CQI Leadership Team Meeting and HEMS
October 15, 2020
4210 Riverwalk Parkway, #300, Riverside, CA 92505

Attendance:
Lisa Madrid, REMSA
Dawn Downs, Symons
Leslie Duke, REMSA
Nick Ritchey, REMSA
Jeff Seirup, AMR
Holly Anderson, Cal Fire
Noelle Toering, RFD
Dustin Rascon, REMSA
Sudha Mahesh, REMSA
Stephanie Dvorak, Cal Fire

Bryan Hanley, REMSA
Stan Hall, DRMC
Shane Race, REACH
Sabrina Yamashiro, RCH
Dr Reza Vaezazizi, REMSA
Lisa Mackie, RUHS
Dan Sitar, IVMC
Henry Olson, REMSA
Melissa Schmidt, Hemet Fire
Evelin Millsap, JFK

Daniel Martinez, Mission
Lisa Higuchi, AMR
Chris Madrid,
Shanna Kissel, REMSA
Thomas Crain, Riverside Sheriff
Jennifer Antonucci, Murrieta F
Catherine Farrokhi, REMSA
Patrice Shepherd, REMSA
Evelyn Pham, REMSA
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<tr>
<th>Agenda Item</th>
<th>Discussion</th>
<th>Action</th>
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<tr>
<td>1. Introduction</td>
<td>Attendance is taken through the participants list on Zoom.</td>
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<td>2. Discuss Previous Meeting Minutes</td>
<td>There were no objections to the July 16, 2020 CQILT meeting minutes.</td>
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<td>3. Action Items</td>
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<td>4. HEMS</td>
<td>HEMS data was displayed in charts and reviewed. 9-1-1 scene data includes flight agencies: Mercy Air, Native Air, Reach and Tri State Care flight. HEMS volume by month in 2020 saw a dip in April, most likely due to the COVID pandemic, which also correlates with the lower ground transport volume as well. From May on, the volume increased back to normal levels. Destination volume showed a bulk of the calls were from the desert region, with Desert Regional Medical Center as the highest volume center. A few of the destinations were listed as not documented. These cases will be analyzed and reviewed more in detail at the next HEMS meeting. About a quarter of the calls year to date did not have procedures or medications documented. A chart displaying general breakdown of procedures by 9-1-1 calls showed orotracheal intubation as one of the highest procedures. Medications chart showed fentanyl as the highest. A draft 2020 Helicopter EMS map was displayed for the 168 year to date calls, with each agency color coded. The SCOPE page has the finalized 2019 map along with quick snapshots of key data elements. HEMS agencies are working on a presentation to bring forth to the next PMAC meeting in November.</td>
<td>Discussion.</td>
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<td>5. Case Review/Discussion</td>
<td>Riverside University Health System case review tabled to the next meeting.</td>
<td>Information only.</td>
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<td>6. System Issues</td>
<td>Last month a system advisory was put out regarding an opinion poll to survey how field providers felt about the current REMSA policy manual. Participants were asked to give their input on how to make it easier to</td>
<td>Information only.</td>
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navigate and utilize on a daily basis. The responses would then be analyzed to help shape its next iteration.

Results of this poll:

- 323 responses, 236 comments
- 78% of poll submissions were paramedics (about 20% of all active field providers)
- 15% of poll submission were EMTs (about 1.7% of active field providers, a small amount)

Findings:

- 42% of them found the current manual difficult to understand
- 37% found it easy to understand
- Others commented to structure the policy manual similar to neighboring counties
- Would like to see simplification in policy presentation/language clarity

Conclusion:

- A revised 2021 policy manual (4000 series – treatment protocol)
- REMSA will change the overall structure of each policy
- Going forward, every word will be searchable, dosages will be added back
- REMSA is currently working on an authorized mobile app that will be free to users, estimated to release in 2021
- There will be a desktop version of the manual available for Base Hospitals to use

A short video demonstration of the REMSA policy app was displayed. The app includes tabs for pediatrics, medications, weight-based medications, treatment protocols, ALS drug index, facility contacts, out of county contacts and REMSA staff contacts. The committee suggested to also add in APS and CPS contacts to the app. Overall response for the app was great! Providers are excited to see and use the app when ready.

Traumatic cardiac arrest cases from January 2019 to September 2020 was reviewed. For quarter 3 2020 under injury mechanism, there was a significant jump from 19-46 cases in the penetrating numbers, as well as other, went from 13-33. 27 of those 33 were drowning cases. Quarter 2 numbers dropped most likely due to COVID, but picked back up in the
other quarters. Base hospital contact yes/no we saw an increase for quarter 3 in 2020, jumped again from quarter 2, also could be due to COVID. We are seeing improvement on not calling base hospital due to dead on scene. Median times highlighted, 25 minutes was unusually high due to a firearm injury of multiple patients, if this outlier was taken away the mean time would be at 12 minutes, which is more consistent with previous quarters.

Medical cardiac arrest cases from April to September 2020 was reviewed. Data showed consistent data throughout the quarters. Pronounced in the field showed an increase in percentage, which is more compliant with the protocol. Scene times remain consistent as well, but has slowly been increasing. Transport destination to non-STEMI centers was discussed further. In other systems they try and get post ROSC patients transported to STEMI centers, the numbers to a STEMI center directly from the field is usually in the 90% range, our transports are lower. The committee advised to look deeper into why some of the cases are sent to non-STEMI centers. A significant amount of our transports with an extended transport time is from the central area, due to our geography. Statistically, post ROSC patients benefit going directly to STEMI centers. The data since the policy change has shown consistency, but our percentages can be higher. REMSA will conduct a deeper geographical analysis into these cases and map them out from the origin location to the hospital where they went to versus where the STEMI centers are located.

Going forward, this data will be included on the SCOPE dashboard as a standing item.

### 7. Protocol/Policy Update

| Policy update, no large changes for spring. The Drug and Equipment list is pending. BBVM and CPAP. HEMS expanded scope piece will do their presentation at PMAC. New policy manual through the app should give us time to sort and make our policies better aligned with each other and more consistent. The FirstPass program from FirstWatch, will also give us the opportunity to write protocols into FirstPass, to monitor protocol information only. |

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compliance and how it works out. FirstPass is still pending and REMSA hopes to move forward with it soon.

CQI module getting an upgrade in November/December that will gives us the ability to write rules that surround CQI and gives us better control of what filters we use in the CQI module, more user friendly and wider scope on what we can use it for.

Train to trainer for Spring 2021 will be coordinated and conducted by Bryan Hanley and Dustin Rascon.

REMSA will be writing a data standard policy, that is in relation to the state mandates. It also encompasses the local control of data standards. Data will be aggregate able amongst agencies. Agencies can go on their own data system, if they choose, as long as they follow the standard policy and still submit data to the state for CEMSIS requirements. The data standard will be clarified at the local level and will go through the standard process of stakeholder comments and brought to PMAC for implementation. Estimated timeframe to be adopted by Spring 2021. If agencies stay on our system, the dataset will be met automatically.

PLN group in collaboration with REMSA created a new base hospital log through ImageTrend. The new change was brought forward to gain a better view on what base hospitals are utilized for, how many calls they are receiving, directions they are giving and overall to better understand and CQI the processes. October 1st, 2020 was the big push to get people compliant in documenting and entering data into the electronic base hospital log. So far, we have seen 82% in compliance. Once we have a couple of months’ worth of data, we will get into the lining up of the prehospital and base hospital data to see if it flows logically and can help us align our protocols better. Throughout this process, REMSA is open to feedback from the Base Hospitals to better improve the log.

8. Roundtable
Nick Ritchey, REMSA will be previewing the CCT module on elite later at the ePCR workgroup meeting.
| Shanna Kissel, REMSA addressed questions she received regarding cardiac monitor specifications for resuscitation, CPR feedback device and whether it needs to be external or internal. REMSA has not changed anything regarding monitor requirements/specifications. As long as the agency can import into the ePCR system, it is valid. |
| Jeff Seirup, AMR, asked other agencies if they noticed an uptick of cases for cardiac/STEMI where some newer medics do not have the foresight to put on pads, which lead to a delay in recognizing patients decompensating. AMR has looked at their internal training processes and has updated their education to ensure better treatment. |
| Question regarding allowing EMS agencies to train and allow their EMTs to push Narcan under title 22 regulations. They can, but they would have to apply for local option of scope, and go through the training process, and have the training laid out for the year. |
| DRMC and Mercy air will host a Base Hospital meeting/ trauma and pregnancy workshop from 10am – noon on Monday, October 19th. On October 27th will be hosting a rotor safety class from 10am – noon. Please RSVP, space is limited due to social distancing. |
| Next CQILT and HEMS meeting is on January 21st, 2020, from 9:00 a.m. to noon via Zoom. |