MAC June 2024 Public Comments

Policy	Agency	Public Comment	Action
5050 – Destination	Sac City Fire Department	"1 If it is determined, by hospital identification armband or from patient verbalization, they were transported, treated, released, refused care, or departed against medical advice from the identified Hospital within the past twelve (12) hours, and there exists no medical condition that the prehospital personnel believes is unstable, and no Special Triage Policy applies, the patient can be transported back to the identified Hospital" Would like it to read as "and no Special Triage Policy applies, the patient is highly encouraged to be transported back to the identified Hospital" Change from "can" to "highly encouraged"	OK to make the change to highly encouraged.
5050 - Destination	Cosumnes Fire	Under Transport of ALS and BLS Patients to the Emergency Department Waiting Room C.5. --> Suggest to add criteria B. to complaint of syncope, to indicate that if after 2 consecutive vital sign assessments and meets A. in both assessment cycles the patient can go to the lobby.	Agreed. OK to amend.

5050 - Destination	Naik	Transporting of ALS and BLS patients to WR Patients with ANY of the following CANNOT go to the WR -Patients with a known communicable disease such as C. Diff, TB, or other need for isolation. So ...you are saying patients with COVID or FLU if they meet the 5050 criteria would not be able to go to the WR with a mask per this policy. As this is an isolated patient in the hospital but could go to the WR if stable in my honest opinion.	Obviously not the intent. Current CDC guidelines do not call for isolation of COVID/Flu patients. These patients can be placed in the WR. Encourage masking for suspected viral illness.
9016 – Pediatric Parameters	Sac City Fire Department	My suggestion is to have a make base contact consultation for children One year and less. My reasoning for this is that it will get more eyes on the patient to help get these kids the best care possible. The BRUE protocol is so wide in definition that this will help close the gap for the field in procedure and most importantly get a physician assessment on our pediatric population less than 12 months old.	Not sure if this under the correct policy.
8062 – Behavioral Crisis/Restraint	Kaiser	Under ALS protocol, edits propose that line #5 be struck. I would argue that it should remain. It guides and defines specific re-assessment documentation during what should be considered a high-risk transport. Regular re-assessment is critical to safety and documentation of that re-assessment protects both patient and provider.	This language was moved into the BLS section under 7 and 8.

XXXX – Decreased Level of Consciousness	UCDMC	I wanted to again bring forward my request to consider a new policy for DLOC. I have had many paramedics throughout the county requesting to bring back the general DLOC protocol as they feel there are some conditions (mostly ETOH intoxication) that is no longer covered by the individualized protocols and can be quite sick requiring IV medications or even intubation and they do not feel protected. I got the old version from Dr. Mackey when he was interim last year and created this protocol. I would appreciate it coming up for consideration. I had previously sent it to Mr. Magnino and Dr. Kann, and Dr. Kann had suggested it be brought forward with some of the other protocols, June 2024 is reviewing overdose. I do not want to replace the current individualized protocols, I want to add this along with those.	This policy was broken up based on provider and MICN request. Follow consensus on reinstatement if deemed necessary.
2210 – EMR Scope of Practice	Sac City Fire	Policy A.9.d. Assist with administration of oral glucose. Who are they assisting? If it is an EMT or higher, no concerns. If it is a patient, I think that goes outside the scope of EMR. Looking at the national EMS education standards, an EMR learns about diabetic emergencies, but the medication administration is outside their scope. Just needs clarification. Policy A.13 Have no concerns. The reference in Title 22 goes to FIRST AID RESPONDER. For cleanliness, probably should not reference a first aid responder when we are discussing EMR, since EMR is not mentioned in State Regulations. Remove the reference to Title 22. The LEMSA medical director does not need special permission here since both are specifically covered in EMR education standards.	Agreed. EMSA scope of practice statement document #300 2017 page 50 states oral glucose EMT or above. Auto-injector medications are only public safety intervention – Epi, Naloxone, Atropine. Agree with Title 22 reference removal.
2103 – Off – Duty Provisions of ALS	Sac City Fire	Policy, C: Current wording: "If only Basic Life support (BLS) personnel are on scene, assistance may be provided only at the request of the Incident Commander." As our county begins to have more and more BLS only units, isn't it theoretically possible that the scene won't call for an incident commander? How would the off duty medic rendering assistance handle this?	Seems operational. BLS crew to make contact with supervisor to coordinate off-duty ALS provider intervention.

8001 – Allergic Reaction & Anaphylaxis	Sac City Fire	Can we reword (for clarity) the following: Old: Epinephrine: 1:1,000 a. 0.3 mg IM (Max dose 0.9 mg). b. May repeat in 15 minutes up to three (3) doses if symptoms persist. To Read: Epinephrine: 1:1,000 a. 0.3 mg IM b. May repeat in 15 minutes up to three (3) doses (Max 0.9 mg) if symptoms persist. The current wording makes it seem like a single dose of 0.9mg IM is the max first dose.	OK to make change.
8001 – Allergic Reaction & Anaphylaxis	Brian Morr	RE: "NOTE: EMTs who are not currently working for an ALS provider are only able to assist the patient with their OWN epinephrine auto-injector." Please consider rewording to: "All provider levels are allowed to assist the patient with any medication that is prescribed for that patient. EMTs who have received Epi autoinjector training pursuant to SCEMSA policy 2220 B 4 or possesses a CAEMSA Epinephrine Certification may administer an autoinjector that is not specifically prescribed to the patient." In the future we might have BLS agencies that have a need to administer an epi auto injector. For Example, Golden 1 center EMTs, water park personnel, rangers, etc.	I am comfortable with proposed wording. We currently have EMTs in the south County BLS agencies that administer Epi.
8038 – Shock	Sac City Fire	Protocol ALS 4. Push dose pressors are covered in the key policies already (like Sepsis, Cardiogenic, Anaphylaxis. Do we want medics to even consider using a PDP in hemorrhagic shock? Neurogenic shock? If we are going to keep this, please make it consistent with all other PDP wording If no response to titrated IV Fluids, consider Epinephrine: 0.01 mg/ml (10mcg/ml)-0.5-2 ml every 2-5 minutes (5-20mcg) IV/IO. Titrate to a minimal systolic B/P > 90 mmHg OR a total of 0.5 mg. is given. In a separate note, what does "titrate" mean? Do they give a bolus, a fast drip? For consistency, consider changing "titrate" to "administer 500cc bolus of normal saline. Reassess. May repeat up to 2000mls total if SBP remains <90"	Pull push dose language.

8038 - Shock	Brian Morr	Re: Push Dose Epi. While generally supportive the expansion of push dose epi, It should not be in this policy, or this policy needs to specify what types of shock push dose should and should not be used in. I am not sure that the use of push dose epi is appropriate for Hemorrhagic shock.	Pull push dose language.
8808 – Vascular Access	Sac City Fire	Only question is the preferred sites in Pediatric patients. I did a pretty exhaustive literature search about this. For proximal humerus, the literature discusses that this site is not a choice in infants, and should be used in children and adults only. I am guessing 8 years and up. Also, there is no choice for distal femur in children which is a large site that is easy to access. There is considerable literature about this site. Do we need to reconsider the suggested order of sites for IO in kids?	Recommend removal of proximal humerus. Add distal femur. Order: Proximal tibia Distal tibia Distal femur
8827 – 12 Lead ECG	Sac City Fire	Is there a better way to say this? "Repeat EKGs can be performed if there is a change in the patient's clinical presentation, Serial EKGs are particularly useful after obtaining ROSC following a cardiac arrest as the immediate EKG can reveal STEMI, but subsequent EKGs may normalize. but otherwise, prehospital serial EKGs are not indicated due to the high instances of false alerts." Is there evidence that serial repeat EKGs are better in ROSC, rather than a single EKG approximately 5-6 minutes post-ROSC, for which there is published evidence? Obtaining repeated EKGs is likely going to yield a lot more false positives	Language was determined here from the STEMI meeting. Review minutes. The evidence suggests EKG at 7 minutes is when STEMI pattern will normalize.

8827 – 12 Lead ECG	Cosumnes Fire	Special Considerations: C.a. this is confusing. Keep it simple and in-line with ROSC bundle. Delay 12L in ROSC until 5-10 minutes for more accurate reading.	Agree with this. Follow language from STEMI meeting.
8065 - Hemorrhage	Naik	F. states TXA is only indicated by protocol below for traumatic bleeding, epistaxis and oral bleeding. Where is the arm on the protocol for this as it currently reads if bleeding for the head and neck apply direct pressure.	TXA arm is provided.
8065 – Hemorrhage	Cosumnes Fire	Epistaxis/Oral Hemorrhage is on page one, separated from the boxes. BLS: 2. Secure Airway may be mis-leading. Please consider "ensure patent airway by suction or positioning patient in forward seating position." F indicates TXA to be given for bleeding, epistaxis and oral bleeding. In the treatment box there is no mention of TXA administration. Nor is there clear direction for epistaxis/oral bleeding in the decision tree. If the route is not specified, the medic will give it the way they know how to, 2 mg IVP not topical if that is the intention. The decision tree on page 3 is confusing at the head, neck or torso bleeding.	BLS 2 comment: Do we need to be that specific with this language? Could move NOTE: Consider base consult for TXA into ALS treatment box. We had previously agreed that we would not be overly prescriptive here as there are numerous clinical scenarios that are not easily captured in one policy statement. Austin Fire includes TXA routes and notes in their formulary document.

8031 – Non-Traumatic Cardiac Arrest	Brian Morr	• Thank you the proposed changes are a great step forward. • Aggressive push-dose epi and pacing lead to more ROSC's at SFD • If Post ROSC LOC is not increasing then intubation should be considered • As currently proposed, the average paramedic will wait to get all 1000ml NS on board before going to the next step of push dose epi. Consider: o Manage hypotension/shock ♣ SIMULTANEOUSLY complete both of the following: ♣ Normal Saline 1000ml, switch to wide open with pressure bag, if not already done. ♣ Push Dose Epinephrine 0.01 mg/ml (10mcg/ml). Dose: 0.5-2 ml every 2-5 minutes (5-20mcg). Titrate to SBP ≥ 90 mmHg. • Bring Back Lido? Seattle alternates between lido and amnio. This way we would be administering 2 different classes of antiarrhythmic to our stubborn VT/VF cases?	Agree with proposed IVF bolus and PDP use.
8031 – Non-Traumatic Cardiac Arrest	Naik	This was discussed at the STEMI meeting. The wording is to confusion. Per the STEMI meeting, one EKG that is obtained 5-10 minutes after ROSC should be obtained (8 minutes is the most optimum time.) Otherwise, the way it reads it is 3 EKGS. We only want the one obtained 5-10 minutes after ROSC as if this reads STEMI then that is the one that would be sent to the hospital. This should be reflected in the 12 Lead EKG policy 8827.13 12-Lead EKG policy should be consistent with 8031.26 and post ROSC bundle.	Policy per STEMI meeting discussion.
8031 – Non-Traumatic Cardiac Arrest	Sac City Fire	Complements!!! on limiting epinephrine to a total of 3. Suggestions: 1. Spelling of "Bundle" bottom of algorithm page 3 is misspelled 2. For Post ROSC care, how do you want them to manage hypotension? There are two choices without guidance. I realize this may be training, but just a suggestion: medical cardiac arrest is not a hypovolemia problem almost always. It's a pump problem. If possible, if you will list both, can you reverse the order? I feel the science shows that PDP is preferred and has better success.	This was addressed by Brian Morr's comment.

8031 – Non-Traumatic Cardiac Arrest	Cosumnes Fire	Suggest to changed proposed language in Post-ROSC Care ROSC Obtained: a & b: The language indicates the only scenario of apneic patient. For the spontaneously breathing patient who may have an iGel or advanced airway, it may be necessary to extubate if the patient has a gag reflex. Instead by saying "Optimize oxygenation and ventilation" this allows for the paramedic to provide what the patient needs for both the apneic and breathing ROSC patient. d. propose only 1 12L done at 5-10 min after ROSC not 3. Previous discussion regarding max dose of epi @ 3mg. Any thought to double sequential defibrillation for refractory V-Fib after 2 shocks. #1 Shock #2 Shock #3 Double Shock. End of algorithm box "Care Bundl" missing e on Bundle	End tidal CO2 measurement target is critical. We will not change this to vague language. EKG per STEMI language. Double sequential defib may be operationally difficult? Prefer 2nd anti-arrhythmic agent.