MAC September 2024 Public Comments

Policy	Agency	Public Comment	Action
• 8068 – General Medical Complaint	• UCDMC	• My intention of adding an ALOC policy was not for the education component of adding in the list of ALOC diagnoses, it was for the interventions (airway, vascular access, IVF, narcan, etc) that medics often need to provide and have no policy to support them or to reference in their documentation. I think this would be better in a stand alone policy, but if people just want to expand the general medical complaint, then I think the components for interventions should be added from the ALOC policy draft that I submitted previously.	• SCEMSA will not be establishing a stand-alone ALOC policy. Medics should dig deeper into the causes/symptoms and how the patient is presenting, and document on the policy used. • Initiating a broad policy for “ALOC” will lead to data infidelity.
• 8026 – Respiratory Distress	• Metro MIH Paramedic	• Adult Respiratory Distress - Adding Atrovent/Ipratropium bromide into our treatment regiment. Our district has already purchased this medication regularly but only for MIH or for "shortages of albuterol". I felt that regular Duo Neb treatments started in the field would conduct better treatment for patients and provide a possible shorter disposition or even admission time frame. I have utilized this in San Joaquin with great success and feel that both medications would broncho dilate and reduce edema in different ways that would overall have better patient outcome while enroute to the hospital. I currently believe within our system of albuterol only, it sometimes exacerbates already increasing symptoms by itself when provided in multiple doses. An example of proposed changes would be like; Treatment #1- Mild Bronchospasm: 1. Albuterol 2.5 mg/3ml NS & atrovent 0.5mg/2.5ml via nebulizer with 4-6 LPM O2 x1. • I would also like to propose treatment for pediatric respiratory distress with bronchospasms/croup. As described above, our treatment regiment is very limited to our pediatric population and a leading cause to pediatric arrest is respiratory. I feel that these proposed changes would provide additional treatment options. Similar to	• Dr. Kann agrees with the clinical benefits of adding ipratropium bromide however, is this costly for our providers? • Comments regarding pediatric respiratory distress will be addressed in March 2025 when that policy is reviewed.

		the adult treatment above, i would also like to propose racemic epinephrine for severe croup emergencies. I would like to propose the below examples of a treatment regiment for mild - moderate bronchospasms as well as croup treatments. Treatment #1- Mild Bronchospasm: 1. Albuterol 2.5mg/3ml NS, via nebulizer, repeat as needed. Treatment #2- Moderate Bronchospasm: 1. Cardiac monitor. 2. Albuterol 2.5mg/3ml NS & atrovent 0.5mg/2.5ml NS via nebulizer, do not repeat atrovent administration without BHO. 3. Repeat albuterol 2.5mg/3ml NS every 5 minutes as needed. 4. Consider IV, NS, TKO. For pediatric croup an example would be; Treatment #1- Without Stridor: 1. Keep patient calm. 2. Monitor SpO2, if <94% O2 1-15 LPM via NC, NRB or blow by, titrate to 94%. Do not use humidified O2 or nebulized saline. Treatment #2- With Stridor: 1. Monitor SpO2, if <94% O2 1-15 LPM via NC or NRB or blow by, titrate to 94%. 2. Consider cardiac monitor. If HR <200 and no cardiac history: 3. 2.25% racemic epinephrine 0.5mL in 2.5 mL NS via nebulizer. OR 4. Epinephrine 2.5 mg 1:1,000 via nebulizer.	
• 7500 – MCI/Disaster Medical Service Plan	• David Buettner (Versa Care EMS)	• MCI levels should list # of patients rather than stating/describing that resources are "adequate", "impacted," or "inadequate" Level 1 - 6-25 patients Level 2 - 26-50 patients Level 3 - >50 patients Consider the following: In the event of multiple MCIs being declared, example two (2) Level 1 MCIs, now totaling >25 patients, CF shall notify SRFECC of MCI elevation to Level 2 and non-MCI Involved EMS units: Destination per CF, no direct contact with receiving hospitals. SRFECC should have/employ mechanism to notify non-911 EMS providers of same. Optional: Consider the allowance/use of commercially available triage tape	• The language in this policy is being removed and a workgroup is currently building an MCI plan that will replace it.

		systems in the event that triage tags are unavailable or conditions do allow utilization of standard triage tags. * Should SCEMSA adopt a Patient Distribution/Dispersal plans/form(s), it should be reviewed annually to allow for adjustments related to expanding/decreasing hospital capacity and/or services. ** HAZMAT MCIs (excluding trauma triage criteria in all patients) - while all primary decontamination should be performed in field per SCEMSA 8029, CF should be activated to facilitate patient distribution to hospitals controlling over-activation of decontamination teams.	
• 2512 – Designation Requirements for Administration of Naloxone by Law Enforcement	• KEM	• Please clarify the QIP program for law. Do they also write their own EMSQIP? I am concerned about putting too many obstacles in front of law to continue the great work they are doing with naloxone.	• Law Enforcement is aware of these requirements which come directly from Title 22 and is already abiding by them.
• 8031 – Non-Traumatic Cardiac Arrest	• KEM	• Shockable "at any time"? Does that follow the science? And are we sure we want a ? fine vfib to go to a SRC?	• SCEMSA recommends keeping the language of only “initial shockable rhythms” being transported to a SRC and not including “a shockable rhythm at any time”.