Sacramento County
Department of Health and Human Services - Emergency Medical Services Agency (SCEMSA)
Joint Medical Advisory (MAC)/Operational Advisory (OAC) Committees
9616 Micron Ave. Suite 960
Sacramento, CA. 95827
September 10, 2020

Due to COVID-19 this meeting was conducted via ZOOM

Facilitator: Hernando Garzon, M.D. SCEMSA Medical Director
David Magnino, EMS Administrator
Scribe: Kristin Bianco, EMS Specialist II

Meeting Attendees:

Agency:	Representative:	Agency:	Representative:
Mercy San Juan/American River College/AlphaOne Ambulance	Nathan Beckerman, MD	Sacramento City Fire Department	Brian Pedro
UC Davis Medical Center (UCDMC)	John Rose, MD	Sacramento City Fire Department	Rob Walters
American Medical Response	Jack Wood, DO	Folsom City Fire	Mark Piacentini
Fire and Rescue Training Authority	Cristy Jorgensen	Mercy General/Methodist	Dave Haller
AlphaOne Ambulance	Matthew Burruel	TLC EMS Ambulance	Sean Pfeifer
UC Davis Medical Center (UCDMC)	David Buettner, RN	Falck Ambulance	Adam Blitz
Cosumnes Fire District	Jim Bugai	American Medical Response	Dennis Carter
Cosumnes Fire District	Julie Carrington, RN	Medic Ambulance	Mark Mendenhall
American Medical Response	Daniel Iniquez	Norcal Ambulance	Anthony Gallardo
Norcal Ambulance	Anastasia Pieda	Sutter Health Hospital, Sacramento	Jen Denno
Mercy San Juan	Paula Green, RN	Sacramento Metropolitan Fire Department	Barbara Law
Falck Ambulance	Jared Roberts	Sacramento Metropolitan Fire Department	Brian Benton
Life Assist	Becky Rowe	Sacramento Metropolitan Fire Department	David Sutton
Sutter Roseville Medical Center	Debbie Madding, RN	Sacramento Metropolitan Fire Department	Cindy Hamilton
Portola	Troy Biell	Sacramento Metropolitan Fire Department	Ben Cargile
SCEMSA	Dr. Hernando Garzon, EMS Medical Director	SCEMSA	David Magnino, EMS Administrator
SCEMSA	Ben Merin, EMS Coordinator	SCEMSA	Dorthy Rodriguez
SCEMSA	Kathy Ivy	SCEMSA	Kristin Bianco

September 10, 2020 Meeting Agenda can be located at:
https://dhs.saccounty.net/PRI/EMS/Pages/Committees/MAC-OAC/MAC-OAC%20Meetings%20in%202020/December-10%2c-2020-MACOAC.aspx

Topic	Discussion	Action Item
Welcome and Introductions: 9:00 am	**Dr. Garzon-** Zoom has a window where we can see the participants so we will forgo introductions.	
Public Comments: None	None	
Agenda Review: No Minutes to Review	No Minutes to review. June meeting canceled. The meeting in March, was discussion on Covid related policies/procedures and EMS safety. No EMS policies were discussed so there are no minutes to approve.	
Chairman's Report: APOT Report Quality Improvement Update Dashboards Core Measures	**-Dr. Garzon- APOT Reports** done by Dorthy Rodriguez. The key thing is you will see the same graphs you have been looking at for wall times. These are the two-State wall time Measures. We have been looking at these now for over a year and the typical trends with the winter bumps that we see with increased wall times. You can see as a system we are still not hitting 90% of runs with transfer of care under 20 minutes. This is concerning because we are getting an early seasonal bump. Even though EMS traffic, and hospital census are at expected levels for August and September ~~levels~~, we are not seeing the business yet of a winter surge but the wall times have increased significantly. I think Emergency Department operations and flow are still very impacted by COVID. Many hospitals have alternate triage areas, are limiting the number of patients in hall beds, waiting room chairs in order to accommodate for COVID protocols and that has created a significant delay in throughput. APOT times are shown just for the month of August, the hospitals are in alphabetical order. It is concerning to see numbers higher than usual. We have been looking at a new third metric to track for wall times. It is being called "Excess Wall Time". It is essentially adding up all of ~~the~~ wall times above the 20-minute state target. There is a significant impact to the EMS system. We take those minutes and divide by 60 to get a total of excess hours of wall time. We are going to be looking at this and publishing it by agency and by emergency department. Clearly for both, the number of transports, and the number of received are going to affect the total numbers here. This is the total number of excess hours spent on the wall above 20 minutes trended and you can see how significant it is. Again, this is going to follow the pattern of the APOT 1 and APOT 2. There is a concerning rise in July and August of this year	PowerPoint attached to minutes

	compared to last year. This is a comparison by hospital, so you can see the hospitals excess hours for July in red and the excess hours for wall times for August. This depends on the ED ambulance traffic received and hospitals that receive more ambulances are going to have more cumulative wall time minutes overall. I think we will show this metric in the future in comparison with number of transports so you can see what the wall times hours are. Each ALS provider does a different number of transports. The entire pie here is all the transports done in Sacramento County. You can see by the key on the right, the percentage of those transports that are done by each individual agency. -Sacramento Metropolitian Fire Department (SMFD) and Sacramento City Fire Department (SFD) have the lions share of the ambulance transports with, smaller portions going to other agencies, so that has to be taken into consideration. The next slide is the number of wall time hours by agency. With the number of transports being so much larger for SMFD and SFD, their total of excess wall times are larger. The excess wall times in hospitals have significant impact in Human Resource and cost for EMS agencies when they are waiting literally hundreds of hours a month on the wall. This is the first time we are showing this data. This will be shared with Fire Chiefs, EMS Chiefs and hospital representatives. I think in the ongoing conversations about wall times and what happens in the system, this is just one more metric to inform that discussion. Daniel Iniquez-Can we get this report emailed to the group Dr. Garzon-Kathy Ivy will send out that report. **-QI Report:** We have received a number of QI Plans from ALS Providers that is a requirement of our system that every agency submit a yearly QI Plan. Dorthy has done a tremendous amount of work based on our QI policy and what is needed in the QI Plan. We have looked at and are trying to create a more objective scoring system to review those plans and make sure they include all of the things that they are supposed to include based on the QI Policy. **-Jennifer Denno-**One of my charge nurses mentioned that we had about 20 psych patients come in within two hours and a couple of the rigs we had already seen within that two hours, and we asked why they kept coming to us when they knew we were already impacted. They said there is an old Policy that they can only bring Psych patients to UC Davis and SMCS. I would like to somehow get the word out to the agencies that, that policy does not exist anymore. **-Dr. Garzon-** There is no policy that states that. We track the number of Psych Holds per hospital, although we have not looked at EMS Psych transports specifically for about a year, but I think we are sharing the wealth of Psych patients fairly well within the	PowerPoint attached to minutes. Dorthy Rodriguez sent out report to providers while at meeting.

	system. When I looked at this Data, I actually looked at Behavioral Health transports, Because UC Davis had a question about it. We ran numbers about a year ago and showed a fairly even distribution of Psych patients to all of the Emergency Departments based on EMS transports. **-Jennifer Denno-** Can we look at those numbers again? **-Dr. Garzon-**Yes. That is a fairly easy number to run to look at Behavioral Health by transports by hospital and we will send that information out relative to the total numbers. I should mention that I do think that's probably another cause of the delays that we are seeing. In addition to all of the modifications for COVID that are slowing throughput in most Emergency Departments because most Psych patients have to get COVID tested before they get placed. I think hospitals are having an increased burden of Psych holds which of course is also affecting through put for other patients. Returning back to QI, between Dorthy and myself, we came up with a templetated scoring sheet for QI Plans. The groupings between personnel equipment and supplies based on what is in the QI Plan and the policy. These are things that should be included. We will go through each of the plans that were submitted and come up with a raw score so we can give each agency feedback, examples include: • plan looks great. • plan is missing X, Y, Z. This allows a slightly more objective way to give each agency feedback about their QI Plans. Just so you know, one of the scoring points is submitting your plan on time. Covid update from the EMS side, I have sent some of this information out regularly before and most of you are probably tracking it. Statewide and in Sacramento, we have been fortunate to see a decrease in total number of new cases and total hospitalizations of COVID patients since July since the re-imposition of closures of bars and restaurants and all of those other measures. Projecting forward, there is concern among the Public Health community that with a combination of influenza (flu) season coming in the Fall and Winter, many experts are suggesting that there will be an increase in Flu and COVID resurgence again in the Fall, once the warmer weather dies down. I think what we are experiencing in low COVID numbers will probably go away and we may have another surge in the Fall so we have to prepare for that. In Sacramento-we're just under 20,000 cases. Sacramento is eighth in the in the state in terms of number of cases. In follow-ups with the COVID conversation, we have been tracking the five primary impressions that are respiratory related: • Cold and Flu symptoms	QI Scoring sheet sent to providers

	• Difficulty breathing calls The green line is the 2019 and we started matching that. When COVID first had it's initial "Bump" around week 12 or 13 in Sacramento is when we started monitoring this, because people started staying home, stopped going to the Emergency Department, EMS and Emergency Department traffic decreased. We actually saw a decrease in the count of cases. 2020, is the blue line and you can see at about week 13, which I think is sometime in April, you can count your weeks, we saw a decrease. Then week 25, which is in June, after people had started to go out and the State moved to Stage 2, we saw an increased number in the calls and then fortunately with the decrease in COVID cases we have seen, there has been a drop in the last couple of weeks. So, we will keep monitoring this and presenting it to this group. Core Measures. I just want to comment that we are still working on those reports. The new Core Measure definitions came out just 3-4 weeks ago, and we are still working on creating the 2019 Core Measure Report. Last item on the Chairman's report is the use of masks or respirators with exhaust valves. I want to make a comment on this because one of the hospitals brought it up and I think a number of EMS Agencies are using these face masks, surgical masks or N95's with a valve. The valve is meant to make the breathing more comfortable for the wearer, but because the valve can let out particles and other things, you lose the safety for the person who is close to the wearer of the mask with a valve. So for patient's safety in an ambulance, the safety of family members or the hospital staff when they drop the patient off any medic that is using a mask with a valve should cover over that with a surgical mask as well. That letter was sent out a couple of days ago to the entire MAC/OAC. **-Scott Clark-** We just wanted to comment that we have a hard time fit testing and keeping masks in stock right now. Especially our P100 and our N100's. We do a quantitative fit test to protect our personnel and we are transporting COVID positive patients in our ambulances. I really feel it is inappropriate for anybody to tell us what type of masks to wear to protect our personnel. If a hospital has a big objection to that when we arrive, we feel that they should provide the mask to put over it, and also everyone else is wearing some type of mask to protect themselves at the same time. It seems a little absurd to be honest. We are using the best masks we can to protect our personnel, so I wanted to discuss that and share that with you and get some opinions. **-Dr. Garzon-** Scott there is obviously no problem for the wearer to wear a mask with a valve, as you are saying, it is fit tested and appropriate. But again, OSHA and CDC	PowerPoint attached to minutes showing maps and data.

	information indicate that those masks do not provide protection to the other people in the room, whether it is family or a patient in a household or the hospital staff. So the issue that I would have with the hospital providing you a surgical mask to wear over a N95 is that is doesn't protect the patient or the family members in the room so that is part of the reason to wear a mask as well. The masking mandate by the Governor came from California Public Health and the idea behind that is to protect others more so than yourself. I think there's a health care reason obviously N95's provide the respiratory protection to the wearer in the presence of a COVID patient, but the whole concept of masking is also to protect others as well. I work with a number of Physicians who wear N95 masks and to preserve their healthcare we have the re-use and the extended use to maximize use of limited supplies. Many of my colleagues wear a surgical mask over the N95 so it doesn't contaminate the N95 and can wear it not just all day, but multiple days they will use the same N95 mask. We are happy to discuss with Ben and Dave Magnino and the MHOAC if you're short on surgical mask supplies we can make requests through the state to get surgical masks for you to use to cover your valve N95 masks. Anyone else have thoughts or comments on that? **-Ben Merin-** As far as those supplies go, right at this moment I have 114 thousand surgical masks in stock, you just need to submit a request to get them. I understand your concerns Scott about the N95's, unfortunately the only supply available for those is the BYU N95's and there is about a 40% fail rate and one of the hospitals is actually reporting about an 80% fail rate. Unfortunately those are the only ones we can get. The procedure masks or if you want face shields I have 120 thousand faceshields here that can supplement your concern. We can talk about your options to get stuff, make sure you reach out. **-Scott Clark-** We have N95 masks available but we can only do a quantitative fit test with the hood and spray bottle as opposed to the best testing we can do with the machines that absolutely give us a seal and protect our personnel. I think our personnel are our utmost important to keep protected as their exposed to COVID people. I fail to see the reason to do it. If we are wearing an exhalation valve, they have already been instructed to put a dust mask over their fitted mask. **-Dr. Garzon-** No one is asking you to compromise the safety of your personnel. If you have the best mask for that purpose, that's great, we just need to comply with other CDC guidelines to protect other patients and family members and hospital staff as well so know the masks are there.	

	I wanted to ask a question I think of Paula Green and Barbie too, in terms of distributing the slides to the MAC, are you talking wall time slides? **-Paula Green-** ~~A~~nything that is presented at this meeting that is distributed as mentioned before, it's helpful if we got it to reference it. In the past, the data that has been presented and then when we talk about it, we don't have it to reference. Really we are the people making anything move inside our organizations. It works against us if we do not have access to what we are referencing. **-Dr Garzon-** I agree Paula I think that is really important. What I would really like to do is really create a meeting packet of distribution and we will get these as PDF's out and then have them available to send out to the MAC. The plan would be in advance of the MAC so you can at least review them and look at them for discussion. I agree with that comment very much. **-Kristin Bianco**- I am going to see if Dorthy can email it out now, all of the graphs and everything so they have it. **-Dr. Garzon-** We will work on getting those out actually now. Barbie was talking about the QI plan scoring. Barbie, we will also send out the QI Plan scoring document as well. Any document that we display at this meeting, we will put in the packet. This will be the standard moving forward to do this. Thank you very much for the feedback on the chat. Hopefully you guys are following the chat as well. I think there is important exchange and dialogue there as well. We can move on and we are at the point of reviewing Policies and again, this is the place and meeting where we tend to have much of the interchange and the dialogue. I think it would be just very difficult here to do in this format for the meeting. Back in June when we did this, we reviewed policies off line. I said moving forward even when we have these conference calls and Zoom calls that we really need to rely on you to view the documents in advance and send us your comments. My apologies for getting the documents out less than four weeks. We want to give you guys enough time to review them and I know you didn't have as much time so we can allow for additional feedback after presentation and discussion at this meeting and take input if you guys have additional input that we can get into the weeds about something and review that input and analyze these via email distribution as we did for the June policies.	

Supplemental New Business: • PD# 8830 – Supraglottic Airway (iGel)	**-PD# 8830 – Supraglottic Airway (iGel):** We only have one policy in the supplemental new business that is the Supraglottic Airway Policy. Two (2) things regarding this policy. When we introduced IGel's and we have-taken this approach a number of other times, like when we introduced Fentanyl and the idea of eliminating Morphine. We left both the King Tubes in place while agencies took different time lines to incorporate the use of IGels. Now it has been over a year since we have had the IGels. So in this version we are removing King Tubes in the Policy. So when this policy goes into effect in July 2021, everyone should be on IGels. We also cleaned up language based on input we received in the public comments and separated out the indications for EMT's versus medics. We removed all of the language regarding King Tube. **Question:** will EMT's be required or can they use Capnography for continuous placement confirmation? **-Kristin Bianco-** No, It is not in the EMT's scope to use Capnography. **-Jennifer-** Should we have Jet Insufflators in the ED **-Dr. Garzon-** Jennifer, If I read your question correctly about having Jet Insufflators in the ED, that is really the call of your Emergency Medical Group if they want to have that as a mechanism for ventilation in patients. We are not really using them in EMS. So you don't need to have them to continue an intervention that EMS is doing. I hope that answers your question. Alright we are moving on to the scheduled Program Documents for review this month.	
Scheduled Program Documents for Review: • PD# 2512-Designation Requirements for Administration of Naloxone by Law Enforcement First Responders • PD# 5060-Hospital Diversion • PD# 5070-Hospital Transfer Agreements • PD# 7500-Disaster Medical Services Plan 2 • PD# 7501-MCI Critique • PD# 7508-Simple Triage and Rapid Treatment (START) • PD# 7509-Out of County Response	**-PD #2512-Designation Requirements for Administration of Naloxone by Law Enforcement First Responders**: No edits were made to this document and there were no requests from the shareholders or the members of the MAC Committee to make any edits to this. So unless someone chimes in, I will consider this a policy approved as is. **APPROVED** **-Kevin Mackay-** I just want to say a big shout out to law enforcement. Law enforcement has done an amazing job with this. Chief Loesch and I went to Sacramento City and gave out some awards recently to the police. 3 officers were involved in a situation where 2 vehicles were taking each other on, and a lady became unconscious while they were approaching the vehicle. It turned out that the lady was altered and she had taken an overdose, and that is why this guy who she hit, thought she was being crazy. The officers busted out the window and hauled her out, gave her Naloxone and two rounds	

• PD# 8020-Respiratory Distress-Airway Management-Respiratory Failure • PD# 8026-Respiratory Distress • PD# 8027-Nerve Agent Exposure • PD# 8067- Sepsis-Septic Shock • PD# 8801-Percutaneous Cricothyrotomy, with Jet Ventilation • PD# 8805-Intubation-Stomal • PD# 8826-Medication Administration, MARK I Nerve Agent Antidote Kit • PD# 8833-Ventricular Assist Device (VAD)	of CPR and she had a neurologically intact survival. I just wanted to say that they are doing a great job. **-Dr. Garzon**- Thank you Kevin, good feedback. -**PD #5060-Hospital Diversion:** Dr. Garzon: I would like to make a comment about diversion. Just as we have seen an increase in wall times, we have also had an increase use of diversion for overcrowding. The other thing that is concerning to me is that we had also increased use of advisory, closing special services because of the COVID impact. South Sacramento Kaiser has been the most COVID impacted facility in Sacramento County. They had essentially 100% census in their ICU and at times not having a single bed available. It's the lack of available ICU beds that has caused them to go on STEMI Diversion. So it is not a cardiology or Cath Lab problem, it's an ICU bed availability problem there. This is a big challenge in our system. I think a lot of the COVID impact for South Sac has been bleeding from San Joaquin County because the Central Valley has been massively impacted. Fortunately all of that is improving and hopefully it will improve for South Sac as well. My concern is again, if we see a more significant fall bump for Flu and COVID that could be more than one facility that closes specialty services if they end up with very impacted ICU space in the future. **-Kristin Bianco-** So the one change we did make to this policy was that we are now requiring the medics to verify the status of the receiving hospital upon leaving the scene and that any planned services outage and any outage that is expected to last more than 12 hours must be communicated by email and phone to SCEMSA to ensure the communication of the status so we can get it out to all of the stakeholders. **-Dr. Garzon-** Those edits were made based on the experience of these extended closures from South Sacramento. In addition that the hospital status was appropriately recorded on EMResource, but somewhere between dispatch and the medic choosing a destination facility, that information was not known to the medic who chose South Sac as the destination. The importance here for any specialty service it is really incumbent on the medics to confirm the status of the hospital that they are picking as a destination. Kathy Ivy- We have a couple of questions: with who will we be verifying the status and how will this be verified? Barbie asked: Will this be implemented next July or earlier to address the concerns sooner? Dr. Garzon: So, I can say that this policy will go into effect in July 2021, but I think we also have a problem that we need to solve immediately. We have discussed this with the EMS Chiefs and the hospital as well. Our current mechanism is for hospitals to put	

	their status on EMResource. If they are doing that there is not much else we can do. We did put in a bullet, that if you have an expected closure that is going to last a significant number of hours, you should notify EMS and we can get a letter out to the MAC and have a higher level of notification across the system. Ultimately if the hospitals have their status updated in EMResource it becomes incumbent on dispatch and the response units to confirm that status. That should be happening now. So this is putting in policy just to confirm that we are doing that. Whether or not this policy goes into effect tomorrow or July, we need to avoid these situations where specialty care patients are being taken to facilities that can't receive them. That should be a process that is already happening with dispatch and with the ALS providers. **-Question-** How can the medic verify the status of a hospital? **-Kristin Bianco-** Correct me if I am wrong, but can't the medics go through their dispatch to verify if these hospitals are open, if they are on divert or if they are unable to handle the specialty care patients? **-Ben Merin-** My understanding from the Fire Departments is that they have a new dispatch system it's basically a robot system. Barbie, you can correct me if I am wrong, the dispatcher has the ability to put information in somewhere about closures and the crews would have the ability to look that up in their MDT's? For the other providers, my experience is that it is not regularly verified. I have had this suggestion for a while, I don't think it is a policy, I think it is an organizational procedural change. I have come from many different systems and almost every one, when I get the dispatch information it would be when I received the information for the call, dispatch would state All Hospitals Open or if hospitals are on diversion. The information is upfront from the dispatch to the medics so the information is already in their head and they can re-verify if they need later. So I don't know if it needs to be a policy change, but defiantly a procedural change across the board. **-Barbie Law-** Previously there was a command in CAD that the crews can use to check hospital status. It brings up all hospital status so they don't have to impact dispatch with radio traffic. They can just check the status's as long as dispatch is in the loop with the closures and diversions. **-Ben Merin-** Every provider in the county has access to EMResource. I believe that fire dispatch does monitor that regularly. When I would see status changes, I would call and notify them and they would already know. Every dispatch center should have the up because that is the primary communication for everybody in the OA to know what is going on.	

	-Kristin Bianco-Are there any further questions or comments? **-Dr. Garzon-**We will approve this policy with these edits – **APPROVED** **-PD #5070-Hospital Transfer Agreements:** **-Kristin Bianco-** The only changes made to this policy was just some cleanup of the language. We replaced Policy with Program Document (PD). Did anyone have further comment that they would like to make or any changes that they would like to make? **-Jack-** In item A. Physician Staffing. So a physician is in the transport vehicle? **-Ben Merin-** It is not the requirement that you have a doctor on the transport it is just and option. **-Jack-** I understand, just change Medical Doctor to Physician. **-Dr. Garzon**- We will approve that document with that edit. **APPROVED** **-PD #7500-Disaster Medical Services Plan:** **-Dr. Garzon-** Ben can you comment on the status of 7500? I thought we were editing this with a small specialty group. **-Ben Merin-** My intention is to resume the MCI group towards the end of November if not then, it will be after the first of the year. **-Dr. Garzon-** I think we have a few formatting changes. Let's approve so there is a policy there. We can take this off line after the first of the year and bring it back to a future meeting out of turn and get it updated then. **APPROVED** **-PD #7501-MCI Critique:** **-Ben Merin-** The current one that we have, first of all, relatively no one fills it out. It is going to be altered to whatever our new MCI protocol is. The current forms don't really have much value. We are going to change them and make them all online just like EMS event forms. We are going to work with the group to identify what is valuable information and what is not. That again will be part of that MCI workgroup. We will work on if there is new information that we should be collecting. We are going to do the online format that can be downloaded to run reports and pull data. The current format is just really not that valuable. **-Kristin Bianco-**So do you want to leave that policy in place until we get the work group going again? **-Dr. Garzon-** Yes. We will leave that policy in place as is until the work group edits it further. **APPROVED** **-PD #7508-Simple Triage and Rapid Treatment (START)**: Again, no significant changes recommended.	

	-Kristin Bianco- Only edits were to clean up the document. Everything remained the same except for we corrected "Procedure Standard" to "Standard Procedure". Does anyone have feedback or changes that they would like to purpose? **APPROVED** -**PD #7509-Out of County Response**: Kristin Bianco- The only changes to this document was ~~again, just~~ cleaning up the language. We got rid "Or Physician Order Only" and replaced it with "Base Hospital Physician Only" We added "PD" in front of the Policy numbers. **APPROVED** -**PD #8020-Respiratory Distress-Airway Management-Respiratory Failure**: Kristin Bianco- We removed King Tube in this policy, added another cross reference for non-invasive ventilations. **-Dr. Garzon-** I don't think we got any comments from this policy. We will approve this with these minor edits. **-Dr. Mackey**- I did send in several comments on this, and I am not sure how they did not go in. Here is a question, this policy is going to be effective in 2021. Have you considered adding in the pediatric use of IGel? **-Kristin Bianco-** This was in the comments. And the comment back was that we were going to discuss it further. I did look at other counties and if they use IGels in pediatrics and the only County I found in the surrounding areas that uses IGels on pediatric patients is San Joaquin. This conversation was going to be put off until we investigated it further. **-Dr. Garzon-** Sorry Kevin, I don't have my comments on the Public Comments we received ~~up. I can't look at those~~ so I missed it. It is something worth considering and I had asked Kristin and Kathy to do a little more research on what other LEMSA's are doing with the use of those at the pediatric level. It is not something I wanted to have for deeper discussion here because I need more information. If you have information please feel free to forward, but I am not ready to put into this policy at this go around. **-Dr. Mackey-** Ok, so if you're not going to put it into this policy this go around, can we table it instead of approve it? Because if we approve it then, it is not going to be reviewed again until 2022, and effective in 2023. That is just a little too long to change the policy. I would recommend tabling it I would recommend tabling it until we have enough information to approve the policy. **-Dr. Garzon-** We pull policies out of turn all of the time, so I think the first thing to do is do the review and discuss because if it is not something I am willing to consider, then we don't need to change the policy. Doing a deeper dive and having a discussion about this doesn't preclude getting it approved and passed today. Let's get it approved so at	

	least it is on the table to go into effect in July and we can pull it out of turn if it turns out that we do need to modify it after deeper review. Ok, so the feedback from the chat is that they support tabling it, so let's do that. We will bring it back in the next meeting. Thank you all for the feedback. TABLED UNTIL DECEMBER 10 **-PD #8026-Respiratory Distress:** Kristin Bianco- The only edit was made under Caveats. Number "D" we added BiPap. Dr. Garzon- As discussed previously, we had approved the use of BiPAP or CPAP. I think Consumes was interested in using BiPAP so we wanted to get it added to this policy Kristin Bianco- Any feedback on that? Dr. Garzon- So approved with that minor edit. APPROVED **-PD #8027-Nerve Agent Exposure**: **-Kathy Ivy-** We want to merge the two policies, so we are tabling it. TABLED UNTIL DECEMBER 10. -**PD #8067-Sepsis-Septic Shock:** Kristin Bianco- We did make some changes under Indications. We got rid of the SIRS. Dr. Garzon – A couple of edits made to this policy based on feedback that we received. Blood Pressure is technically a SIRS criteria but it is a Septic Shock criteria. We just removed the SIRS comment and we changed the supplemental oxygen level to what we have been updating other policies throughout. Those were the only two minor edits. No other changes to this document. We will approve this with these minor edits. APPROVED -**PD #8801-Percutaneous Cricothyrotomy, with Jet Ventilation** **-Kristin Bianco-** No changes were made to this policy, and I didn't receive any feedback regarding changes to this policy. Does anyone have anything they want to add? Can we accept it as is? **-Dr. Garzon-** Yes APPROVED **-PD #8805-Intubation-Stomal** Kristin Bianco- The changes made to this policy were that is brought to our attention that we needed to add Cardiac Arrest under indications. We changed language under equipment for manufactures kit. We removed the rest of item "A" under equipment and we removed "B", "C", "D" and "E". We changed "Procedure" to "Policy". We got rid of the old language and added proper tube placement, secure the tube. Continuous wave form Capnography shall be utilized. Re-evaluate the position of the tube after	

	each move of the patient and document the findings in the PCR. If feasible pull over to perform a Stomal Intubation. -**Nathan Beckerman-** What was the reason for changing from endotracheal tube (ET) to manufacturer kit only? If the manufacturer kit is not available, is there a reason we do not want to allow an ETT to be placed through the stoma to establish an airway, particularly if the dislodged tracheostomy is the reason for the arrest. Are just referring to a manufactures intubation kit? If so, I'd state this. I was confused by "manufacturer kit" too and couldn't find a stomal intubation kit. It seems to me, if our units are carrying ET tubes already, I think the reasonable way to do a Stomal Intubation would be a small ET Tube. **Dr. Garzon-** Can we solve this problem by putting Manufacturer Kit or appropriate sized ET tube? **Dr. Beckerman-** That sounds reasonable. That would give the option to place an ET tube through the Stoma if available. **Dr. Garzon-** I think if we just put appropriate sized ET tube we will leave it to training and skills review to make sure that agencies are training their medics on appropriate size for this procedure. APPROVED **-PD #8826-Medication Administration, MARK I Nerve Agent Antidote Kit** **Kristin Bianco-** We were going to table Mark 1 and Nerve agent exposure until we combine them until December. **Dr. Garzon-** Yes TABLED UNITL DECEMBER 10 **-PD #8833-Ventricular Assist Device (VAD)** **-Kristin Bianco-** We did not receive any comments or feedback on this policy. **-Dr. Garzon-** I would like to put it out there ~~too~~ for the hospitals because I know there has been change over time. I think when we first started this it was one hospital in Sacramento, now I think at least 3 hospitals, but also they are using different VADS. So from the hospital side, have you seen any issues or problems with this? I am just asking for the hospital side to double check this policy to make sure that you folks are still OK with that. Kristin Bianco- I am sorry, we did strike out some language, I just didn't highlight it. We struck out the "Emergency Medical Technician or Paramedics" so it would just read "To Serve as the Treatment Standard for Treating Patients with a VAD". Any feedback on that?	Hospitals to review and give feedback on VAD requirements
New Topics:	- None	

Roundtable:	**-Question from Rob Walters-** Can we change the double negative verbiage for defibrillation In the VAD policy? "Defibrillation or Cardioversion is Not Contraindicated". Would it be ok to say something along the lines of is "allowed" or "possible", or "advised in a shockable rhythm", or something like that? - **-John Rose-** I would take "may be indicated" out, it is a passive voice. I would say advised with appropriate shockable rhythms. **-Barbie Law-** How about is permitted for an appropriate shockable rhythm or for a shockable rhythm if indicated. **-John Rose-** or we could just say V-fib and V-tach. **-Dr. Garzon-**Just say permitted for V-fib and V-tach. **-John Rose-** What about unstable SVT? Do we want to use the term "permitted" or "advised"? **-Barbie Law-** Do we use "indicated" in all of the other protocols? So defibrillation and/or cardioversion as indicated for V-fib, V-tach and symptomatic SVT. **-Kristin Bianco-** Cant I just put for "Shockable Rhythms" because there is more than just two. **-Barbie Law-** Yes, I think so **-Dr. Garzon-** Thank you all for the input. CHANGED to Defibrillation and/or cardioversion is advised for an appropriate shockable rhythm. **APPROVED** **-Kristin Bianco-** All of the strike trough's are because we updated the Format, not the language. **-Kathy Ivy-** I leave the strike-throughs there so everyone can see I did not change the language. Kristin Bianco- that is it for policies. **-Dr. Garzon-** This has been in my mind a remarkable meeting. It has been a little slow and a little difficult to follow but you guys have been terrific. We have not had a lot of cross talk and thank you very much. That is the end of the policy reviews. No new topics We are on round table, so please feel free to un-mute and speak your mind**.** **-Kevin Mackey-** I know that we tabled the policy on agitation or excited delirium. I think now is probably not the time to discuss it, but can we put it on the December calendar. There is a lot of discussion on the Eagles website and the Eagles list group about Ketamine, especially with what has happened recently, I think it was in Minnesota-the use of Ketamine and the gentleman passed away. There has been a lot of literature that	

	has come out and specifically ACEP and the anesthesia world has come out with a policy in NAEMSP is taking to task. I just wanted to make sure that we could talk about that because I think it is time to talk about our policy and maybe we can help our patients a little better. **-Dr. Garzon-** I am more than happy to do that. I forget when that policy actually comes up for review. I am very happy to be part of that conversation and I am open to discuss. I want to make sure that we are implementing changes and additions to the system just because everyone else is doing them, but rather, we are solving a problem that we have. I think that we get plenty of mental health patients and intoxicated patients that are challenging and difficult, but excited delirium is a very, very focused diagnosis that I think is over called in the prehospital setting a lot. It is actually pretty rare. We have a behavioral restraint policy where we are using a Benzo right now, and the question I have, is do we really have problem that is not being resolved with our current policy where Ketamine would make a significant difference. In addition to reviewing the literature that is out there, I would like to look at what we are seeing in Sacramento County and seeing if there is really a need or a gap for that. Part of this discussion, I want to do a little bit of a QI dive, I think I have already asked Dorthy to pull that, into the use of benzo's for behavioral restraint and review those policies.. I would like to ask agencies are you having problems managing these patients that the discussion of using Ketamine as an alternative to what we currently have, would improve the system. So I would like to make a decision based on experiences in Sacramento, not just because everyone else is doing it because it is the latest thing to do in EMS. **-Kevin Mackey-** We totally agree Hernando. I think that we did remove it in June and it was tabled until we could have a discussion because it was up for review. The agency may not always be aware that one, at least large police agency implemented a policy that they would no longer respond and be hands on in behavioral crisis's. That makes the work for our personnel significantly different and they need a tool that works quicker than a Benzo. Dr. Garzon- If you can give me individual cases. I think Barbie made a comment in the chat, that you are right, we had tabled it in June to have a further discussion. I am sorry it did not make it on here. I will make a note to do that. Again, I sort of frame the things I want to address in that discussion. If you have specific cases, or any of the provider agencies have specific cases that have been a challenging management wise because of the lack of Ketamine, please send them to me and lets review.	

	Let's put the policy on for December. I will do that deeper QI review and I am sorry we did not do it for this meeting. Besides our QI review, please get us specific cases and concerns you have. Let's look at our behavioral restraint policy specifically. I think rather than a separate policy, if we are going to amend this and have an agitated delirium category and the use of Ketamine, it should be in our existing behavioral restraint policy where it becomes one of the options to use. Anything else for Roundtable? **-John Rose-** I would like to introduce our Fellow, Matt. **-Dr. Garzon**-Welcome! John could you comment, because you had made a chat comment about not using Ketamine for behavioral restraint at this time but perhaps Haldol if need be. What is your point of view? John Rose- The optics are now kind of complicated with the cases that are out there in the press. I think it would not be the best time for us to try and sell this. I know there are other EMS groups that are using it. I would agree with Kevin that Versed sometimes does not work. We probably need to have something to be able to augment that. I know some agencies are using Haldol. It is mostly having some other agent to be adjunctive to it. I know a lot of groups right now are careful about how they are handling this. I would say at least for us, it is not time for to use Ketamine for that yet. That is just my own opinion. **-Dr. Garzon-** Thank you. Matt Maynard (Fellow) are you on the mail list for EMDAC? Matt- I am **-Dr. Garzon-** Okay, good. Anyone else for Roundtable? **-Barbie Law-** I wanted to let the group know, we will have a new EMS 24 coming on board effective July 25th (?) so Steve Craig is returning to the line and Captain Sean Burke will be coming on A shift. I updated all of the EMS 24 names in EMResource already. We did make a change to our Dyco notification e-mail, and EMResource, we are using a different email group. We put that up in EMResource. We will have faster recognition if we have any exposure. **-Kristin Bianco-** Chief Law, does he need to be added to any of the email lists? **-Barbie Law-** yes. I will send that to you after the meeting. **-Dr. Garzon-** Julie Carrington on chat-Chief Shurr has retired and Rick Clark is the new EMS Assistant Chief for EMS at Cosumnes. Welcome Rick. Then Jennifer, related to the Haldol Ketamine issue, asks, "Has anyone used inhaled Naloxopine for Psych Crisis"	

	Dr. Garzon- For EMS it is not scope of practice. To use that in the prehospital setting it would take a special request from EMSA and then it would be on a trial basis. If others from the hospital side can comment if they are using inhaled Naloxopine for behavioral crisis in the ED and how that works. **-Kristin Bianco-** I appreciate all of the patience with me trying to slowly take over the MAC/OAC. Kathy is still working very closely with me. If you have any suggestions or critiques please email me or call me. **-Dr. Garzon-** All right all, Thank you and I truly miss seeing you all in person. I miss the chatter and the comradery. Hopefully these remote meetings will go away someday and we can have them in person again. As of now the next meeting is set for December 10th so put that on your calendar. Barring any other comments, let's close the meeting. Thank you all and have a great day.	
Adjournment:	Adjournment: 10:40 AM	

Next MAC/OAC Meeting: December 10, 2020 0900-1300 hours