COUNTY OF ORANGE HEALTH CARE AGENCY
EMERGENCY MEDICAL SERVICES
405 W. Fifth Street, Suite
301A Santa Ana, CA 92701

FACILITIES ADVISORY COMMITTEE

Tuesday, January 10, 2023 – 9:00 a.m.

MINUTES

MEMBERSHIP / ATTENDANCE

MEMBERS	REPRESENTING
☒ Peter Anderson, MD	- OCMA/ED Physician
☐ Vacant	- Base Hospital Physician Directors
☒ Michael Lekawa, MD	- Trauma Medical Directors
☒ Chien Sun, MD, MD	- Managed Health Care Physicians
☒ Alaine Schauer, RN	- Base Hospital Administrators
☐ Vacant	- ERC Hospital Administrators
☒ Meghann Ord, RN	- Base Hospital Coordinators
☒ Titus Ynares, RN	- OC ED Nursing Leadership
☒ Mary Slattery, RN	- Trauma Program Coordinators
☐ Bryan Johnson, RN	- Fire Chiefs EMS Committee

	OCEMS STAFF PRESENT
Carl Schultz, MD	– EMS Medical Director
Gagandeep Grewal, MD	– Associate EMS Medical Director
Tammi McConnell, MSN	– EMS Director
Mike Noone, NRP	– Assistant EMS Director
Laurent Repass, NRP	– EMS Information Systems Chief
Adrian Rodriguez	– EMS Performance Chief
David Johnson, RN	_ EMS Facilities Coordinator
Genise Silva, RN	_ EMS Facilities Coordinator
Meng Chung, EMT-P	_ EMS BLS Coordinator
Philip Grieve	_ EMS ALS/CQI Coordinator
Jason Azuma, EMT-P	_ OC-MEDS Coordinator
Drew Bernard	_ EMS Specialist
Erica Moojen	_ EMS Office Supervisor
Eileen Endo	_ Office Specialist

GUESTS PRESENT

NAME	REPRESENTING	NAME	REPRESENTING
Kristen Karpow, RN	- Orange County Global Medical Center	Laura Cross	- Mission Hospital
Jill Patt, RN	- Huntington Beach Hospital	Benjamin Grunbaum	- Hoag Memorial Hospital
Sandra Schulz	- OCFA	Heidi Yttri, RN	- St. Jude Medical Center
Julie Mackie, RN	- Mission Hospital	Amy Waunch, RN	- Children's Hospital of Orange County
Julia Afrasiabi, RN	- UCI Medical Center	Mary Ellen Lowrey	- TIP
Ryan Creager	- Mercy Air	Kim Zaky, RN	- Children's Hospital of Orange County
Colette Baeza, RN	- UCI Medical Center	Phil Robinson	-
Shelley Brukman, RN	- Children's Hospital of Orange County	Georgia	-
Annabella Anderson, RN	- Mission Hospital	Nicholas Berkuta	- One Heart
Claus Hecht	- OCFA	Justin Horner	- Costa Mesa Fire & Rescue
William Orr	-	Jennifer Gonzales, RN	- Orange County Global Medical Center
Rhonda Rosati, RN	- Fullerton Fire Department	Josh Dean	- Premier Ambulance Service
Desiree Thomas	- St. Joseph Hospital	Todd Costa	- OCFA
Richard Pinon	-	Vishal Raj	- Falck Mobile Health Corporation

I. CALL TO ORDER

- Meeting called to order by Peter Anderson, Chair.

II. INTRODUCTIONS/ANNOUNCEMENTS

- Carl Shultz introduced two new EMS Employees, Mike Noone, Assistant EMS Director and Genise Silva, EMS Facilities Coordinator.

III. APPROVAL OF MINUTES

- Approved Minutes from November 8, 2022, meeting.

IV. OCEMS REPORT

- OCEMS Report:
  Carl Schultz – Ebola in Uganda. If you don't hear about any more Ebola cases on the 11th, then we will have passed the 42 day incubation period. Actually it is two 21 incubation periods without any case that defines the end of the episode. The CDC said that they will officially declare the episode over on the 11th. We do have people we are watching, but they are not under quarantine. RSV has stabilized and somewhat improved. It has gone from horrendous to just bad. It seems the big capacities are at both CHOC and Mission have

improved. It is better than it was and looks like it's improving for demands for pediatric services. In that respect, it is hoped RSV will improve._Regarding APOTs and diversion hours, we have run low diversion hours throughout the year with the exceptions of the spikes from COVID. After the end of February through mid-May, we saw what we considered normal numbers for the county. Month after month low numbers for diversion and numbers for APOTs doing pretty well, and then around May it started climbing. Last month December, we had 6 hospitals finish at or very near the 200 diversion hour mark. Some exceeding it quite a bit. One institution had 332 diversion hours. So, I've been trying to reach out to one hospital at a time reach out and doing site visits and trying to reach an agreement about not exceeding 200 diversion hours. That's the point where all the hospitals were to go to in diversion hours, we would basically have to abandon diversion hours all together because we would be closed most of the time. We are trying to work with that, but it is becoming more of an issue. When it was one or two hospitals, we could deal with it on an individual basis. Now that it is five to six hospitals, it is becoming an issue for us. I'm going to reach out to them and make a request that they bring their hours down on their own, figuring out how they can best do that, down to 200, but if we continuing to see more hospitals reach that barrier going forward, then I'm going to have to abandon diversion, which I really do not want to do, as you probably know. So for all the institutions that are having issues with a lot of demand, not enough resources, staffing is an issue. I get all that, but I've got to keep the EMS system running. As the total number of diversion hours continue to expand at some of the hospitals that are reaching the 200 hour barrier increasing we will come to a point where it is not reasonable to continue to have diversion. We will see a rapid expansion of that, because once one hospital goes on diversion for that many hours then it forces the other hospitals to stay open and when they all get saturated then they go on diversion. So I want this group to understand that I am not going to do it for the month of January, but I do not know what the month of February is going to look like and if we are to avoid that, then I would really like to promote that. Then each hospital that is having issues with diversion hours, exceeding substantially 200 hours. I will have to pull those in or we will have to do it as a system.

Gagandeep Grewal – Case rates of COVID 19 have been steady. 13 cases per 100,000. It's been around that number for the last month. It peaked at about 18, comparatively a low lever surge. Positivity is a bit up but hospitalizations and ICU admissions are steady. It is unclear if that is a flattening before it increases again or it is the start of a drop. Other countries, especially China, are experiencing some surges right now. The BQ variants are still the most prominent. There are other variants in other countries, but we don't know if they will come here in the US. The variants are significant because of resistance to the monoclonal antibodies and all the EUAs have been pulled for them. The FDA is preparing to remove the EUA for Evusheld as well. The vaccine is thought to have some efficacy against the variants so they are still recommending the vaccine. As far as influenza goes the numbers statewide have dropped significantly. Just as Southern California led the way with increasing levels, we have been decreasing ahead off the rest of the State. A couple of weeks ago we were at the high level and now we are in the middle of the moderate level. RSV, rhinovirus and enterovirus statewide is seeing a similar pattern. Those numbers are dropping as well. Monkey pox has not been increasing either so on the infectious disease front. AOC was still helping support vaccination PODs activated for the virus surge, but the pediatric virus surge portion deactivated in December. The vaccination PODS have stopped and now the public health department is using their clinic on 17th Street. They are still operating clinics for COVID vaccine. We do still have some supplies available, especially gowns and face shields in surplus. Please reach out to us if you cannot get supply from your regular vendors or if you want to bolster your stockpile. We have professional and over the counter test kits as well for organizations with a CLIA waiver. The over the counter test kits are for the disadvantaged uninsured and underinsured population but the professional test kits are available for anyone in the medical field. Please reach out to us if you have a need for any of those. The rest of Health Emergency Management (HEM) is still working on updated plans and solidifying schedules.

Mike Noone asked if the EMS agency has enough gowns, we want people to ask for them even if they can get them from their vendors, if they want to stockpile some if they are thinking I have some extra storage space, I'd like to some.

Gagandeep Grewal answered that we generally want people to be self-sufficient, but this is one-time offer for facilities to expand their capacity and keep it for further need. Ultimately we do need to get rid of those gowns to clear out some storage space. They are available.

Tammi McConnell said the short answer is Yes. All hospitals or health facilities who would like to request those items and stockpile them, even though they have access to purchasing them, because there is not a supply issue with gowns, Yes, but know that this is a special situation and we are not setting the precedent that we will be getting rid of all of our stockpile. This is a logistics problem that we have. That

we cannot maintain the gowns that we have safely. We need to surplus them and there will be a time probably mid to late this year where we will shut that process down, but until then, hospitals are highly encouraged to send their requests in.

Carl Shultz clarified that this is not a precedent. This is a unique situation, but general philosophy is that if the supplies are available in the general community that the expectation is for the MHOAC program that they who would expect each hospital to reach out and use their own vendor for just their own equipment and only when they are unable to do so would then be the source of next resort. We are not the first resort. We are best second, if not third, going forward.

Michael Lekawa inquired about the earlier OCEMS report. He felt the sting of ED impacts and the pressure it puts on trauma center. Should the 200 hours be EMS wide? Would not mind if it did not put heavy pressure on trauma centers. We have seen more hospitals go up over 200 hours. UCI is an outlier. Carl Schultz reached out to three hospitals. They met yesterday and understands their dilemma barrier. If hospital gets numbers down to 200 or less a month it evens out the system. Third approach with UCI in three months will try with other hospitals and give same amount of three-months-time. If difficulty doing that then will temporary suspend across the board.

- Specialty Centers (CCERC, SNRC, CVRC, Trauma):
  Annabella Anderson – Mission is meeting with collaborative in Orange County. Worked with Jason Azuma, finished trauma center and lining up.

- Ambulance Patient Off-Load Times (APOT):
  Laurent Repass - APOT October and November reports were sent out. Just posted December report.
  10-15 hospitals APOT. 18-19 over 30 minutes this morning. Overall 37 minutes 48 seconds. Busiest month ever for transport 16,000-7,000. Dashboard continuously updated in real time. We have website
  APOT gauges 24 hour period under certain circumstances, hospital gauge may reflect something that happened previously, not in real time. Working on set at 12 hour now, so more accurate real time data.
  24 hour gauges are still available. Some hospitals have 3-4-5-12 transports a day. Some have more.
  Get a better option to look at what APOT time looks like out there. Be aware that it is coming.

- Bi-Directional Data Exchange Project:
  Laurent Repass - The Bi-Directional Data project is underway. UCI most progress in testing Bi-Directional Exchanger. Working with Dr. Katzer to finalize data. Number of hospital groups working with assessments, business integration. When more information comes up, will share that.

V. UNFINISHED BUSINESS

- *Informational Item Only: by Tammi McConnell.*
  Orange County EMS Policy/Procedure #714.00: Maximum Emergency Ground Ambulance Rates
  Ambulance rates that 911 transport ambulance charges patients. Approved by Board. Rates become effective on January first.

VI. NEW BUSINESS

- #4477 Refresher Memo EMS Interventions *by Carl Schultz*
  Attachment # 4 has tools to manage APOT. These actions are summarized here and these things are still in place. Some are incorporated into policy 310.96. I will make a decisions to either make those listed just in the memo permanent or back off soon. Some of the directives some are set to expire February 15th. No evidence things will get better in near future. In the past, APOTs average 26 minutes, now 40-50 per month. Will issue another memo on 1st of February going forward. This memo will list both directives and actions identified in policies going forward. As of February 1, these actions will become standard operating procedures, including all directives from agency in attempt to balance what is going on in the field. If necessary to decrease demand. Carl Schultz will re-visit interventions in the future but for the foreseeable future, these summaries will be in effect.

  Michael Lekawa - Stroke Neuro Receiving Center if hospital is on diversion, no matter what have to accept every patient. Is that really necessary? Or should another SNRC center be better to treat patient. Carl Schultz answered SPOKE hospital UCI. Los Alamitos - not spoke your ERC is on diversion, cannot take them. If Garden Grove has a SNRC patient, UCI is closed – then waived, because they are a spoke hospital. UCI still expected to receive patient from spoke hospital. Same as trauma set-up.

- Letter #4522 NEMSIS v3.5 Implementation Plan 01.03.2023 by Laurent Repass
  We are currently on v.3.4. It will subside at end of year. Then v3.5 is required by January 1, 2024. State requirement gradually making transition in fall months.

- Calling 911 for ICU transfers *by Carl Schultz*
  911 system is not designed to transfer an in-patient to another facility. This results in a higher (ICU with nurse) to lower (ambulance with paramedic) standard of care. 911 is not designed for Interfacility Transfers (IFT) for in patient. Transfer by ambulance staff with less training puts paramedic and patient in jeopardy. Potential liability. Use Specialty Care Transport IFT transfer system for patient transfers from In-patient to new facility. 911 system used for ER to ER transfers where delay of ½ hour-45 minutes is harmful to patient. Those providing ER to ER are not supposed to be used for ICU care. ICU patient in hands of paramedic is detrimental due to less training. Under very rare circumstances to move out a critically ill patient – that will be accepted for a higher level of care, 911 medics can be summoned to ICU for transport. Should make base contact to have a nurse involved as much as possible. As a rule, use Specialty Care Transports (SCT) IFT system for ICU patient transfers.

  Michael Lekawa was at hospital in ED to support a friend with life threatening for 5 hours. Paramedic was frustrated. Patient should be transferred in real time. We may have a problem of not being able to access paramedics.

  Carl Schultz several ambulance companies that can respond in 30 minutes specifically designated ER to ER. There are companies that have to be called to transport ventilators. These are ER patients, not ICU patients. IFT-ALS system sometimes so much demand attending sick patients. If patient needs to go to a higher level of care can utilize 911 call is appropriate.

- Refusing patients from the field/requiring Base Hospital Contact *by Carl Schultz*

  Receiving Hospital is refusing patient from the field. Institution is asking paramedic to make Base Hospital Contact before accepting the patient. This is not acceptable. The decisions to make base hospital contact is driven by policy or paramedic judgement. The receiving hospital does not have the authority to require Base Hospital Contact.

  Chest Pain patients can go anywhere to nearest receiving; only patients with an acute MI on EKG are routed to CVRCs.

- *Informational Item Only:* Facility Redesignation update *By David Johnson*
  Corrective action plans a handful of receiving centers not up to date yet. We are working with them to get updated.

VII. **NEXT MEETING** – Tuesday, March 7, 2023, at 9:00 a.m.

IX. **ADJOURNMENT**
The meeting was adjourned at 10:04.