CQI Leadership Team Meeting and HEMS
July 16, 2020
4210 Riverwalk Parkway, #300, Riverside, CA 92505

Attendance:
Lisa Madrid, REMSA
Tim Buckley, Cal Fire
Misty Plumley, REMSA
Nick Ritchey, REMSA
Jeff Seirup, AMR
Holly Anderson, Cal Fire
Noelle Toering, RFD
Catherine Farrokhi, REMSA
Richard Blumel, AMR
Ryan Holkamp, AMR
Vanessa Hayflich, Mercy Air
Henry Olson, REMSA
Patrice Shepherd, REMSA
Evelyn Pham, REMSA
Lisa Higuchi, AMR

Paul Duenas, PSFD
Stan Hall, DRMC
Brent Lopez, Reach
Sabrina Yamashiro, RCH
Kay Schulz, RUHS
Lisa Mackie, RUHS
Dan Sitar, IVMC
Shanna Kissel, REMSA
Dustin Rascon, REMSA
Debbi Givot, JFK
Desiree Estrada, Mercy Air
Jay Leon, Cal Fire
Sudha Meheesh, REMSA
Melissa Schmidt, Hemet
Fire Kristen Butler, LLUMC

Thomas Wofford, EMC
Ron Taggart, Reach
Shadrach Smith, Idyllwild Fire
Steve Wilford, City of Calimesa
Thomas Craine, Riverside Sheriff
Jennifer Antonucci, Murrieta F
Shawn, Calfire
Jennifer Lee, IVMC
Dr Reza Vaezazizi, REMSA

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<th>Agenda Item</th>
<th>Discussion</th>
<th>Action</th>
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<td>1. Introduction</td>
<td>The committee introduced themselves via Webex chat. Going forward, all meetings will be held online either through Webex, Zoom or Microsoft Teams until further notice.</td>
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<td>2. Discuss Previous Meeting</td>
<td>January 16, 2020 meeting minutes were reviewed.</td>
<td>There were no objections to the January 16, 2020 CQILT meeting minutes.</td>
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<td>Minutes</td>
<td>HEMS excel spreadsheet data collection will be moved to report writer type of reports. The committee will drop off working with auto launch since there has been no updates since the last meet over a year ago. Mercy Air updated the committee regarding carrying blood, it will be pushed back to later this year, by Fall to have all carriers carry blood. Regarding condensing the duplicated items on the drug and equipment list the air providers have no met yet to discuss which items to remove, the providers will follow up on the progress of this request. Time off chest data has been a challenge to collect due to field providers using two different type of monitors and the output it generates are read differently. REMSA will forgo this project for now but emphasized that it is still important for providers themselves to look at QI for their cardiac arrest cases. Due to the rising cases of COVID-19, the review of inappropriate administrations for TXA and Ketamine have been put on pause until further notice. REMSA met with the CORE Measures committee at the end of February and convinced them to remove anything that had time intervals. REMSA has been trying to align the measures with</td>
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CEMSIS and have it done correctly in ImageTrend before bringing it back to the group for review. Due to COVID-19, the state has not released an expected due date for the measures at this time.

### 3. Action Items

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<th>CQI Plan</th>
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<td>The updated CQI Plan is complete and available on the CQILT page at REMSA.US. The CQI Plan was condensed and categorized to the appropriate sections. Overall, it has been simplified but still maintains its same structure. REMSA will be in contact with individual providers who have not updated their CQI plan in 5 years or more to get them up to date and current. The biggest goal is to have all CQI plans to be fluid.</td>
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### 4. HEMS

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<td>HEMS data was reviewed. Looking at the data for ETA given, most have been under the 10-minute mark difference. Newly added column for actual flight times was reviewed. Reports are available for individual agencies upon request. Regarding COVID-19, the committee discussed methods used for decontamination. Most carriers cannot use the fogger but opted to use UV light or vital oxide. As far as PPE goes, they have a sufficient amount.</td>
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### 5. Case Review/Discussion

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<td>Jay Leon, Cal Fire presented on an alternative product for BVM in the drug and equipment list. He demonstrated with a sample of the Mercury Medical equipment which offers only one small adult bag. Stating that often times, patients are either ventilated too fast, with too high of a pressure or too much volume. The new 1-liter (1000 mL) bag is smaller than the standard 1600mL bags, which prevents over inflation and creates smaller tidal volumes. With a smaller bag, it would be easier to adhere to AHA guideline recommendations in delivering tidal volumes of 400 to 500 mL or 6-7 mL/kg. In addition, coming soon there will be markings on the bag to further assist in delivering the correct volume. The 1-liter bag also comes with a pop off override for more pressure if needed, along with a built in peak and easy to collapse bag for storage capability. Jay also presented on a disposable bi-level CPAP therapy system called Flow-Safe II. Flow-Safe is ideal for pre-hospital and hospital use. It includes a color-coded manometer that verifies delivered CPAP pressure, uses 50% less Information only.</td>
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oxygen consumption than the original, is comfortable for patients with a forehead support to reduce pressure to the nose and easily adjusts.

The committee discussed their current use has been restricted to CPAP only on the EMS level. In addition, their consideration to add in a new product would first need to be part of a standardized equipment to allow for maximum troubleshooting capability. Mixing and matching products would be problematic. Before making a decision, the approval process would have to pass through another committee as well.

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<td>EPI administration data was reviewed from 1st quarter and part of 2nd quarter. From January – March there were 94 administrations. Providers not documenting fluid given is still a standing issue. At the next ePCR workgroup meeting, they will strategize how to ensure fluid is documented if patients are given EPI.</td>
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<td>Medical cardiac arrest report was reviewed for 1st quarter 2020, which included about 1,175 patients. Median time was tracked separately. Since the lockdown due to COVID-19, the data has shown an increase of dead/pronounced on scene or left on scene. Once quarter two data are ready, it will provide a deeper understanding of if the increase is due to COVID-19. Transport to non-STEMI centers is still high and will be closely monitored.</td>
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<td>Traumatic cardiac arrest data includes only a small number of patients; 137 incidents in 1st quarter 2020. Documentation may be a slight factor in the low number due to provider selecting cardiac arrest instead of traumatic cardiac arrest. The type of injury documented also play a factor in how crews document these types of calls. In regard to times, a lot of factors can contribute to long times since our county is wide-spread and our low counts, every outlier can skew the numbers more. It would be better to look at the median time instead. A question was also brought up, is unmanageable airway factored into non-trauma center transports. The problem is that each medic views that as something different. But the MICNs continuously stress</td>
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the difference between unsecured and unmanageable airway. It is an education piece that will need to be reiterated to field providers.

Ketamine administration data remains pretty much the same compared to last quarter, with about 8-10% of administrations as inappropriate, which is a deviation of about 2.5 milligrams plus or minus. The majority were overdoses and those issues were identified and QIed. We identified the issue arose from providers scanning patients’ driver’s license to input weight automatically but could be inaccurate as opposed to going back in to manually correct the weight.

TXA, 63% of the time had appropriate administrations with 27% as questionable or inappropriate. The request to add estimated blood loss as a field in the PCR will be reviewed by the board, and after board approval, will be added as a field in the PCR. Overall TXA has been put in LSOP, administration has been strong in the county, given in a timely manner, and has been showing improvement in patients for blunt or penetrating trauma. A reminder was noted regarding blood loss and tourniquet usage. The committee discussed concerns about using TXA for head injury, but overall decided head injury should not be an exclusion if the patient fits the criteria. It is important for providers to stay within the protocols for TXA administration. The committee concluded that providing more frequent training along with an updated fact sheet to include in PUC education would be beneficial.

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<td>The surge plan piece to help assist with the COVID-19 surge was planned to put into effect on October 1st, 2020; but will likely be needed before, made it through the processes and stakeholder groups to be added into Fall PUC. REMSA along with Public Health will continue monitoring call volume and hospital surge to adopt policies. Coming updates include centering around source control for patients (patients coming in with a mask on),</td>
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looking at policies that surround emergent virus and working with health officers to best address on how to manage. Changing protocol to remove designated base hospital piece and replacing the language. Trauma policies that went into effect July 1st were the pediatric trauma center piece, 5305, trauma protocol. As of July 1st, also removed stroke diversion, based on stroke committee recommendation.

For Fall, COVID-19 surge plan pieces will be reviewed. Ketamine to snake bite protocol, COVID-19 policy regarding medics providing other resources to patients if they refuse care. In the event of a disaster, we have a process that is currently being finalized by EMD on where to congregate. LVAD policy will not be updating this Fall.

Interim infection control guidelines follow CDC guidelines for their standards of care. A recent recommendation was for healthcare providers to wear eye protection consistently in any patient care area. 3307 update on source control pieces that will apply to prehospital and hospital. PPE recommendations.

8. Roundtable

Mercy air proposed an expanded scope of practice in PCP when California has approved a list that includes chest tubes, ventilator management, blood product, nitro, IV administration, thrombolytic etc. 15 LEMSAs are in the approval process for the PCP and CCPs to provide. Currently they are trained in PCP and CCP but are unable to provide care because our LEMSA will not allow it. They felt this will provide a higher quality of patient care in the IFT setting. Mercy air will collect data to present their case at the November PMAC meeting.

Hospitals noted to field providers that if they are picking up a patient with a DNR or any documentation regarding DNI, to please bring it to the hospital so the ER does not intubate the patient, which potentially could expose the whole ER to COVID.
Base hospitals will be participating in ImageTrend Elite to use the Base hospital form with the intention of building out the MICN contact form. The form will document how often providers are contacting base hospitals and to create a standardized reporting for educational modules. IVMC has been using the form and once the other hospitals are on board with the form, education will be provided for both MICNs and prehospital providers. Full implementation estimated for Fall 2020.

Next CJILT and HEMS meeting is on October 15th, 2020, from 9:00 a.m. – Noon via virtual platform.