

EMSAAC Board of Directors Meetings
Sheraton Gateway LAX
March 21, 2006

Dr. Cesar Aristeiguieta, MD

Priorities

We've had EMSA Vision, establishing the large picture, its time to implement, with more specifics than vision (which was a grand view) My instructions to staff are to develop goals which are specific, measurable, achievable and put together a 3 year strategic plan.

4 main categories (reflecting the operational divisions of EMSA)

Executive Administration/Info Technology:

Stable funding for EMSA: Preventative Block grants have been zeroed out. EMSA depends on these dollars for 30 positions; all multi county funding would be eliminated under the current proposal; (paramedic licensure, discipline, EMS-C and disaster are all that would be left)

HRSA Grants and Office of Homeland Security grants: Many funding sources are starting to dry up, and there are more requirements with less dollars.

Must continue to seek funding for mandated activities. Historically, EMSA hasn't had the resources to do this.

Richard spent a lot of time building constituent relationships. I desire to continue that, but there are style differences and how I approach command and control. I will focus less on consensus building, more on problem solving. I keep an open door policy; I'll tell you what I can although I do have some limitations in terms of what I can share (political process limitations).

I will continue dialogue with both EMSAAC and EMDAC. Usually Dan and I split time, Dan is not here today, but Sean Trask is here as a liaison.

May 15, 2006 we will be celebrating our the 25th anniversary (of California EMS) on the steps of the capitol, we will have a little fair, 4 hours long, or so, information booths for the community, getting the word out, etc. This is not intended to promote the Agency but rather the components, and highlight the day to day work. We've invited the Governor and others to attend.

The Administration (EMSA) has other concerns. There are many differences in the application of EMS at the local level (policy, discipline, medical control). We need to

work to standardize. There should be similar response requirements, Policies and Procedures should be similar to achieve a unifying concept across the State, providing the same level of care.

IT at EMSA is a challenge, with server problems, email problems, etc. These are internal fixes requiring tech and support. We are working to correct.

My final executive priority is to personnel. We are the smallest State Gov Department. We need the right tools and are recruiting. The last time we had an open recruitment was 7 years ago. Deadline has been extended to 30 March, 2006, and it will generate a one year list.

EMS Personnel:

Enforcement program has come a long way in case handling expediency and quality. We're a little more aggressive now, especially with drugs and alcohol. Public safety is first, salvaging career is second. Ultimately we like to develop a full diversion program in EMSA to help personnel with problems. Want to handle all cases fairly, quickly and in accordance with due process of the State.

I'd like to pursue a new criteria for low level offenses; this will require regulations and will need to go to Commission.

We remain customer service focused. For example, paramedic licensees should be getting the best possible service whether its enforcement, legal issues, applications, technical assistance, etc.

EMT Licensing Bill and the Governor's budget proposal: There are 70,000 EMTs in the State with no centralized EMT registry. Can't get to them to voluntarily participate in our disaster response efforts. Are they public or private? Our number one priority is public safety. What is the best way to carry this out? I will take as much comment as possible to make it workable whether you're a LEMSA, public safety certifying authority, etc. I want a well integrated registry with background checks including FBI and DOJ. Let's work out the details.

EMS Systems

Statewide Trauma Plans to be delivered to the Governor by June 1st of this year. Trying to get ahead of this deadline to legislature so they can review and fund in the proposed budget. Probably about a month away from the final plan. Move to an integrated trauma system as opposed to local trauma systems, not pulling away, but work with and integrate quality control, patient flow patterns, with regions. QA and QI to have a Statewide trauma registry to evaluate what might be working or not. Romero has proposed 25 million for trauma, 15 million budget augmentation to EMSA for trauma efforts.

Emergency Medical Care Continuum

This might be longer than the 3 year strategic plan. EMS is the third leg of the first response stool (along with fire and law). Strengthening an EMS system regardless of where you work or how EMS works is important. I want a comprehensive approach, from 911 to discharge, the entire continuum . Not sure how this will play out, but I'm interested in thoughts and ideas to create this continuum.

With regards to patient flow in the prehospital setting, the Access to Healthcare Committee is meeting. Diversion doesn't work, it just transfers the problem. ED saturation is a hospital flow problem, not an EMS problem. We need to push to eliminate diversion as other States have. I'm not ready to yet, but I'm looking in that direction. Arizona, tracks how long the offload is. EMTALA and CMS have ruled that hospitals cannot delay offload and there is a written position by CMS on this.

Interoperability:

Need to unit EMS, first responders, State departments, etc. Envision using a gateway (black boxes) initially. Long range will be systems that work with each other. We don't know where this will go, but we are part of the discussion. It's a 6 billion dollar problem.

Other EMS System Issues:

Dealing with various modes of EMS (air, non-transport, transport, ect.) Public safety is the key.

We need to look at medical errors in the prehospital setting. Once we have the legal support to share QA/QI via peer review, then perhaps sentinel events or lessons learned can be shared to educate all providers throughout the system. Ideally, we'd link enforcement to education. Most cases have themes of abandonment between midnight and 6 AM. There is value in an electronic newsletter to share stuff, where medics can share their experience and environments which may have resulted in medical errors. We want a way to identify and share sentinel events.

Disaster Medical Services

CALMATs. Its rare, but everyone understood and agreed on this and we're moving in the right direction with the Governor's support. This will make us better prepared. I have not seen another State as well prepared as California. We're more exercised, have developed Mutual Aid, ICS, SEMS and now moving to NIMS. We're doing well. CALMATs will need to be coordinated with DMATS, don't want to Rob Peter to pay

Paul. Keep working on our all-hazards approach. Earthquakes, floods, long fire season, etc.

We have begun operational licensing for ESAR-VHP, since 2/28/06 we've been registering individuals into the database. Beta testing and evaluating now. Within 6 months hope to have about 5000 people. We're getting the word out. Pre-credentialing is designed so that when they show up at the hospital, they will have their paperwork, be prescreened and pre-credentialed. They will come with training and marching orders.

Mutual Aid System

Joint Emergency Operations Center (JEOC) is now opened, and I will try to arrange for a tour next EMSAAC meeting in Sacramento.

Medical Reserve Corps was a great program which became unfunded after creation. We have been working with them to create an effective organization for local use.

Four major projects in short term:

EMT Licensing

Medical and Health Search Plan Development to inventory all resources (with DHS) to determine where are the gaps and how can we fill the holes.

ESAR-VHP is high priority since manpower as a limiting factor

Trauma Plan I've already discussed.

Current budget initiatives include the PPE grant, CALMATs, EMT proposal (SB1811).

QUESTIONS:

EMSAAC: We need to expand EMSA into continuum of care. So much of in-house affects EMS which we can't control. State DHS ED regulations are 30 years old and predate modern systems. The need to be looked at now.

Dr. C: DHS says it would take 5 years and too much staff effort to reopen regulations. Some fear it may lead to further erosion of the system, such as issues with staffing ratios, etc. CALACEP sent a letter to Gov that authority for regulation development should be given to EMSA. It didn't include much detail, but it's a step forward. Licensing is a really big effort, maybe consider splitting policy from the actual licensing (like trauma). Not exactly sure how to accomplish.

EMSAC: What is the Role of EMSA in flu planning?

Dr. C: We're very active with DHS on this. Working with the Mark Cordin and Sandra Sheerey. Our role in a pandemic is somewhat limited, but this is a protracted disaster, this belongs to other agencies in HHS. We will participate with and support medical response efforts.

In next 6 months, the birds will be here. If not already preparing for what to do when birds arrive, need to now. There will be some measure of fear and panic in population, even though this is limited to birds. Have your risk communication plans now...
In a few weeks, a unified message from all State agencies on this issue. The real question is what will be the economic impact?

EMSAAC: Regional funding, where is it?

It's there, in a more generic form. Regional budgets have actually decreased over 10 years. We're committed to regions and poison control systems, which are also underfunded. We're taking these issues through the process.

EMSAAC: The federal pandemic plan with its emphasis on infect control and droplet procedures are fine, but DHS wants N95. There's confusion, not enough N95, not enough negative pressure rooms, etc. And it would seem that EMSA must work closely with EPO, but they're not, there's much conflict, EPO has all the money

Dr. C: Closer coordination with DHS-EPO is certainly our goal and we are meeting regularly on this matter.

EMSAAC: AB2554 has LEMSAs very concerned. Locals must always be able to investigate locally.

Dr. C: Well, the devils's in the details. Some locals want to continue certifying, some don't. If we can integrate the two (certifying and investigating) and providing background checks and data for registry, there should not be a problem.

Welcome and Introductions

Approval of Agenda

M-Inch, S-Frenn Carried

Approval of Minutes , December 6, 2006

M-Lathrop, S-Inch Carried

New Members - Lathrop

David Nevins CAA
Debbie Meyer Cal Chiefs Northern
Chris Piper
CALSTAR need a name (use Joe Cook)

M- Lathrop, S- Inch Carried

Consent Agenda

M-Lathrop, S Frenn Carried

Old Business

Draft Legislative Committee Policy

M-Leonard, S-Karstead Carried

2006 EMSAAC Conference – Meyer

Propose a new budget (handout). Conference will May 30 - 31, with EMSAAC on June 1. Have at least one hundred registered attendees, including 12 waived slots (speakers). Still need vendors!!

Hotel cost is \$155/night. Get registration in ASAP. You will receive info on how to register.

M-Inch, S-Burch Carried

To accept the revised proposed budget of \$37,273 and authorize signing a contract.

EMT-II Task Force Update - Martignoni and Trask

Have been meeting about 1 year 3 months, a really great task force, looked at Imperial County, considering 88 hours for EMT II, 24 for field internship, 40 hours didactic, hospital model curriculum, standardized skills, using Imperial county and LA county skills. The big issue at the Commission tomorrow is CAL-Fire, want a public comment period for any upgrade or downgrade (program change). Task force agrees for downgrade only, or, if impact evaluation is already done, waive it.

Predominantly a consensus document with the exception of the public hearing requirement. Two level of IIs: basic II with Narcan, D50, combitube, IV, saline, blood sample, glucometer, glucagon, Inhaled beta 2 epi-subcu; and the current EMT-II to be called the advanced. Existing EMT-II Jan 1, 1994, to use advanced, all other programs restricted to basic, very consistent with the EMT-Advanced as proposed nationally. This is still a few years out.

Commission (Skipped)

Legislation

AB 2554

CPF sponsoring this. LEMSA can only take action if they certified the individual. Programs that have EMT-I certification can do the discipline, not LEMSA. Contrary to medical control. League is in support, and it may get legs.

M - LaPolla, S-Osur, Carried

Take an active opposition, including sending a strong letter of opposition on this to the Author.

AB 586

Partners with Public Health over the MHOAC. Leg Committee has been following.

M-Frenn, S-Lee Carried. Support AB 586 Lapolla will email current draft.

SB 1339 Romero

Evaluation of emergency and trauma care services. Two Senators are introducing this bill. Recommend a support position.

M-Lathrop, S-Lee Carried To Support SB 1339.

SB 1350 Romero

Push for a regional approach to trauma system planning and implementation. Divides the State into three regions, with Kern County going to the southern Region. EMSAAC has been asked to sponsor the bill. This is very important to EMSAAC as an organization, and also requires a lot of work. Much discussion about how many regions, sponsorships; we should follow along disaster medical health regions and not create new. No specific action requested.

SB 1773 Alarcon

15% for pediatric trauma centers. Scarce resources, Actively Support but question the pediatric piece implementation.

M-Lee, S-Burch Carried Strong support for SB 1773

SB 1811 Romero

EMSA Bill to capture licenses and certifications of EMT-Is. Money to be borrowed, paid back by 67% of EMSAAC think it's a good idea, others not. Massive opposition from fire service. Committee recommends a watch position, see how everything shakes out.

M-Ross, S-Frenn, Support SB 1811 if amended.

Discussion:

Let's see if we can identify what we all agree on right now, and wait and see how this plays out

The motion was withdrawn by the maker in favor of watching this bill develop.

Procedural motion: At the December meeting the following motion was made:

M-Inch, S- Karstead, Support concept of Authority taking over the licensing of EMT-IIs, recognizing that a statutory change would be required.

A motion to table was then made:

**M-Lathrop, S-Burch Move To Table to next meeting (2/3 vote required). 17
Yay, 2 No Carried.**

This motion was made because several LEMSAs with EMT-IIs were not present. That this item is to be discussed needs to be duly noticed in the next meeting announcement.

A 2/3 vote to bring the motion back from the table was taken which passed. The original motion was then withdrawn.

New Business

2006/2007 Slate of Officers

This year there are multiple candidates for some of the Executive Officer positions. The slate is as follows:

President:	Carol Meyer	
President-Elect;	Michael Frenn	Bruce Lee
Secretary	Dan Burch	Michael Petrie
Treasurer	Art	

M-Greg S-Miles Carried To approve ballot as drafted.

Directors Joint Advisory Meeting Fisher/Meyer

Dan Burch - EMSAAC, Barbara Pletz-CHEAC/CSAC have attended.

Several issues:

Fire Depts. as certifying authority

EMSA is interested in pursuing a First Responder Certification program. Not supported by fire.

2006/2007 Planning Meeting - Meyer

What should we do for our planning meeting? Some discussion to continue the EMSA, EMDAC, and others Strategic Alliances that we started last year.

Ambulance Strike Teams - Meyer

We need to start implementing this program. The plan is on the Authority website. Carol will get a list of Regional Representatives out. There is 2.3 M for ambulance PPE. Get selection criteria. LaPolla to send matrix of training for PH personnel

Autopulse – Lee

Concern about the efficacy of this device and its appropriateness in the field following an experience in Riverside County.

Diversion, Alternate Destination Trial, Patient Parking - Lee

All fall under the general heading of the Access to Care Task Force. At a juncture, continue or disband? Various groups have dug in to their various positions. Trying to get consensus on some issues:

Diversion Guidelines. Bad thing, goal to eliminate or serious reduction. Lean to latter to give hospital a relief valve under critical circumstances.

1. Diversion events limited to critical patient overload, critical patients to resources
2. Diversion episodes must be time limited
3. All hospitals wanting diversion privilege must develop a diversion reduction plan that the LEMSA would have access to.
4. Hospital not participating would loose privilege

Alternate Destination Trial Study

Develop a trial study to transport focused amount of patients to a non-acute care facility.

Patient Parking

CMS office has issued memorandum that this is a potential EMTALA violation p 20 minutes. An EMTALA stick may be necessary.

Nevada has just legislated transfer of care at 20 minutes.

State Unveils Public Health Disaster Center

Joint Emergency Operations Center (JEOC) – Pletz

Dr. Ceaser discussed this morning. Next EMSAAC in Sacto meeting we should go visit.

Review of EMSAAC Fiscal Reports - Petrie

Michael as performed an audit of Art's reports to EMSAAC. Certified excellent!

Cal State Interoperability Executive Comm. – Lathrop

Goal is to develop an interoperable radio system statewide. There in the process of setting up some meetings. There are communication regions North, Central, and South. Any agencies wanting to attend should call Mary Cook at EMSA. There are workgroups fire, law, EMS, each region has a rep plus Mary from EMSA. Region IV is vacant, and Region II needs a new rep.

Medics on DMAT Teams - Petrie

The issue is that they re sometimes used for non-federalized functions (fighting fire with CDF). We should get a position and possible solution from EMSA.

Adjourned 2:37 PM

Minutes by Michael Frenn, Secretary
Respectfully submitted