS scene provider the patient exhibits any of the following conditions, the patient is no longer considered eligible for ALS to BLS transition and care must be provided by an ALS provider.

- 1. Acute altered mental status (excluding patients whose mentation is GCS 14 or lower as their baseline)
- 2. Acute cardiac dysrhythmias
- 3. Any patient requiring specialty care services (Trauma, Stroke, STEMI)
- 4. Airway obstruction
- 5. Hypoglycemia that persists after oral glucose administration
- 6. Influenza-like illness which falls outside of the vital sign eligibility criteria listed below
- 7. Overdose, poisoning, or ingestion
- 8. Pregnancy / OB delivery-related complications
- 9. Seizures (active and / or presenting as postictal)
- 10. Suspected cardiac chest pain
- 11. Water-related submersion incidents

ALS to BLS DOWNGRADE ELIGIBILITY – VITAL SIGN ELIGIBILITY

If at any point during the ALS assessment, or in the presence of an ALS scene provider, the trend of the patient's vital signs falls OUTSIDE of the parameters listed below, the patient cannot be downgraded to a BLS level of care. Trending vital signs require A MINIMUM OF TWO SETS during the patient encounter.

- 1. Blood Glucose (BGL) is less than 60 mg/dl OR reads "LO"
- 2. Blood Glucose (BGL) is greater than 250 mg/dl OR reads "HI"
- 3. Pulse oximetry (SpO2) of 93% saturation or below
- 4. Pulse rate is less than 60 beats per minute
- 5. Pulse rate is greater than 120 beats per minute
- 6. Respiratory rate of 10 breaths a minute or below
- 7. Respiratory rate of 24 breaths a minute or more

- 8. Sustained systolic blood pressure greater than 180 mmHg
- 9. Sustained systolic blood pressure less than 90 mmHg
- 10. Sustained diastolic blood pressure greater than 100 mmHg
- 11. Temperature is less than 93.2°F
- 12. Temperature is greater than 101°F

ALS to BLS DOWNGRADE ELIGIBILITY – PEDIATRIC PATIENTS

If at any point during the ALS assessment of a pediatric patient, or in the presence of an ALS scene provider, the patient's vital signs fall OUTSIDE of the parameters listed below, the patient cannot be downgraded to a BLS level of care.

- 1. Acute altered mental status (altered for the patient)
- 2. Acute cardiac dysrhythmias
- 3. Apparent life-threatening event / brief resolved unexplained event (ALTE / BRUE) in the pediatric population
- 4. Evidence of poor perfusion and / or cyanosis
- 5. Severe respiratory distress
- 6. Status epilepticus
- 7. Systolic blood pressure less than 50 mmHg (4 years of age and under)
- 8. Systolic blood pressure less than 60 mmHg (5 to 12 years of age)
- 9. Systolic blood pressure less than 70 mmHg (13 years of age and over)

GENERAL CONSIDERATIONS PRIOR TO DOWNGRADE

- Patients who require immediate medical attention will be transported to the closest most appropriate hospital.
- Patients who have received ALS interventions, or those who would likely benefit from ALS intervention(s), cannot be downgraded to a BLS level of care.
- Patients, parents, or guardians must be alert, oriented, and acting appropriately for their age and do not present with any significant impairment due to drugs, alcohol, organic causes, or mental illness.

DOCUMENTATION REQUIREMENTS WHEN DOWNGRADING FROM ALS to BLS

In addition to the minimum NEMSIS requirements, the following must be documented in the ePCR:

- After selecting Patient Treated and Care Transferred to Another EMS Unit as the disposition, "BLS" must be selected as the Transporting Ambulance Level of Care in the "Ground Transport" panel
- Physical exam findings (must include a full head-to-toe exam within the Assessment Panel)
- Treatments provided, if any
- All pertinent findings and observations

CONTINUOUS QUALITY IMPROVEMENT

All patient dispositions where the level of care was downgraded from ALS to BLS will undergo a minimum of 50% CQI by the ALS service provider who initiated the downgrade.