Emergency Medical Care Committee

Meeting Minutes
8:30 AM January 16th, 2025
2995 McMillan Way, Suite 178
San Luis Obispo, CA 93401

MINUTES

MEMBERS PRESENT:
Chair Chris Javine, Pre-Hospital Transport Providers
Vice Chair Matthew Bronson, City Government
Jonathan Stornetta, Chief, City of Paso Robles Fire
Alexandra Kohler, Consumers
Dr. Brad Knox, Physicians
Rachel May, Emergency Physicians
Jay Wells, Sheriff's Department

MEMBERS ABSENT:
Bob Neumann, Consumers
Michael Talmadge, EMS Field Personnel
Julia Fogelson, Hospitals
Diane Burkey, MICNs

EX OFFICIO:
Dr Penny Borenstein, County Health Officer
Ryan Rosander, EMSA
Bill Mulkerin, EMS Medical Director

EMS AGENCY STAFF PRESENT:
Alyssa Vardas, EMS Administrative Assistant
Rachel Oakley, EMSA
Kaitlyn Blanton, EMSA
Eric Boyd, EMSA

PUBLIC COMMENTORS:
Natasha Lukasiewich
Heidi Hutchison
Rob Jenkins, CALFIRE

1. CALL TO ORDER

Chair Chris Javine called the meeting to order at 8:32 a.m. He led the reviewing of the meeting protocols and meeting agenda.

2. REVIEW AND APPROVAL OF November 21st, 2024, MINUTES

Action: Jonathan Stornetta moved approval of September 19th, 2024, Emergency Medical Care Committee Meeting Minutes with corrections of Michael Talmadge asked about hemodynamics for downgrades and Natasha Lukasiewich asked about ketamine for pediatrics and epinephrine for cardiac arrest. Rachel May seconded. The motion carried unanimously with no abstentions.

3. Protocols/Policies

PSFA and CPR Policy: San Luis Obispo County Emergency Medical Services Agency (SLOEMSA) developed several PSFA policies and procedures, primarily for law enforcement agencies requesting to utilize the optional skill of naloxone administration. Prior versions that will be replaced are:

- Policy #213, Naloxone for Public Safety-First Responders Requirements (dated 3/1/18)
- Policy #214, Naloxone for Public Safety-First Responders, which is a clinical procedure guide (dated 2/1/19).

The purpose of developing new PSFA policies is to align with California State regulations that apply to Public Safety personnel (peace officers, firefighters, and lifeguards) and provide a clear process to apply for PSFA training program approval or PSFA optional skills authorization. SLOEMSA removed the requirement to submit use and annual reports for optional skills; however, Public Safety providers that apply are required to have an EMS quality improvement (QI) program in place for any issues or necessary retraining that are identified within their agency. There is no expiration date for optional skills authorization.

Discussion:

Jonathan Stornetta asks why the contagious disease policy is mentioned here.

Rachel Oakley states that it is to inform them of what to do. If you are in an EMS provider agency, you should be aware of that policy. Law enforcement agencies might not be aware that that policy exists, but it applies to them, too.

Bill Mulkerin mentions that it is also because it is not covered in standard training.

STEMI and TRAUMA Destination Policies:

Over the past year, several stakeholders have approached SLOEMSA with a request to incorporate catchment areas into the STEMI and Trauma destination policies. Currently, the field operates without a defined boundary or cutoff for decisions on transporting STEMI or trauma-alert patients to SVRMC/FHMC (SLO County) or MRMC (SB County). The proposed policy revision will help operations by providing clear boundaries. Furthermore, there has been a lot of discussion surrounding prolonged on-scene times for trauma, STEMI, and CVA. A depart scene time goal of 10 minutes or less was incorporated into policy and protocol to reflect these concerns.

Discussion:

Rachel May asks what literature are you using to support the 10-minute times? Is there any literature to support that time?

Ryan Rosander says he has been talking with Dr. Mulkerin and French Hospital. If the patient is having a STEMI, then the patient is likely going to the Cath lab. Why are EMS crews waiting on scene, delaying Cath lab entry?

Rachel May says but what EMS literature have you found to support this? I know there are some traumas and data for traumas, so what literature are you using to support that specific time of 10 minutes?

Bill Mulkerin says he is not aware of any literature. Short on-scene time is relatively standard care for STEMI patients.

Brad Knox asks if it is mirroring other policies.

Bill Mulkerin says if crews are on scene longer than 10 minutes, we want to understand why.

Brad Knox asks if we are close to that time.

Rachel May says that sometimes, we have ALS firefighters on the scene who would be making the initial contact. I have concerns that the on-scene time is not the transporting agency; it is the ALS fire agency.

Chris Javine asks, are these circumstances something you are going to be evaluating in-house?

Bill Mulkerin says yes.

Jonathan Stornetta says we are exceeding 10 minutes, Ryan Rosander and Chris Javine agreed.

Rachel May suggests aligning our data with the SRC metrics. We shouldn't create an arbitrary number to follow.

Brad Knox mentions there is a lot that has nothing to do with EMS. I read this as this is the goal.

Jonathan Stornetta says It is obvious to us, and it is longer than 10 minutes. We should have a goal.

Chris Javine mentions that maybe we should change the expected language to goal.

Brad Knox says It's like saying the expectation is they don't get into a car accident on the way.

Matthew Bronson says he is okay with expectation, but is 10 minutes truly obtainable?

Jay Wells mentions he thinks confusion is that it is an arbitrary 10 minutes and expectation is sterner than goal.

Rachel May says she agrees with a word change because EMS personnel will think that it is punitive.

Brad Knox says there are many aspects involved.

Matthew Bronson mentions he thinks a first step would be to have this as a goal.

Rachel May asks if there is a drop-down to fill in why they are on scene longer?

Katy Blanton says, Yes, there is, but it isn't required, so many personnel don't use it. We are making it required.

Rachel May mentions we should clarify the issue that no STEMIs are going to Marian.

Katy Blanton says that they transport to Marian.

Ryan Rosander mentions South County transports to Marian frequently if the call is located closer to Marian than French.

Public Comment:

Heidi Hutchison thinks Dr. May has good questions, and this was a good way to answer them.

Rob Jenkins mentions he forwarded you studies on the 10-minute discussion.

Natasha Lukasiewich says ten minutes is standard across all pre-hospital specialty care within California, including STEMI.

Discussion:

Brad Knox mentions that over the years, much of that golden hour idea has fallen by the wayside. I want a medic to take the time to look at the patient.

Bill Mulkerin says the plan would be to document why it is taking longer than 10 minutes.

Brad Knox thinks we could be setting ourselves up for failure. If the message is not to rush these patients, we should do this right.

Alexandra Kohler mentions that it does seem strict because it just says "depart" scene.

Rachel May asks if we can include literature to support this. These are often consultations, and sometimes, they need a little more time. I suggest removing the depart scene time from step 3.

Jonathan Stornetta thinks if you are ejected, you will be a code 3, which is step 3. This concerns me in North County because it is going to take a longer time to get to the Trauma Center. Where it talks about the closest transport, would it be helpful to put ground transport? Trauma is misspelled in one section.

Public Comment:

Rob Jenkins says he thinks it is dire to have this in policy since the on-scene times are far longer than 10 minutes. Thank you for putting this into the policy.

Policy 219 Assisting Patients with their Emergency Medications:

Several Congenital Adrenal Hyperplasia advocacy groups have reached out to SLOEMSA, proposing a policy that addresses the need for paramedics to assist patients with their emergency medications, especially for patients in adrenal crisis. This policy will allow paramedics to receive base hospital orders to assist the parents or caregivers in drawing up and administering medications such as Solu-Cortef. It covers not only patients with Congenital Adrenal Hyperplasia but also any patient who needs assistance from a paramedic with their physician-prescribed emergency medications.

Discussion:

Alexandra Kohler mentions that it says medics can help with the medication. Should we write a specific medication here?

Brad Knox says he thinks this is just a specific example. I like this policy being broad.

Public Comment:

No Public comment

Protocol 601 Universal:

During SLOEMSA's 2024 EMS Update Class, numerous paramedics mentioned that they would like to see a discretionary 500 mL fluid bolus (with repeat if hypotensive) within the Universal Protocol. This would eliminate the need for paramedics to call a base hospital for orders to administer fluids.

Discussion:

Rachel May asks does it have to be a base hospital order to give patients their own emergency medication?

Bill Mulkerin thinks base contact is reasonable.

Jay Wells says he would say if language were a goal in others, it should be changed here as well.

Rachel May says she would probably remove stroke since there is no designated stroke facility.

Bill Mulkerin mentions he would like to keep stroke there. Are we changing everything to goal?

Matthew Bronson says yes but we can always change it back later.

Jay Wells mentions he thinks we should change it to goal or target for everything.

Rachel May thinks stroke is much more complex. It would not be good if you were so busy trying to get off the scene that you did not do a full assessment.

Ryan Rosander mentions that medics cannot provide much in the way of treatment for stroke except to get off the scene and to the hospital as rapidly as possible. All specialty care patients need definitive care from a physician, not a medic.

Brad Knox says he agrees with getting stroke patients off scene rapidly.

Public Comment:

No Public comment

Protocol 611 Allergic Reaction/Anaphylaxis:

During our last CAC, an MD mentioned that they are seeing an increase in anaphylaxis patients being brought into the ED without EPI being administered. This was discussed, and a possibility might be the lack of language clarity surrounding anaphylaxis within the protocol. This has been addressed within the revision.

Discussion:

Brad Knox says he wants to applaud everyone who worked on this. We are not giving enough EPI in the field.

Rachel May says she thinks this is an excellent change.

4. ANNOUNCEMENTS

Brad Knox mentions Twin is having significant issues with transfers to French for STEMI, and French is saying not to come.

Jonathan Stornetta says that he just forwarded a case to Ryan about them getting held up because of French.

Rachel May says she feels your pain because of what we have heard happening.

Bill Mulkerin says there have been no changes at the county system level.

Brad Knox says It is becoming a significant issue.

Natasha Lukasiewich mentions that there is another committee to discuss these issues.

Rachel May asks a follow-up question about the Brown Act: Do TAG and STEMI fall under the Brown Act?

Ryan Rosander says he has not heard back from counsel about those yet.

5. FUTURE AGENDA ITEMS

Dr. May asks if we can look at OB as well as discuss Dual Sequential Defibrillation.

Bill Mulkerin says he would like to look at the AMA policy.

Ryan Rosander says we are looking at the QI/QA and Investigations policies.

6. ADJOURNMENT

Action: Brad Knox moved to approve PSFA, 152, 153, 219, 601, & 611 with changes. Matthew Bronson seconded. Motion carried unanimously.

Chair Javine adjourned the meeting at 9:45 a.m.