PREHOSPITAL MEDICAL ADVISORY COMMITTEE MEETING AGENDA (PMAC)

PMAC MEMBERS PER POLICY 8202:

Base Hospital Physician
Andrew Pachon, MD - RUHS

Non-Base Hospital Physician
Karan Singh, MD – San Gorgonio

Non-Base Hospital RN
Kim McGranahan, RN - Kaiser

Pediatric Critical Care Physician
Melanie Randall, MD - RUHS

Stroke Hospital Coordinator - RN
Kathy Cash, RN - Eisenhower Health

STEMI Hospital Coordinator - RN
Katherine Baca, RN - Temecula Valley

Prehospital Liaison Nurse (PLN)
Robin Boardman, RN – JFK Memorial

Trauma Program Medical Director
Stephen Kernop - RUHS

Public Transport Medical Director
Zeke Foster, MD – Multiple FD

Private Transport Medical Director
Seth Dukes, MD - AMR

Fire Department Medical Director
Steve Patterson, MD – Corona FD

EMS Officers
Jennifer Antonucci – Murrieta FD

Public Transport Medical Rep (Paramedic/RN)
Scott Philippbar – County Fire

Private Transport Medical Rep (Paramedic/RN)
Dawn Downs – Symbiosis Care

Non-Transport Agency Rep (Paramedic/RN)
Noelle Toering - Palm Springs FD

Riverside County Policy Association
Donald Sharp – RSO Undersheriff

Tribal Partner Representative
Ken Cardin - Morongo Fire

Private Air Transport Medical Director
Brian Harrison – Air Methods

EMS Training Program Representative
Bob Fontaine - Moreno Valley College

This Meeting of PMAC on:
Monday, February 3, 2025
09:00 – 11:00 am
Riverside University Health System: 26516 Cactus Ave, Moreno Valley, CA 92555

1. **CALL TO ORDER & HOUSEKEEPING (5 Minutes)**
   Andrew Pachon, MD (Chair)

2. **ATTENDANCE (taken based on participant sign in sheet)**
   Evelyn Pham (REMSA)

3. **APPROVAL OF MINUTES (5 Minutes)**
   December 2, 2024 Minutes— Andrew Pachon, MD (Attachment A)

4. **STANDING REPORTS (5 Minutes)**
   4.1. Trauma System—Shanna Kissel (Attachment B)
   4.2. STEMI System— Loreen Gutierrez (Attachment C)
   4.3. Stroke System— Loreen Gutierrez (Attachment D)

5. **Other Reports (15 Minutes)**
   5.1. EMD Update – David Platz
   5.2. California Resuscitation Outcomes Consortium Trial Update – Dr. Vaezazizi
   5.3. Cal-Drop Project Update – Dr. Patterson/Kelley Long

6. **DISCUSSION ITEMS, UNFINISHED & NEW BUSINESS**
   6.1. CQILT Update – Holly Anderson (15 Minutes) (Attachment E)
   6.2. Policy/ Education – Kristie Hinz (45 Minutes) (Attachment F)
   6.3. Prehospital Blood Transfusion (5 Minutes) - Corona Fire

7. **REQUEST FOR DISCUSSIONS (5 MINUTES)**
   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 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.

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 Chair.

9. **NEXT MEETING / ADJOURNMENT (1 Minute)**
   May 12, 2025 – Riverside University Health System

PMAC Agendas with attachments are available at: www.rivcoready.org/remsa. Meeting minutes are audio recorded to facilitate dictation for minutes. Any questions or comments please contact REMSA staff.

PMAC Draft Minutes
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TOPIC	DISCUSSION	ACTION
1. CALL TO ORDER	Dr. Andrew Pachon called the meeting to order at 9:05 a.m.	
2. Virtual Attendance	Attendance taken based on sign-in list	
3. Approval of Minutes	Dr. Foster, Multiple Fire Departments, motioned to approve the minutes. Ken Cardin, Morongo Fire seconded the motion.	The August 26, 2024 PMAC meeting minutes were approved with no changes.
4. STANDING REPORTS		
4.1. Trauma System Updates	1. REMSA will continue to QI Versed and Push-dose Epi. Outcomes will be presented at February 2025 TAC. TAC in November 2024 was canceled. 2. Tentative trauma policies (4302, 5301, 5302) were presented at August TAC with approval to move forward, excluding conversations around Pediatrics. Further conversations are needed regarding some components of Pediatric Trauma. 3. DRMC went through their ACS Level I survey in November.	Information only.
4.2. STEMI System Updates	1. STEMI 2022 System Plan approved by EMSA, 2023 plan update to be submitted. 2. The STEMI Dashboard posted on rivcoready.org was updated to reflect quarter 2, 2024 data. 3. Q2, 2024 STEMI data uploaded to EMSA.	Information only.
4.3. Stroke System Updates	1. Stroke System Plan update 2022 approved by EMSA, 2023 update to be submitted with the 2023 EMS-Plan. 2. San Gorgonio Memorial Hospital was designated as a Primary Stroke Center, effective December 1, 2024. 3. The Stroke Dashboard posted on rivcoready.org was updated to reflect quarter 2, 2024 data. 4. Stroke data State reporting completed for Q2, 2024.	Information only.
5. OTHER REPORTS		
5.1. EMD Update	• EMD County-wide under response is under 1% • Chief Philippbar, County Fire announced that they are now part of the accredited EMD center • Providers who join the accredited centers can embrace the opportunities that come with it to do nurse navigation, to be more resourceful with their resources on how they assign calls, etc.	Information only.
5.2. California Resuscitation Outcomes Consortium Trial Update	The California Resuscitation Outcomes Consortium Trial is still in the process of applying for grant funding.	Information only.
6. DISCUSSION ITEMS, UNFINISHED & NEW BUSINESS		
Unfinished Business	None	
6.1. 3308 Data review	Patient follow-up on 3308 incidents. Data was pulled from May 2024 to September 2024 and was CQI'd at the first response agencies and sent to the receiving hospital for patient outcome. Inappropriate downgrades were reviewed. PMAC discussed if	Discussion.

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	continuation of the policy is needed. After discussion amongst the Committee, a majority felt they wanted to keep the policy. REMSA will work on fine tuning the policy to ensure proper compliance.	

6.2. CQI/Policy/Education	PUC Updates July 2025
	
	Housekeeping
	• PFSA LOSOP and language updated – manual review for consistency
	• 1207 Paramedic Accreditation – added TPATC for trauma training and ARC for ALS/PALS
	• 3204 Safety Net – CQI Update
	• 6203E/6203W Special Event Designated Base Hospital Update – Identifying two different base stations for designation for special events in each region of the county January 1, 2025
	• 7101/8301 Update conversation
	  ○ 3308 – changed back to 100% CQI review requirement, change in policy?
	• 8101 Update – 2 BLS/CCT providers contact updated. San Gorgonio updated as a Primary Stroke Receiving Center as of December 1, 2024
	LOSOP Update
	• PHBT update to system (3303, 4301, 4302) – Corona Fire start date November 20, 2024
	• POCUS update to system (3303) – updated in drug and equipment list, more to come
	• Tele911 (3313 live in policy manual, Corona Fire)
	
	Changes for 2025
	• BRUE
	  ○ ALTE updated to BRUE in 3308
	• Traumatic Injury/Arrest
	  ○ All traumatic arrest language that was listed in 4301 – Shock due to trauma and 4405 – Cardiac arrest has been added to Policy 4302 – Traumatic Injuries.
	  ○ 4405 has been renamed Medical Cardiac Arrest
	  ○ 4301 has been renamed Traumatic Injury/Traumatic Arrest
	• Neonatal Resuscitation/OB – NEW
	  ○ Combined Policy 4801, 4802, and 4803 into 1 new Policy 4801 – Obstetrical Emergencies/Newborn Deliveries
	  ○ Request from Dr. Foster, to re-word the portion where is says “remove” prolapsed cord
	• Universal Care – NEW
	  ○ New policy to outline expected standard of care for each patient encounter
		Information only.

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- After discussion with PMAC, the Committee agreed to have this type of policy in the manual. This policy will be taken to CQILT to work on and refine before a final version is added to the policy manual.
- IV Infusion/ Volume Control Device
  - Done, no further discussion needed
- ESRD Treatment Language Update
  - Remove bradycardia and replace with symptomatic dysrhythmia and have them mirror and reflect each other
- WPW Language Removal
  - 4105 – Adenosine
  - Discussion – Remove number 1, reference to treating WPW
  - PMAC agrees to removing it

Proposed Policy Changes 2025

Cal Fire
Adenosine
- Proposal: addition of single syringe adenosine administration for SVT
- PMAC approves to move forward

Pediatric SGA (IGEL)
- Proposal: addition of supraglottic airway devices for pediatric patients > 2kg in mass
- PMAC approves to move forward, with the need for a detailed education and added equipment for all providers. Diligent CQI and proper data entry for documentation will also be needed.

BLS SGA (IGEL)
- Proposal: EMT-B/BLS supraglottic device usage
- PMAC discussed to and decided to wait until a more in-depth review of this is done at CQILT before approving.

Moreno Valley College
Nebulized EPI
- EPI (1mg/ml) nebulized for croup
- PMAC approves to move forward with 1mg/ml for EPI

Corona Fire Department
Expanded TXA and dosage change
- Proposal: TXA dosage, Indication and Administration
- Trauma – 2 GM Slow IVP/IOP
- Postpartum Hemorrhage – 1 GM IN 50 ML IV Infusion
- Epistaxis/Oral Trauma – 500 MG Nebulized or 200 MG Topically
- PMAC approves to move forward with all 4 proposals

Sepsis
- Proposal: Sepsis notification from the field

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	• Looking for opportunities to treat and initiate IV/fluids in field, and contact the receiving hospital using the terms "SIRS Criteria" or "Code Sepsis" • PMAC discussed and decided this should be an educational approach to the field providers instead of changing policy Distal Femur for IO • Proposal: IO line placement at the distal femur for PEDs • PMAC discussed and needs additional information and approval from PACS first before moving forward Palm Springs Fire Ketorolac • Proposal: Remove the 1-5 pain scale requirement for Ketorolac (Toradol) administration for EMS personnel to treat pain with the appropriate medication regardless of the patient's pain scale, as pain scale could be subjective • PMAC discussed and will bring this to TAC for further review and approval first before moving forward Final Notes* • These policy proposals may change after final decision made by medical director • REMSA will be holding a Policy Work Group that will be invite only • Proposals that require specialty care reviews will need to be presented at their respective meetings for final comments/concerns/approval	
6.3. 2025 Clinical Calendar	No objections to the 2025 Clinical Calendar dates	Information only.
7. Request for Discussions	None	

8. Announcements	• REMSA congratulated San Gorgonio Memorial Hospital on their Primary Stroke Center designation
	• San Gorgonio Memorial Hospital dedicated recording line will be updated in policy
	• PMAC congratulated Corona Fire on being the first in the State of California to do PHBT and recognized them for being the pioneer in this field
	  ○ Looking for other participants who would like to join in this effort with Corona Fire
	• Point of Care Ultrasound is live, we can use it
	  ○ Looking for other participants
	• Bob Fontaine announced the new College of the Desert Paramedic program will start in early 2025
	• CQI plans are due January 31st, 2025
		Information only.

9. NEXT MEETING/ADJOURNMENT	Monday, February 3, 2025 (9:00 – 11:00 a.m.) RUHS.	Information only.

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PMAC Attendance:

Voting Members:		**Attendees:**
Andrew Pachon, MD, RUHS, Chair	X	Brian DeMarco, RSO
Erin Noud, DO, San Gorgonio	X	Wayne Ennis, AMR Desert
Kim McGranahan, RN, Kaiser	X	Christian Linnemann, Cal Fire
Melanie Randall, MD, RUHS	X	Caliste Mallory, Cal Fire
Kathy Cash, RN, Eisenhower	X	Tim Buckley, Soboba Fire
Katherine Baca, RN, TVH		Shane Dunnery, NCTI
Robin Boardman, RN, JFK	X	Richard Blumel, AMR
Stephen Kernop, RUHS	X	Lori Maddox, RUHS
Zeke Foster, MD, Multiple FD	X	Wayne Seacrist, Palm Springs Fire
Seth Dukes, MD, AMR	X	Amanda Sweeden, Cal Fire
Steve Patterson, MD, Corona FD	X	Chris Lowder, Cal Fire
Jennifer Antonucci, Murrieta FD	X	Brennain Gorter, Canyon Lake FD
Scott Philippbar, Cal Fire	X	Chris Douglas, Corona Fire
Dawn Downs, Symbiosis Care	X	Kelley Long, Corona Fire
Noelle Toering, Palm Springs FD	X	Matt V Payne, Calimesa Fire
Donald Sharp, RSO		Thomas Wofford, Eisenhower
Ken Cardin, Morongo FD	X	Dawn Hall, RUHS
Brian Harrison, Air Methods		Ryan Besneatte, Advantage Ambulance
Bob Fontaine, MVC	X	Vanessa Hayflich, Mercy Air
		Veronica Arellano, IVMC
REMSA:		D. Michelle Ingersoll, DRMC
Reza Vaezazizi, MD	X	Ky Kalousek, Riverside City Fire
Dan Bates	X	Anthony Roman, Kaiser
Shanna Kissel	X	Ryan Putnam, REACH
Holly Anderson	X	Julie Puzzo, MD, JFK
Kristie Hinz	X	Lacey Page, RCH
Evelyn Pham	X	Erin Bailey, Cal Fire
Dustin Rascon	X	Julius Ibanez, MD, EMC
Mike Moore	X	Joseph Meyer, LLUMC-M
Sean Hakam	X	Joe Silk, Cal Fire
Karleen Wade	X	Ryan Putnam, REACH
David Platz	X	Robin Smith, RUHS
		Nathan Kass, RSO
		Joshua Johnson, CHP
		Robert Ower, Primary Ambulance

FOR CONSIDERATION BY PMAC

DATE: February 2, 2025

TO: PMAC

FROM: Shanna Kissel, RN, Assistant Nurse Manager

SUBJECT: Trauma System

1. REMSA will continue to QI Versed and Push-dose Epi. Outcomes will be presented at February 2025 TAC.
2. Tentative trauma policies (4302, 5301, 5302) will roll out with PUC July 1.
3. New TAC chair for 2025- 2027 is Dr. John Woods from Desert Regional Medical Center.

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

FOR CONSIDERATION BY PMAC

DATE: February 3, 2025

TO: PMAC

FROM: Loreen Gutierrez, RN, Specialty Care Coordinator

SUBJECT: STEMI System

1. STEMI/Stroke System Advisory Committee has reconvened and created two subcommittees, one to create a statewide Data Dictionary, and the second to work on the 2026 State STEMI/Stroke summit.
2. The STEMI dashboard posted on Rivcoready.org website was updated to reflect Q3 2024 data related to the Image Trend STEMI patient registry. https://rivcoready.org/remsa/programs#2741959481-1182105694
3. The STEMI committee met on January 14th via teams.

Next STEMI Committee meeting is April 8th, 2025 meeting. The meeting will continue to run via TEAMS.

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

FOR CONSIDERATION BY PMAC

DATE: February 3, 2025

TO: PMAC

FROM: Loreen Gutierrez, RN, Specialty Care Coordinator

SUBJECT: Stroke System

1. Stroke/STEMI System Advisory Committee has reconvened and created two subcommittes, one to create a statewide Data Dictionary, and the second to work on the 2026 State STEMI and Stroke Summit.

2. System updates: Things are going well with San Gorgonio Memorial Hospital (SGMH) Primary Stroke Center.

3. The Stroke dashboard posted on Rivcoready.org website was updated to reflect Q3 2024 data related to the Image Trend Stroke patient registry. https://rivcoready.org/remsa/programs#2741959481-1532242908

Next Stroke Committee meeting is February 11th, 2025, via TEAMS

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

3308	ALS to BLS Downgrade
Operational Policy	

Last Reviewed: **January 22, 2025**	Last Revised: **January 22, 2025**

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. For agencies that utilize Emergency Medical Dispatch (EMD), and the patient is identified as an Alpha (A) or Omega (O), a BLS ambulance will always be dispatched. The first response agency paramedic will determine if the patient meets the criteria for downgrade below; if not, the paramedic from the first response agency **MUST** initiate and continue to provide all patient care until transfer of care at receiving facility. 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 ALS ambulance. 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. This policy excludes patients that have met REMSA Policy 3312 *Assess and Refer* criteria related to behavioral health emergencies and who have been referred out of the 911 system.

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
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. Overdose, poisoning, or ingestion
7. Pregnancy/OB delivery-related complications
8. Seizures (active and/or presenting as postictal)
9. Suspected cardiac chest pain
10. 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 (two or more) 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 (5 minutes apart).

1. Blood glucose (BGL) is less than 60 mg/dl **OR**
   a. Glucometer reads "LO" **OR**
   b. The patient presents with symptomatic hypoglycemia: a BGL less than 80 mg/dl, **AND** a persistent (unchanged by treatments provided) **ACUTE** altered mental status
2. Blood glucose (BGL) is greater than 250 mg/dl **OR**
   a. Glucometer reads "HI" **OR**

   b. The patient presents with signs/symptoms of diabetic ketoacidosis (DKA): polydipsia, polyuria, generalized weakness, fatigue, nausea/vomiting, Kussmaul respirations, fruity odor on their breath, dry/flushed skin, etc.
3. **ACUTE** Hypoxemia with SpO2 < 93%
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. Brief resolved unexplained event (BRUE) in the pediatric population
4. Evidence of poor perfusion and/or cyanosis
5. Severe respiratory distress
6. Status epilepticus
7. HYPOTENSION:
   a. In neonates (1 day to 28 days) = SBP less than 60 mmHg
   b. In infants (1 to 12 months) = SBP less than 70 mmHg
   c. In pediatrics (1 to 10 years) = SBP less than [70 + (age x 2)]
   d. In adolescents (11 to 14 years) = SBP less than 90 mmHg

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 100% CQI by the ALS service provider who initiated the downgrade and reported quarterly to REMSA's CQI Coordinator.

Please see the information below in relation to the updated REMSA Policy 3308 *ALS to BLS Downgrade*. The goal is to provide agencies/hospitals with an easy reference/rational for the updates that were made. Please email REMSA_Clinical@rivco.org with any questions.

In the "Application" section there was language added in reference to the use of Emergency Medical Dispatching:

"For agencies that utilize Emergency Medical Dispatch (EMD), and the patient is identified as an Alpha (A) or Omega (O), a BLS ambulance will always be dispatched. The first response agency paramedic will determine if the patient meets the criteria for downgrade below; if not, the paramedic from the first response agency ***MUST*** *initiate and continue to provide all patient care until transfer of care at receiving facility."*

- This language was added to re-emphasize the importance of a paramedic assessment needing to be performed to determine the ability to downgrade the patient based on the criteria listed within the policy.

In the "ALS to BLS Downgrade Eligibility – Primary/Secondary Impression" section:

"6. Influenza-like illness which falls outside of the vital sign eligibility criteria listed below"

- Number six (6) was removed as it was added during COVID

"1. ***ACUTE*** *altered mental status"*

- "**ACUTE**" has been emphasized and bolded in number one and two in this section. That is to reenforce the notion that if it is a chronic medical condition, the downgrade may be considered if there is no other complicating factors to consider after an ALS assessment has been performed.

In the "ALS to BLS Downgrade Eligibility –Vital Signs Eligibility" section updates are as follows:

"…trend (two or more) of the…"

- "Two or more" was added to emphasize the need to get multiple sets of vital signs. There is further clarification in the paragraph that delineates these vital signs must be, at minimum, 5 minutes apart.

"1. b. …persistent (unchanged by treatments provided), ***ACUTE*** *altered mental status"*

- "Persistent" was added to clarify that, if a BLS treatment was provided to the patient resulting in no change in the presentation, then the patient would benefit from ALS interventions and should be transported with an ALS provider. "**ACUTE**" is again emphasized and bolded in this section (reference rational above)

"3. ***ACUTE*** *hypoxemia with SpO2 < 93%"*

- "**ACUTE**" has been emphasized and bolded in number three in this section. That is to reenforce the notion that if it is a chronic medical condition, the downgrade may be considered if there is no other complicating factor to consider after an ALS assessment has been performed. (Ex: A COPD patient whose baseline saturations are 91% with no respiratory complaint, has a chief complaint (CC) of toe pain may be downgraded to BLS **IF** the ALS/paramedic assessment doesn't

identify any respiratory issues/compromise. Even though the CC of the patient doesn't state any respiratory issues reported, the expectation is there will still be a lung assessment performed to rule out the abnormal vital sign finding.)

In the "Continuous Quality Improvement" section, there was updated language on the reporting requirements:

"…undergo a minimum of 100% CQI by the ALS service provider who initiated the downgrade and reported quarterly to REMSA's CQI Coordinator."

- This language was updated to fall in line with the conversations at PMAC and updated review requests.

Policy/Education update

Housekeeping:

4202, 4203, 4104 – HEMS Unified Scope added to policy manual 1/6/25

5801 POCUS – live in policy manual 1/17/25 (Corona fire)

3308 – Update and education 1/23/25

Education/PUC:

Workgroup meeting invites were sent out to those respective agencies.

Train the trainer week has been scheduled for March 17-21st. There will be sessions held in the desert region at Roy Wilson and at Ben Clark Training Center. Invites will be sent out for providers to plan attendance. Each session/date can accommodate 15 people.

PUC Education Summary:

- BRUE
- Traumatic Injury/Traumatic Arrest
- OB Emergencies/Newborn Delivery
- Universal Patient
- ESRD (both Bradycardia and Tachycardia policies updated)
- Adenosine (route addition)
- TXA:
  - increase dose (**pending TAC review/approval 2/19/25**)
  - PPH language added
  - Epistaxis treatment (atomized with MAD)
- Nebulized Epinephrine – Croup
- BVM Education and Documentation

✓ Pediatric i-gel will be on hold for the 2025 roll out pending BVM education
✓ Distal Femur IO will be on hold for 2025 pending PAC discussion
✓ Ketorolac pain scale changes will be on hold pending TAC review of current use and appropriateness
✓ Sepsis education will continue to be reviewed in 2025 in collaboration with hospital partners