October 2024 EMSAC Public Comments and Medical Director Responses

Protocol/Policy	Name of Commenter	Public Comments	EMSA/Med Director Responses
7.01 Airway Management	Drew Barnekoff on behalf of Jeremy-SFFD	I would suggest: "VL may also be used for mechanical confirmation of ETT placement." I wouldn't limit it to just EtCO2 not working, because it can/should be used for every airway, not just ones where EtCo2 is problematic.	Agree
7.02 ETI		NO COMMENTS	
Policy 5000-Destination	Eric Silverman-King American	Please explain rationale for this change. This will decrease the number of potential receiving hospitals for pregnant patients (<20 weeks GA) from 12 to 4. This change will likely increase APOT times and diversion for those 4 hospitals (which includes the trauma center), as well as the wait time and LOS for pregnant patient who are less than 20 weeks GA (who can usually be cared for by an emergency physician without OB/GYN consultation at a non-OB specialty hospital).	After speaking with OB/GYN specialist at UCMB- this was their recommendation. The number of anticipated patients is low, EMSA will continue to track via EMSC (EG). Open to discuss further
	Ben Tapparo-King American	5.1. Our current basis for EMS alert is a half step to where it needs to be. It does not address the gross offender for extended triage times for our units, UCSF. From King's metrics, there's no clear correlation between EMS alert and UCSF triage times. EMS alert does not account for the current load to the ER as a whole, only as it pertains to ambulances. UCSF is an outlier to hospital offload turnaround times with last month's data showing UCSF had 25-45% longer wait times than any other hospital, Kings avg offload time at UCSF was 1 hour (2x that of policy 4000.1) with a regular wait time in excess of 2 hours. I'm constantly checking EMS alert to see if this is reflected and it is often not. It appears nod data from the UCSF's "intake board" is being fed back into our EMS alert calculation. There has to be a better way to proactively obtain current hospital metrics when considering EMS alert. 6.11.6 PES has been closed for 4 years. I think it's time our protocols reflect this or we clarify a new process that is in collaboration with PES.	Reviewed - Thank you for your feedback. Improvements to EMS Alert, including a future state with near-real time hospital data is under active discussion. EMS Alert is only a reflection of ambulance volume and does not consider other aspects of an impacted ED (type of patient, length of stay, walk-ins, and in-patient volume) due to the availability of hospital data at the moment. The EMSA continues to collaborate with ZSFG on utilization of PES, recognizing the importance of BH patients transported from the field.
	Cassi Rashleger-King American	Generally: add in hyperlinks, they are time saving and extremely useful. 6.10 This reads like every pregnant pt has to go to an OB center regardless of their complaint. Maybe this can be rephrased to something like, "with a pregnancy-related complaint" or "if complaint is unrelated to their pregnancy and would not otherwise cause detriment…" 6.11.6 PES has been closed since 2020, are there plans for this to reopen for field personnel?	Agree, will update hyperlinks on final document. For 6.10, reviewed comment. For 6.11, see above comment.
	Antenor Molloy-SFFD	Language should be added to mirror preeclampsia and eclampsia, it should include 20 weeks gestational age to 6 weeks postpartum. All recent updates as it relates to OB include the language of treating OB patients up to 6 weeks postpartum. "Pregnant and recently pregnant patients up to six weeks postpartum…"	Under review (EG to email specialty 6 weeks postpartum)
	Drew Barnekoff on behalf of Jeremy-SFFD	I think the easiest thing we can do to help this policy is to include a line that says: "We recognize some patients not meeting the above criteria may still receive specialty care at Mission Bay. In those cases, you may transport to Mission Bay with base physician approval. Additionally, some patients who are >20 weeks gestational age with non-obstetric related complaints may be best treated at a facility with both obstetric and adult general receiving capabilities."	The EMSA will meet with UCSF MB and BH to discuss further for future revision. Agree with second comment regarding best interest of patient with multiple complaints. Proposed Language: if multiple complaints, consider transport to a center that has multi-specialty care.
7.19 Cardioversion **NEW**		NO COMMENTS	
		For 2nd bullet, compressions, I would say "apply EtCO2. If low, reassess compression quality and airway."	Agree

2.04 Cardiac Arrest	Drew Barnekoff on behalf of Jeremy-SFFD	The bullet points go compressions, airway, AED, meds, but the flowchart goes AED, airway, CPR. I would clarify the intended order.	Top of flowchart is start CPR, so I think this is addressed.
		Instead of capnography being separate from advanced airway, just say “consider advanced airway with capnography.”	Agree
	Antenor Molloy-SFFD	In flow chart- It says to discontinue epi after four rounds. If we get ROSC and then the patient and rearrests , do we start over with epi, or is the max does of epi 4mg total?	This was discussed at STAR-Med directors and Pharmacy decided on cumulative 4 doses IVP durring arrest and does not mean it's the "max dose" of Epi. In ROSC continue Epi infusion PRN
		In flow chart- "comments/options" box: remove "comments"; change numbers to bullet points since they're not suppose to be in order. This box should be identical to "options" box on page 6	Agree
		Protocol- On page 6 "options": remove numbers and make bullet points	Agree
		Protocol- AED/Defib section under exception: Clarification on pad placement in regards to "chest position"	Updating to include anterior posterior pad placement for initial defibrilations
		In flow chart- First blue box add "immediate shock if EMS witnesses vfib/v/tach" to match notes above	The first box says apply AED and then the flow chart goes to rhythm assessment. Maybe the provide ventilations is confusing? Could change to something like "one provider Start CPR and provide ventilations, second provider applies AED/defib" to clarify
		In flow chart- blue box in lower right: box which lists epinephrine and amiodarone; place header on box and name the box "medications"	Agree
	Cassi Rashleger-King American	This flowchart looks chaotic and cramped. If you’re pulling this up on a call as a quick reference, it takes a while to find the answer you’re looking for. It might be easier to model ACLS in that the flowchart is on one side and the additional clarification is on the other. The old protocol wasn’t perfect but it was simple and easy to interpret, and I prefer that over this.	Reviewed
	Eric Silverman-King American	add section for "hypokalemia" since it is listed at top (#5) of "reversible causes" - while we do not have a protocol addressing this condition, it may be appropriate to add to "consider early transport" section with tamponade/thrombosis.	Agree
2.19 LVAD **NEW-ISH**	Antenor Molloy-SFFD	We recommend providing phone numbers to LVAD centers	Agree
	Eric Silverman-King American	change recommendation to bring "extra batteries and battery charger if available"	Agree
	Drew Barnekoff on behalf of Jeremy-SFFD	Typo for TdP “over 10 minutes over 10 minutes” for mag	Agree
		For midazolam, it’s just sitting there with no indication. I would add more context and have it just be a floating box. “For conscious patients getting cardioverted, consider midazolam”	Agree
		I think these “separate” protocols should point to each other. In other words, If QRS >.12, go to [wide] and vise versa.	Agree
		“Adenosine may be considered for cardioversion” should be “midazolam may be considered”. Adenosine should be if cardioversion fails.	Agree
		You don’t need “narrow QRS and irregular” because the whole protocol is narrow. Don’t need to say “yes, but symptomatic” when you can just say “yes”	Agree

2.08 Tachycardia	Antenor Molloy-SFFD	In protocol- We recommend including the joules dosage in the protocol as well as the joules dosage in the flow chart	Agree
	Cassi Rashleger-King American	Under BLS treatment, “call for ALS resource if pt is symptomatic, or HR >150BPM” The protocol used to say you could substitute Adenosine for cardioversion in pts that were unstable with narrow and regular rhythms. I do think there are pts where this would be appropriate. If someone is GCS15 and hypotensive without any other symptoms, attempting an IV and fluids then moving to adenosine may be appropriate without compromising the pt’s condition.	Reviewed- this is should be addressed via training
	Eric Silverman-King American	-Recommend changing AHA disclaimer to be same as new 2.04 cardiac arrest ACLS disclaimer. -Protocol says that 12-lead should not delay treatment for symptomatic patients, however it also says that adenosine should not be given to patients in 2nd/3rd degree heart block, sick sinus, or WPW. These conditions are likely only identified on 12-lead ECG. -Since hemodynamic instability has a defined heart rate (>150), recommend also including age-based blood pressures to define "hypotension" (or at least <90 as noted in cardioversion protocol) -Missing "regular" from "Hemodynamically Unstable: Narrow or Wide" heading. -Missing "regular" from "If unstable and wide and synchronized cardioversion fails:" heading.	Agree on all points
14.1 Versed		NO COMMENTS	