Draft Policy Public Comments Received: 01/05 - 02/04/2024

P-405 Communications Failure		
DATE	**NAME**	**PUBLIC COMMENT**
2/4/2024	Christopher Kahn	I It seems contradictory to have a policy predicated on system failure to require something to happen “without fail.” The specific purpose should be to create policy that minimizes the potential for complete communications failure by providing structure and mitigation measures, rather than “ensur[ing]… without fail” that communications which have already failed do not fail. III As noted in a previous round of comments, while it is understood that the intent of the policy is to provide actions to be taken in case of equipment failure, the actual use of the policy is for system overload. This is explicitly addressed in the policy, so it should be included here in the definition of what the policy addresses.

2/4/2024	Christopher Kahn (Cont.)	IV.A Thank you for proposing that BHOs be available for use during times of communications failure. There are some BHPOs that are potentially life-saving (as discussed in a prior round of comments) that are still excluded; it may be appropriate to discuss these at EMCC to see if there is consensus that some should also be specifically included in this policy. IV. B Please modify the first sentence to read, “In each instance where assessments, treatments, or procedures are performed in accordance with Section A of this policy, if voice contact with a base hospital is able to be made prior to arrival at the receiving facility, the EMS team who performed such procedures shall promptly make a verbal report to the contacted base hospital. This avoids confusion regarding (a) which base hospital is the “contacted” base when no base hospital was contacted; (b) implying that a report should be made to the base hospital for a patient who has already been received at a hospital, at which point no medical direction is required as base hospitals do not currently provide medical direction for patients at other facilities and no facility notification is required as the patient is already at the receiving facility. The only instance where this sentence should be operative is if a base hospital initially could not be reached, but later could be reached while the patient is still being transported. Additionally, this section does not state who should be completing the online form, although presumably it is a member of the EMS provider team. Finally, although perhaps this is assumed under the “assessments” term, the policy should clarify whether a P-405A form should be completed for AMAs and releases that would normally require base hospital contact under S-415.

2/4/2024	Christopher Kahn (Cont.)	V. A. 3 If an emergency communications center is going to be used as a message delivery service, they should contact the receiving facility directly rather than a base hospital. No medical direction can be provided via the emergency communications center, which will not have capacity to relay messages back and forth between crews and base hospitals. Additionally, the base hospitals will already be too busy to manage this additional communications channel. The clear preference, then, is to contact the receiving facility directly. V. A. 5 Some non-LEMSIS agencies also have the capacity to upload ePCRs via HIE/SAFR if hospitals choose to allow use of those resources. Hospitals should be encouraged to uniformly adopt/allow HIE/SAFR transmissions. Also, while it may not need to be stated in policy, it should be understood that all ePCRs uploaded during transport will necessarily be incomplete.

Draft Policy Public Comments Received: 11/20 - 12/20/2023

P-405 Communications Failure		
DATE	**NAME**	**PUBLIC COMMENT**
12/7/2023	John McCormack	This policy needs to be less restrictive, not more so. I don't mind the change of using only SO/BHO protocols since any truly acute patient will have report done anyway but this protocol is largely used when the bases are overwhelmed with total radio traffic for minor status patients. This policy would be better fixed by allowing very brief or no radio contact for bls and minor status als patients
12/19/2023	Don Sullivan	if the agency is on LEMSIS there is no need for 405A form to be filled out. PCR is available for to both Base and Receiving ED.

12/19/2023	Andrew Pederson	Drafting an extra form and requiring crews to document communication failure via this form is an unnecessary step and will likely get poor compliance from already overworked overstressed personnel. The EPCRs are already accessible to the county and comms failure can be tracked from there by adding or utilizing a few click options on the chart. Additionally, submitting electronically seems like vague instructions and burdens the crews with the additional task.
12/19/2023	Shelby Costa	The events of communication failures are becoming more frequent for myself personally. I believe that attempting to make contact with the base hospital via phone is not going to make a difference- as the bases are either already busy taking other reports, or somehow otherwise unavailable to take our report. Changing to having a radio or phone contact with the receiving hospital would be much more effective and efficient- including when utilizing the communications center to make contact.

12/20/2023	Christopher Kahn	I While the five items listed here are worthwhile, the key purpose of a communications failure policy is to ensure seamless delivery of high-quality patient care pending establishment of base hospital contact. Please include this – perhaps as the lead item – and evaluate the remainder of the policy with this perspective in mind. III This definition ignores the most common reason for a communications failure, which is that you simply cannot reach a base hospital despite good faith attempts to do so. This is explicitly addressed elsewhere in the policy and should be included here as well. Consider the following revision: A situation where EMS personnel are unable to contact a base hospital because of radio or cellular signal weakness, equipment failure (e.g., battery failed, antenna broken), inability to access the radio system with a 'system busy' tone or message, high radio call volume, or inability to maintain understandable voice contact. IV.A Please correct "physician" in the second line (first sentence) to "base hospital physician", unless the intent is that other physicians are considered appropriate contacts for medical direction. This could be considered a reasonable option if online medical direction is in fact emergently needed and no base hospital is available to provide it, but would also require modification of P-403 to explicitly allow it. Our agency has previously provided your office with draft policy language authorizing physician medical direction outside of the base hospital system and can do so again if you would like to pursue this option. Adding BHO is an excellent improvement over the current version of the policy! Unfortunately, it still leaves out some important things. What those things are will depend on protocol updates, but this certainly leaves out all BHPOs.

12/20/2023	Christopher Kahn (Cont.)	That means that, under current protocol, EMS providers: • can't access a dialysis graft/fistula to provide immediately lifesaving treatment • can't give any pain medications to patients with isolated head injury, acute onset severe headache, drug/EtOH intoxication, or suspected active labor. For children, this also prohibits analgesia of all kinds for any pediatric trauma with a GCS <15. • can't do synchronized cardioversion for unstable pediatric SVT • can't give antiarrhythmics for stable pediatric VT (although this particular BHPO is less of a concern) • can't do synchronized cardioversion for unstable pediatric VT (or give midazolam before that) • can't give push-dose epinephrine to pediatric ROSC patients • can't give antiarrhythmics for recurrent AICD firing in pediatric patients • can't pronounce death in any patient outside of the asystole TOR, which is likely appropriate but will result in "no-notice" arrival of patients who are clearly deceased but are being futilely transported in CPR status. Hospitals may find this problematic. Item IV.A only requires "reasonable attempts to contact more than one Base Hospital", but item V.A imposes many more requirements. These should be consistent. As discussed below, the items listed in V.B are unreasonable to expect and impractical to perform, so the language in IV.A – "reasonable attempts to contact more than one Base Hospital" – is preferred. IV.B requires that EMS providers make a report to the contacted base hospital when they couldn't contact a base hospital. When no base hospital is contacted, which of the seven base hospitals they didn't successfully contact is considered to be the one they contacted?

12/20/2023	Christopher Kahn (Cont.)	Further, if the base hospital could have been “immediately” contacted, then there would not be a communications failure, and this policy would not apply. Perhaps this should be amended to “as soon as feasible after the patient’s care has been transferred to the receiving facility?” Alternatively, if the patient has already been transported and turned over to the receiving facility, and a P-405A is already going to be completed, perhaps the verbal report should be removed entirely as it cannot impact patient care and will place further burden on an already overtaxed system. The first sentence of IV.B should be amended to read: “… in accordance with Section A of this policy and where base hospital contact is required under S-415, …”. Additionally, it may be helpful to clarify whether AMAs and releases that would normally require base hospital contact under S-415 require completion of P-405A. V.A: It is not only unreasonable to require EMS providers to do all five of these items, but it will require that the EMS provider cease caring for the patient to do so. This is not acceptable for a patient-centered care system. It will also place significant additional strain on the communications system that is already so overburdened at the time this policy comes into effect that it absolutely cannot handle increased demands. While these are all reasonable things to attempt if and only if they are appropriate for the context of the transport time, patient acuity, and need for online medical direction, it is NOT reasonable to expect all of them to happen in every case. There are also logistical issues which will cause these requirements to be ineffective in some circumstances.

12/20/2023	Christopher Kahn (Cont.)	It would be highly preferable to list these as options/examples of "reasonable attempts" to make contact rather than using this prescriptive "EMS providers SHALL" (emphasis added) language. Fortunately, we do have a QA/QI system in place that can address whether attempts were or were not reasonable should the question arise. More specifically: V.A.1.b: Not all EMS providers have a company-provided mobile phone, and many provider agencies prohibit use of personal electronics (including mobile phones) while on shift. This language mandates that EMS providers have access to a mobile phone during a shift, which will require that employers either (a) purchase and maintain mobile phones for all on-shift personnel or (b) pay EMS providers for a reasonable percentage of their mobile phone expenses per the "necessary expenditures or losses incurred by the employee in direct consequence of the discharge of his or her duties" clause of California Labor Code §2802. This additional expense could negatively affect the availability of EMS personnel to our system if this causes EMS provider agencies to stop doing business in our region. Requiring use of a mobile phone at the scene of an emergency or during transport to the hospital also increases the risk that an EMS provider could be accused of violating California Penal Code §647.9 (photography of a deceased person by first responder); even though the provider would not be in violation of this law by attempting base hospital contact, defense against accusations results in financial and emotional injury to those accused and their employers. Another significant problem with the use of mobile phones to contact base hospitals is that MICNs are already managing three radio channels in addition to at least one phone line.

12/20/2023	Christopher Kahn (Cont.)	If they are too busy to take a report on the radio, then they are too busy to take a report on the phone. Unfortunately, while answering the phone – this always takes precedence over radio reports as a phone call could signify an incoming patient that the MICN must be aware of – the MICN is unable to focus on any of the radio channels. This often results in the EMS provider on the radio (who is not aware that the MICN is on the phone instead of listening to the radio report) having to repeat significant portions of their report, lengthening the total time on the radio, increasing the overall system burden, and causing a cascading chain of further communications failures. This also applies to emergency communications centers calling (V.A.1.c) and use of BLS radio for communication (V.A.1.d). V.A.1.c: Personnel at emergency communications centers (ECCs) are generally non-medical personnel who are not trained in how to give radio reports. They will not be able to provide all the details the MICNs generally ask for the purpose of filling out their base hospital reports; this policy revision specifies only a few required items, but this has not resulted in only those few questions being asked on prior versions of "abbreviated" or "limited" report policies. This will result in either: (a) MICNs being frustrated that they cannot complete their reports as they wish, or (b) ECCs having to relay communications between the MICN and the field EMS provider. Option (b) in turn results in not only more time that the MICN is unavailable for other reports due to the delay in transmitting messages through a go-between, causing further communications failure, but also increases the potential for miscommunication due to the go-between not being fluent in medical terminology.

12/20/2023	Christopher Kahn (Cont.)	It also causes ECC personnel to be unavailable for other critical tasks such as answering 9-1-1 calls, dispatching units, providing pre-arrival CPR instructions over the telephone, communicating critical safety information to personnel involved in complex fireground, rescue, and hazardous materials operations, and repositioning apparatus to ensure availability at a time of high system stress (which is why the communications failure occurred in the first place). If an ECC is going to serve as a go-between, it is extremely important that all parties understand that the information will be very limited as suggested in this policy revision (acuity and destination, although age/gender may also be of value for identification purposes). The ECC should also contact the receiving facility directly rather than a base hospital, as the base hospitals are already unable to accept the additional communication. V.A.1.d: If the MICN is too busy to accept a call on the ALS channels, they are too busy to accept a call on the BLS channel. It is encouraging that this policy revision specifically states that the "receiving hospital" should be contacted rather than the "base hospital", and this should be the expectation in the ECC contact option (V.A.1.c) as well. V.A.1.e: Requiring that a full patient care report be written and uploaded "prior to arrival" interferes with patient care. It is not good policy to mandate that EMS providers refrain from caring for their patients so they can complete paperwork, nor to mandate that an ambulance en route to a hospital pull over and stop for whatever length of time is required to complete a fairly lengthy report "prior to arrival."

12/20/2023	Christopher Kahn (Cont.)	While it may be feasible to complete a report prior to arrival in some circumstances involving stable patients with no need for EMS intervention – a category of patient that should not require online medical direction contact at any time regardless of communications system status – this is dangerous to patients who are unstable. This item alone could serve as an incentive for EMS provider agencies to abandon the use of the LEMSIS ePCR platform so their personnel will not be placed in this untenable position.
12/21/2023	Lynne Seabloom	It appears that the policy will focus on equipment failures and not that the radio traffic is so busy medics can't get access to a MICN. The original intent of this policy was focused and should remain on equipment failure of the comms systems. Also, agencies document all their care so data interface of ePCR data from the agency to the county needs to be the priority so the county will have access to all care provided, included care unable to be verbalized over the radio.