Hi all-

Here is a quick update for WRETAC, state and RMD activities.

Local service visits and suggestions

- In the past several months I have been able to get out and visit: Telluride, Norwood, Nucla/Naturita and Crested Butte. Thank you all for having me! Good to see in person what the different services are doing and what they have as current strengths/needs and anticipate as future issues.
- Some suggestions from the individual services include: Having a running list of courses you can or plan to teach (ie ACLS, etc). Also regionally sharing ideas about mental health for patients and providers. Please reach out to me with either of the above.
- My planned visitation schedule is (but will coordinate with individuals as it gets closer!:
    - October :Telluride, Norwood, Nucla/Naturita, Paradox
    - November: CB
    - December: Montrose, Ouray
    - February: Gunnison
    - April: Northfork, Delta, Olathe
    - June: Lake City

WRETAC November meeting

- Lots of work on injury prevention and Stop the Bleed campaigns, May is trauma month and will be a focus of that month
- Danny working on educational needs assessment for the region
- Discussed possibility of CREATE grant for leadership academy
- Work on developing strategic vision for the next 2 years. Stay tuned....

RMD meeting
I attended the RMD meeting in Keystone last week. Most of the meeting was spent hearing updates from the individual RETACs about their activities within the past year.

- Highlights and cool ideas from them included: New pain protocol developments, progress towards a statewide CARES (cardiac arrest) database, widespread Stop the Bleed campaigns, development of community paramedic programs (especially for patients with substance abuse), improved regional education systems, research regarding c-collar use.
- We talked about the idea of statewide critical care transfer guidelines. Overall, the consensus was that there are not many areas of the state who have ground ambulances holding themselves out as "critical care". But many regions have regional transfer protocols to address the different needs of sick

patients. These can perhaps serve as a guide for us. It will be further talked about at SEMTAC in January.

EMPAC

Much of this meeting talked about Ketamine use. Currently 87 services have waivers for use in pain and 84 for agitated delirium! There is unfortunately a lot of missing data in reporting-- but it appears that statewide about 17% of agitated delirium patients get intubated in hospital following ketamine (although, ?causal). This is consistent with data presented from Denver Health at 20% intubation. Seems safe in pain management-- but recommending decreased speed of admin by diluting in 50 to 100cc NS and giving over minutes to decrease psychoactive effects.

- Also discussion of history of EMPAC, its change from 'rule 500' and scope
- Lots of time on waiver reviews

EMSAC meeting

The theme of the physician section at EMSAC was cardiac arrest resuscitation. There were lectures on High performance (pit crew) resuscitation, evidence for continued use (or limiting use) of EPI, termination of resuscitation protocols and trauma arrest resuscitation.

- There was a round table discussion with medical directors from many of the agencies in the state who talked about best practices surrounding cardiac arrest resuscitation. Overall the consensus within the group was that most services are going to a highly rehearsed "pitcrew style" resuscitation that is guided by ETCO2 monitoring. Most are recommending 2-4 cycles of CPR with passive oxygenation before advanced airway. Then synchronized ventilations every 10 compressions, limiting EPI to 3 doses, precharging the defibrillator to limit pauses and using a metronome to keep on track for 100-120 compressions/min. And using monitoring devices to give feedback on the quality of the resuscitation.
- I am happy to discuss any/ all of the above recommendations with everyone. And if there is interest within the group, we could discuss how our services are measuring the quality of cardiac resuscitation provided, ways to improve assessment and education/processes for improving delivery. Given that the state is likely to start collecting cardiac arrest data in the CARES registry, it might be a good time to start looking at our own processes.

Please feel free to reach out with any questions, concerns, or ideas!

-Avery