Emergency Medical Services Agency
333 Valencia St, Suite 210
San Francisco, CA 94103

Meeting Minutes
Meeting Title: EMSAC
Date/Time: August 2, 2023
Location: MS Teams

ATTENDEES: See attached roster and quorum sheet

Item	Discussions/Notes	Action /Follow up Items
Introductions - Roll Call	Review of meeting rules by new chair Cassie Medeiros. Roll call is taken and quorum requirements are fulfilled.	
Meeting Minutes	Motion to approve minutes of Q2 EMSAC by Kevin Chocker, second by Rob Smuts	Minutes approved
EMSA Announcements	Andrew Holcomb - Introduction of Somersby Jenkins, EMS Agency Certifications Specialist and Will Godwin, Epidemiologist (0.5 FTE with DPH) - Strong focus on hiring in the past year. Anticipate three more EMS Specialists starting in the next 30 days. - Agency priorities for rest of 2023: CP and Triage to Alternate Destination; EMS system ambulance availability; APOT and Diversion Workgroup; APEC; Fleet Week; EMS plan submissions John Brown - Welcome new Field Provider representatives Janelle Cortright (ALS) and Anya Morrill (BLS). - Introduction of new EMS and Disaster Medicine Fellows Lauren Friend and Bryan Fregoso	
Policy 5000-Destination	Andrew Holcomb - Changes proposed for “in custody” patients. SFGH no longer default location, with few exceptions. Motion to approve: Rob Smuts. Second: Mary Mercer.	Approved

Policy 5020-Diversion	Andrew Holcomb - Similar changes in line with the updates to Policy 5000. Will also see minor administrative updates to 5000.1 (destination chart) Motion to approve: Rob Smuts. Second: Rodney Brouhard	Approved
Policy 4001a-Vehicle Equipment and Supply List	John Brown - Addition of Adult Bougie to field supervisor equipment list. Rodney Brouhard - Echoes the public comment from Deb Palmer at SFFD on the very specific cardiac monitor requirements that exist in 4001a; potentially stifles innovation. John Brown - Open to discussing system changes. Intent was to unify the system for one QI and data collection process. Open to discussing proposal for a "next generation" cardiac monitor but want to be careful that it's a systemwide change, would likely involve a workgroup. Focusing today's discussion on the bougie addition. Motion to approve: Rob Smuts. Second: Kevin Chocker	Approved
Protocol 7.02: Oral Endotracheal Intubation	John Brown - Two changes proposed to increase successful intubation: 1. Introduction of gum elastic bougie (as discussed in 4001a) 2. Use of high flow nasal cannula oxygenation. Jeremy Lacocque - Request additional clarification in the protocol re: apneic oxygenation not replacing ventilation between intubation attempts. David Malmud - Expressed strong agreement with Dr. Lacocque. - Believe more appropriate language for bullet point 10 would be "Provide apneic oxygenation using high flow (>15 LPM) nasal canula ~~between attempts~~ **during intubation attempts** when two reliable sources of oxygen are available." Bullet point eleven should read "Provide BVM ventilation between intubation attempts". Motion to approve with language changes proposed by Dr. Malmud: Rodney Brouhard. Second: Jeremy Lacocque.	Approved

Medication 13.1: Oxygen	John Brown - changed the description of oxygen to incorporate the high flow nasal cannula oxygenation technique Motion to approve: Rodney Brouhard. Second: Kevin Chocker.	Approved
Protocol 2.04: Cardiac Arrest	John Brown - Four changes. Two to fix administrative errors/oversights and two new elements. - Two elements of the "H's and T's" have been added: **H**ypoglycemia; considering opiate overdose under **T**oxins. - Change 3: Alternate vector defibrillation (as treatment for refractory ventricular fibrillation) has been moved up in the algorithm. Recent research shows it benefits a patient earlier. This would ideally be done as a dual sequential process, but manufacturers are hesitant to allow this under warranty and it's been difficult to get a direct answer from them. Proposal is when a second defibrillator is available, as early as the 4th shock, that the second defibrillator be used to deliver that shock. We're not changing the technique, just the position of the technique in the resuscitation cycle. The earlier the alternate vector is used, the more likely it is to succeed. - Change 4: positioning patient upright (raise the head of the gurney) when transporting a patient with CPR in progress with the Lucas device. Some evidence has shown beneficial effects for neurological recovery. Kevin Chocker - Request clarification – language in the draft policy says *after* fourth shock, but explanation was 'as early as' fourth shock. - Do we need the second defibrillator to change vector? Medic can change the vector on the primary device and place a new set of pads on the patient. Is that second defibrillator required for alternate vector? John Brown - No reason not to change vector if only one defibrillator on scene at time of fourth shock. Protocol was originally written with the hopes that we'd have clearance from manufacturers for dual sequence defibrillation, which according to the research as the most effective treatment application of alternate vector. With more and more	Approved

	research coming out there will be more pressure from more systems on the manufacturers to allow for this. Kevin Chocker - Is DSED still done at The General? Cassie Medeiros - Confirmation from Doctors Silverman and Mercer in the chat Kevin Chocker - Propose changing the wording to say if shockable rhythm continues past third shock, then user can bring in the second defibrillator or just continue to use their own defibrillator, if changing the shock vector. Josh Nultemeier - Concur with changes proposed by Chief Chocker. - Would like to see us go back to regular AHA ACLS guidelines and not confuse everyone with San Francisco treatment guidelines. John Brown - We should be careful to not contradict AHA recommendations. We have presented some of the evidence around this at some specialty meetings (at STAR and EMS journal clubs); need to be sensitive to these changes. Also want to see us improve the evaluation of our outcomes in cardiac arrest treatment – this one of the tasks for the epidemiologist that's being onboarded. - Want the protocol language to give maximum flexibility to the providers on scene whilst being clear that we are not doing dual sequence defibrillation. Cassie Medeiros - Language proposed by Dr Silverman in the chat: "If a shockable rhythm continues past the third shock, attach a second set of defibrillator pads in a chest position to provide alternate vector defibrillation and switch vectors, or attach a second defibrillator with a second set of defibrillator pads as soon as one is available to provide alternate vector defibrillation." Motion to approve with language changes proposed by Dr. Silverman: Kevin Chocker. Second: Rodney Brouhard	

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Protocol 2.08: Dysrhythmia: Tachycardia	John Brown - Removal of language around morphine. - Standardizing the use of midazolam for sedation and removing the requirement to contact base hospital Motion to approve: Kevin Chocker. Second: Josh Nultemeier	Approved
Medication: Adenosine	Elaina Gunn - Clarified some language re: use of adenosine as a substitute for cardioversion, or if cardioversion fails clarified the preferred IV route. David Malmud - Propose striking the third indication "unstable, wide tachyarrhythmias, if cardioversion fails" (should be doing amiodarone, not adenosine) Motion to approve (striking the unstable wide tachyarrhythmia line): Rod Brouhard. Second: Kevin Chocker	Approved
Medication: Atropine	Elaina Gunn - Clarifying language added to the adult and pediatric doses around nerve agent exposure; minor formatting changes. Motion to approve (striking the unstable wide tachyarrhythmia line): Rod Brouhard. Second: Kevin Chocker	Approved
Medication: Diphenhydramine	Elaina Gunn - Clarified language re: the action of the medication; changed the contraindication for pregnant or lactating females from a full to a relative contraindication; added the potentiation of other CNS depressants to side effects. - We're starting to link our med sheets to a table format, so we switched to a table format here. - Struck "IM preferred if perfusing well" at public comment request. Motion to approve: Kevin Chocker. Second: Rodney Brouhard	Approved

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Medication: Midazolam	Elaina Gunn - Clarification to modify the dose for sedation when administered IM to adults. Motion to approve: Kevin Chocker. Second: Jeremy Lacocque	Approved
Medication: Ondansetron	Elaina Gunn - Adding prolonged QT to contraindication - Changes after public comment around ODT dosing for patients based around age or weight. Jeremy Lacocque - Suggest that we either use weight or we use age; proposed language is confused. - Giving half a tab is logistically difficult – the tabs are small, disintegrate easily and we don't carry pill splitters. John Brown - Admit logistically that providers are in a different arena than the ED. Language was suggested to remain parallel with hospital language, open to better language if there's a suggestion. Jeremy Lacocque - No alternate suggestion. Logistics are a separate issue, reasonable to give the option. Curtis Geier: - Recommend the language "<6 months old or <8kg" under contraindications. Cassandra Medeiros - Dr Silverman has a comment in the chat. "To clarify, we're requiring an EKG on all patients before Zofran to check the QT interval" John Brown - Not the intent. If an EKG record is available or the provider knows (pretty rare the patient would know their QT interval is prolonged), but if that information was available we would utilize it and not administer the medication. Curtis Geier: - Correct. It is not the standard to obtain an ECG prior to administration of this drug.	Approved

	Motion to approve with proposed formatting changes to improve clarity: Kevin Chocker. Second: Josh Nultemeier.	
Round Table Discussion	Andrew Holcomb -Thank you to our new chair Cassie for a great job today.	
Public Comment	(none)	
Meeting Adjourned	Motion to adjourn: Rodney Brouhard. Second: Kevin Chocker	Adjourned