CQI Leadership Team Meeting
December 20, 2018
4210 Riverwalk Parkway, #300, Riverside, CA 92505

Attendance:

Lisa Madrid, REMSA
Tim Buckley, Cal Fire
Misty Plumley, REMSA
Stanley Hall, DRMC
Jeff Seirup, AMR
Holly Anderson, Cal Fire
Shanna Kissel, REMSA
JD Tawney, Corona Fire
Evelin Millsap, JFK
Richard Blumel, AMR
Justin Vondriska, Cathedral City Fire
Steve Wells, Corona Fire

Jennifer Antonucci, Murrieta Fire
Henry Olsen, REMSA
Kristen Clements, Riverside City Fire
Sabrina Yamashiro, RCH
Kay Schulz, RUHS
Evelyn Pham, REMSA
Dan Sitar, IVMC
Lia Gen, Cal Fire
Daniel Martinez, Mission Ambulance
Joe Contreras, Calvary Ambulance
Bret Offutt, Corona Fire
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<th>Agenda Item</th>
<th>Discussion</th>
<th>Action</th>
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<td>1. Introduction</td>
<td>Kristen Clements, Riverside City Fire, announced she will be leaving her role as EMS Coordinator in three weeks and will have a new staff member from Riverside City Fire attend meetings from then on forward.</td>
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<td>2. Discuss Previous Meeting Minutes</td>
<td>There were no objections to the September 20, 2018 meeting minutes.</td>
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<td>3. Action Items</td>
<td>Lisa thanked the CQI group for submitting feedback data on report writer. She received good feedback to assist with improving the reports and to universalize them to produce the closest results.</td>
<td>Information only.</td>
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<td>CORE Measures</td>
<td>Information only.</td>
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<td>4. The future of data</td>
<td>Rivcoems.org and REMSA.US website have both added a SCOPE section for the future of data, which includes System Overview, STEMI data, Certification, APOD/APOT Data, Stroke Data, Primary Impressions and Organ Systems and ETS APOTs. Data on SCOPE is interactive and as close to real time as possible. We hope to also include CQI on SCOPE in the future. FirstWatch purchased First Pass for CQI module, and we will start figuring out how to properly use First Pass to our advantage. Misty continued with the future of data and asked for hospital participation to start a project on integrating the elite ePCR system to hospital systems for direct import. Records would be matched based on receiving facility or base contact. The committee discussed how to maximize the capture of unique patient information to a patient ID. Misty suggested medical record numbers as a unique number that NEMSIS could recognize, but would require EMS to capture this</td>
<td>Information only.</td>
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5. System Issues

Looking at system issues regarding needle decompression cases, there were some found to be inappropriately used, however the volume has been a lot less this time around.

6. Protocol/Policy Update

Call Review

Two separate September 2018 cardiac arrest cases from Corona was reviewed for discussion in cardiac arrest management and treatment protocols in recognizing ROSC, futility of events, how to convey base station radio contacts, withdrawal request of resuscitation and relaying that message to the base hospital, etc.

A concern arose from the cardiac arrest call regarding a patient during resuscitation. In the call, once the field provider recognized/suspected STEMI, and confirmed STEMI with 12-lead EKG, they transported the patient to a STEMI center. What led to further discussion was in the ED; the cardiologist questioned the field provider if this was really a STEMI and asked why the patient was transported here. In addition, the field provider also had a perception that once patient is transported to a STEMI center, their expectation is for the patient to go to the cath lab. There has since been push back recently from field providers about whether or not, transport to STEMI center equals an automatic transfer to the cath lab.

2018 Fall policy update states that if we know or suspect STEMI, we have to transport to STEMI center. In conclusion, we do not dictate whether if the patient goes to the cath lab or not. Ultimately, the ED and
cardiologist can decide. This cardiac arrest subset was added because national data shows 80% of all cardiac arrest who have ROSC, if it is a medical arrest, will need intervention at a STEMI center within 24 hours, and that is why we transport to STEMI centers. The message to convey is that we are going there because of the prehospital triage criteria we established, but we are not driving the action of the STEMI center. In the end, it would also be beneficial for cardiologists to communicate in a more cohesive manner to field providers so they do not question their transporting decisions; and for hospitals and physicians to receive the same education on policy updates so everyone is on the same page regarding patient transport and care.

CQI members continued discussion to another topic relating to the confusion of end-tidal CO2 with cardiac arrest patients; and if it signifies the field provider should stay and continue quality CPR or to transport the patient. Some field providers still make calls based on end-tidal CO2; however, the policy change takes effect in Spring 2019. As the variables can always change, and end-tidal CO2 is an evolving science, we cannot make definitive decisions based on its reading.

CQI members also discussed a valuable question that we do not ask enough, is why transport? What do we gain from transporting? There is a perception that if a patient is transported to the hospital, they will survive; which is not necessarily the case. Field providers have improved at calling on scene; however, sometimes it is the family that prompts them to call for transport. It is a traumatic experience for the family to see patient on the ground. There will always be operational issues that arise in various cases, but it is up to the field providers to manage the scene on how
they would like to proceed. More education on cardiac arrest patients and base hospital contact will be conducted to ensure a system wide culture change on how to manage cardiac arrest patients.

**Coming into 2019**

Going forward with 2019 a few recurring issues will be reviewed which includes: shockable rhythms and how it hinders transport, reversible cause, dying support and social issues.

Last week was the deadline to complete 2018 Fall PUC training. All agencies should have completed training by now.

Spring PUC preview, will start around January/February with tentative training calendars.

Come April PMAC 2019, will be the policies to review for Fall PUC 2019.

It is anticipated that Spring PUC will sit around 4 hours, which includes cycle motor skills, CPR, and push dose epinephrine and we would also like to see quarterly training continue so we can improve on high quality CPR.

Collaborations regarding PUC, Misty has taken feedback from agencies, noted those pieces, and put them into education, from recommendations from CQILT, stroke, STEMI, trauma committees etc.

Final STEMI and stroke regulations is expected for April 2019.

Lisa discussed an upcoming focus on a cardiac arrest piece, and asked providers how often and how do they look at data on their feedback devices? Do they track and trend depth quality and race? This will be the forefront on how we progress with resuscitation in the future. We need to track if our education is stimulating
high quality CPR. There are some documentation, but it is challenging for providers who are using auto pulse, and it may also be out of compliance. Some providers responded for every cardiac arrest case, they review the CPR report card; however, this may be difficult for bigger agencies. CQI members deliberated what would be the best method to collect and present the data. Lisa requested as a group to come to a consensus with three or four variables that can consistently measure high quality CPR that can include time on chest, rate of compression, adjunct devices or recoil. The CQI group concluded with starting with two variables, front code stat and time off chest and analyzing the gaps from there forward to start.

| 7. Roundtable | Next CQILT meeting is on March 21, 2019, from 10:00 a.m. - Noon. |