Sacramento County Emergency Medical Services Agency (SCEMSA)
Joint Medical Advisory (MAC)/Operational Advisory (OAC) Committees

9616 Micron Ave. Suite 960
Sacramento, CA. 95827

Agency	Representative	Agency	Representative
American Medical Response	Mark Mendenhall	Sutter Medical Center, Roseville	Rose Colangelo
American Medical Response	Jared Gunter	Sutter Medical Center, Sacramento	Jen Denno
Cosumnes Fire Department	Tessa Naik M.D.	Sutter Medical Center, Roseville	Debbie Madding
Folsom Fire Department	Bryan Sloane M.D.	Versa Care	Renee Roberts
Kaiser Hospital, South	Wendin Gulbransen	UC Davis Medical Center	David Buettner
UC Davis Medical Center	Samantha Brown M.D.	UC Davis Medical Center	Jeremy Veldstra
Mercy San Juan/Alpha One	Nathan Beckerman M.D.		
NorCal Ambulance	Nic Scher		
Sacramento City Fire Department	Brian Pedro		
Sacramento City Fire Department	Kevin Mackey M.D.		
Sacramento Metropolitan Fire	John Rudnicki		
Sacramento Metropolitan Fire	David Sutton		
Sacramento Metropolitan Fire	Brian Gonsalves		
Sacramento Regional Fire/EMS Communication Center	Julee Todd		
SCEMSA Staff	All		

ITEM	DETAILS	ACTION
Welcome and Introductions		
Public Comment	NONE	NONE
Minutes Review	June 9, 2022, minutes	**Approved by:** Tessa Naik M.D./Dave Buettner
SCEMA Updates		
Dave Magnino SCEMSA Update	The board approved the revised budget to hire two additional SCEMSA specialist positions. One will be a QI/Data position to assist Dorthy. The second specialist with be focusing on the critical care programs. Starting January 1, 2022, EMTs working for Sacramento County providers and hospitals certifying and re-certifying will be required to document what employer they are affiliated with. The employer will then have to verify their employment	

	through the Accela program. The report that is sent out monthly to providers to confirm Paramedics that they employ will now also include EMTs. For hospitals, the list will also include MICNs.	
	NEMSIS has told the state that as of midnight on 12/31/2023, they will no longer accept 3.4, and 3.5 will be implemented on 1/1/2024. Therefore, Providers need to start working with their vendors to start the testing and certification process for 3.5.	Ben Merin would like to make this a TAG project. This will be proposed at the next TAG meeting
	Public Health did a lot of media messaging during this last heat wave. SMFD was the only agency to provide their PIO information and helped in pushing information out.	Ben Merin is requesting that all agencies share their PIO information with Public Health and SCEMSA.
	A reminder is given to ALS providers regarding the need for crews to turn PCRs in, in a timely manner, especially when there is a circumstance like the heat wave, where Regulations state PCRs are to be turned in within 72 hours. 80% of SCEMSA providers do not meet this timeline. data and reports are pulled daily.	Ben Merin is asking that agencies make sure that PCR's are submitted in the period that Regulations require. During incidents like the recent heat wave, the Sacramento County Department of Public Health is tracking EMS response.
	At the June MAC/OAC it was discussed and approved to implement policy changes twice a year.	Starting in May or 2023, Policies will now go into effect May 1 and November 1
Chairmans Report	If feed back on policies are not received by the end of the window given, it is challenging for SCEMSA. In some instances feedback has been sent in regarding policies the day before the MAC/OAC meeting and it does not give SCEMSA the time to properly review and make suggested changes. If feedback for requested changes are not made within the	SCEMSA will try to give more time for comments. A minimum or 3 weeks.

Mobile Integrated Health Update:	window of time given, they may not be considered. If MAC/OAC members email Dr. Garzon regarding policies, please include Kristin Bianco in those emails. The head legal counsel for EMSA has changed. The new legal counsel for EMSA and the department of CA Health and Human Services have some questions regarding this and EMSA is currently reviewing the Mobile Integrated Health with them. SCEMSA hopes to have information regarding this by the next MAC/OAC meeting. There will be no new updates to SCEMSA policy at this time. One way to possibly do MIH is through a trial/pilot program similar to the community paramedicine program. This could also be possible with the alternative destination. As of now the only alternative destinations allowed are sobering centers and psych facilities. Other facilities such as Urgent Care locations are not allowed by statute.	
COVID Update	Decreasing numbers of COVID cases. The CDC is still seeing high transmission rates. CA is seeing 600-700 admissions state wide per week. Sacramento County hospitals are seeing approx. 5-6% that are COVID positive.	
APOT Report	Sacramento County is still one of the worst for APOT times in the state. We are one of the 8 counties that exceed 40 minutes. APOT times have improved since the surge of COVID. SCEMSA has formed an APOT committee that includes Fire Chiefs and hospital CEO's in order to encouraged hospitals to adopt "triage to waiting room". There has been no significant push from hospitals to make this happen.	**Report attached to minutes**

SCEMSA Quarterly Reports	CEMSIS repository has historically been supported by ICEMA. EMSA is working to bring it in-house since Mark Roberts has retired. Some Neurologists would like SCEMSA to identify LVO strokes. Dr. Garzon's concerns are that if units are going to divert to a LVO stroke capable center, we would hope medics are right at least 50% of the time. The problem is the CPHSS is about 48% accurate at identifying an LVO stroke. SCEMSA will need to get good follow-up from the hospitals to determine if the paramedics called the correct type of stroke. Some counties have implemented a LAMS score to help identify LVO strokes. At this time SCEMSA will not be putting this in policy.	**Report Attached to Minutes**
Wall Time Reports	Dr. Garzon would like to refer for review any wall time that is ≥ 3 hours to the hospitals. Once the paramedic initiated triage to waiting room was placed in policy, it seems hospitals have started to work more with the paramedics. We do not have the numbers on triage to waiting room as of yet as it is a very difficult data point. **RIDEOUT FOLLOW-UP:** Dr. Garzon had a conversation with Rideout Hospital's ED director regarding their low wall times. A solution was not found with the conversation. The things Rideout has implemented have already been implemented in Sacramento County.	Dorothy has built a report that looks for key words in the narrative. It is a very extensive task, but she can run the report and send it to the providers and they can "dig" through it. **Slides of Dr. Garzon's notes attached.**
Old Business		
P.D. # 2501 – Emergency Medical Dispatch (EMD)	Tabled until December MAC/OAC for office discussion.	**FOLLOW UP:** This policy will be deferred due to EMSA is in the process of revising regulations which addresses EMS dispatch. Based on this, SCEMSA

		will not be making edits to this policy and will be waiting for the regulations from EMSA to go into effect.
PD# 8044 Spinal Motion Restriction (SMR)	**Approved with Edits** Under Special Notes: Added D.: *If modified spinal restrictions are used, documentation in the ePCR is required to clearly state why SMR could not be performed.*	If a hospital has a concern regarding C-Spine, please refer those to the providers.
PD# 8001 – Allergic Reaction/Anaphylaxis	Clarification of when Glucagon was added to this policy: September 2018, *Glucagon 1 mg IV/IO or IM if not vascular access or delay is anticipated was added to policy*	
New Business		
PD# 4150 – EMT Certification Renewal	**Approved with Edits** Added: Under Procedure for EMT Certification Renewal f.: *The EMT and/or their relatives are not permitted to sign any documentation of proof attesting to the skills, training or education of that candidate. It is the responsibility of the candidate to ensure impartiality and avoid potential conflicts of interest in any documentation.* *Any falsification of documentation is grounds for losing certification for a period of at least twelve (12) months.*	
P.D. # 4400 – Paramedic Accreditation to Practice	**Approved with Edits** Added: Under Policy B. 1.: *a. The Paramedic and/or their relatives are not permitted to sign any documentation of proof attesting to the skills, training or education for that candidate. It is the responsibility of the candidate to ensure impartiality and avoid potential conflicts of interest in any documentation.* *b. Any falsification of documentation is grounds for losing certification for*	Ben Merin: Hospitals do not need to submit the monthly forms. This is only for the ALS providers.

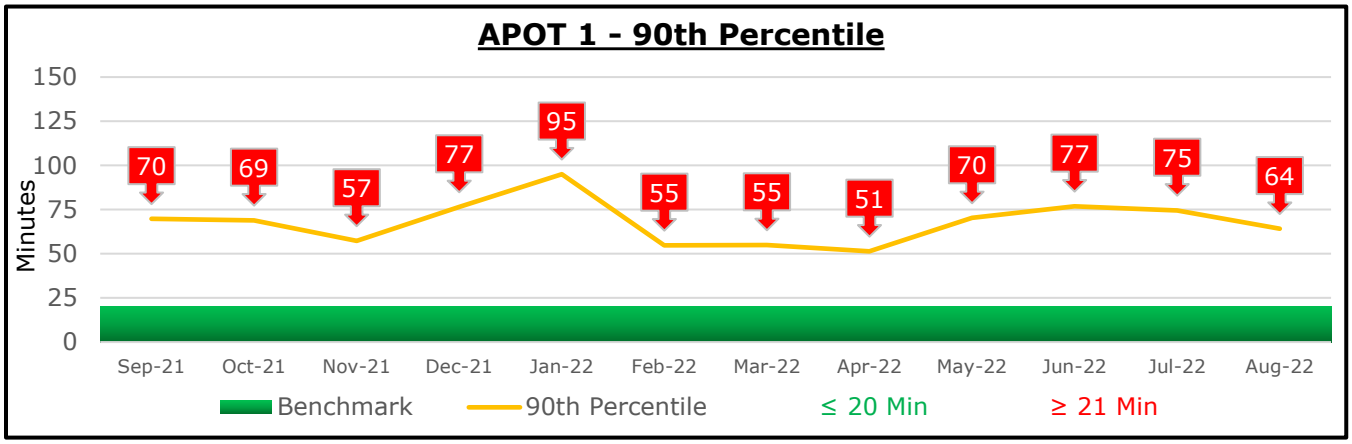
	a period of at least twelve (12) months.	
P.D. # 9005 – Pediatric Traumatic Cardiac Arrest	**Approved with Edits** This policy was created due to the adult traumatic arrest policy that had been created. **Removed:** Under Post Resuscitation Considerations: A. *Any traumatic cardiac arrest patient who has a Return of Spontaneous Circulation (ROSC) during any part of the resuscitation, and who is transported, shall be transported to a Trauma Center* Bullet Points under B.: *Administer TXA as indicated for patients > 14 years of age per PD# 8065 – Hemorrhage Control*	
MAC Revision Schedule	**Approved**	
Scheduled Policy Updates		
P.D. # 2512 – Designation Requirements for Administration of Naloxone by Law Enforcement First Responders	Tabled for December MAC/OAC	
PD# 5060 – Hospital Diversion (Admin Edit)	**Approved – With Admin Edits** **Added:** **NOTE:** *Any patient needing a time-closest facility (e.g. under CPR, unsecured airway) shall still go to the time closest facility even if CT scanner, Cath Lab, and Trauma services are unavailable.*	
PD# 5070 – Hospital Transfer Agreement	**Approved – No Changes**	
PD# 7500 – Disaster Medical Services Plan	**Approved – Minor Language Edits**	Ben Merin: The Disaster Medical Services Plan is operational. He would like to get a group of operational people and hospital people to work on standardizing this policy for all agencies.
PD# 7501 – MCI Critique	**Approved – Minor Language Edits**	Ben Merin this policy will also be revised through a work group at a later date.
PD# 7508 – Simple Triage and Rapid Treatment (START)	**Approved – No Changes**	Ben Merin: This is also a policy that will be worked on at a later

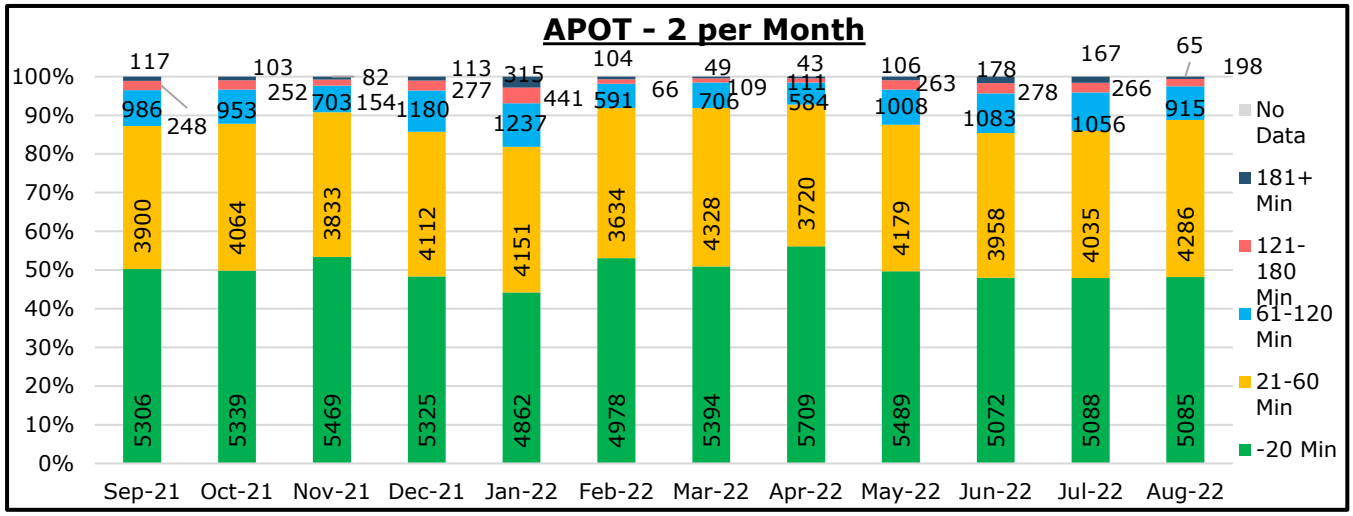
		date with Ben working on changes to EMResource
PD# 7509 – Out of County Response	**Approved – No Changes**	
PD# 8020 – Respiratory Distress-Airway Management-Respiratory Failure	**Approved with Edits** Supraglottic Airway replaced with i-Gel. **Removed**: Under BLS 7: *"Or the need to advance to ALS airway interventions".* **Added** under ALS 4: *PD# 8002 – Diabetic Emergencies.* **Added** under cross references: *PD# 8002 – Diabetic Emergencies*	
PD# 8026 – Respiratory Distress	**Approved with Edits** **Added:** Under Acute Respiratory Distress flow chart: *ETCO2 (continuous waveform) "when available".* **Added:** Under Asthma/COPD treatment tree: Epinephrine: *NOTE: Epinephrine should be used cautiously in patients > 35 years old, or with a history of CAD or HTN* **Added:** Push Dose Epinephrine box: *For SPB ≤ 90 mmHg*	
PD# 8027 – Nerve Agent Treatment	**Approved – No Changes**	
PD# 8067 – Sepsis-Septic Shock	**Approved – No Changes**	
PD# 8801 – Percutaneous Cricothyrotomy, with Jet Ventilation	**Approved – No Changes**	
PD# 8805 – Intubation-Stomal	**Approved – No changes**	
PD# 8833 – Ventricular Assist Device (VAD)	APPROVED – With Edits " *Precautions"* changed to *"Considerations"* *Mean Arterial Pressure"* changed to *"Systolic Blood Pressure"* throughout policy	
Round Table:		
Bryan Sloane M.D.	Dr. Sloan introduces himself as the new Medical Director for Folsom Fire Department.	

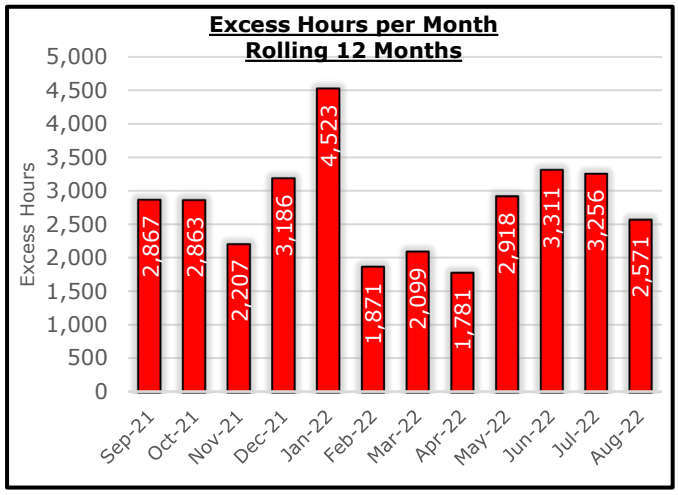
Dave Buettner	Dave Buettner announces his retirement at the end of September and introduces his replacement, Jeremy Veldstra.	
Tessa Naik M.D	Dr. Naik introduces herself as the new Medical Director at Cosumnes Fire Department and SRFECC.	
Julie Carrington	Julie announces that CFD is starting a new training podcast for her department.	
Unknown Speaker	Voices concerns regarding adverse side effects to Ketamine.	Dr. Garzon states SCEMSA can look at the policy and possibly add additional side effects. The speaker is requested to send his concerns to Kristin Bianco. As of the release of these minutes no communication has been received.

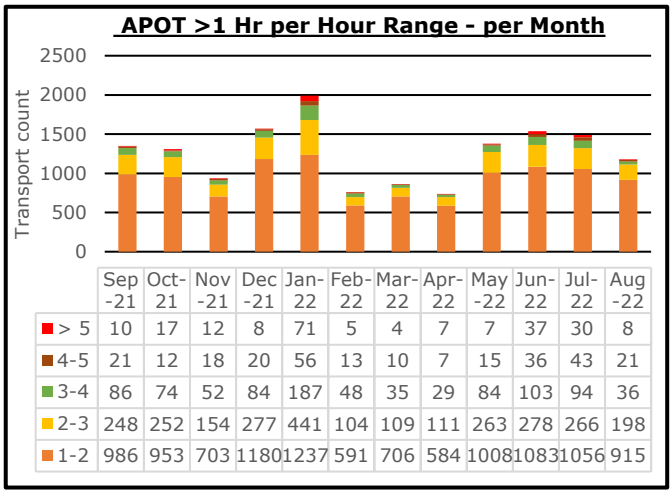
APOT 1, 2 & 3 - ROLLING 12 MONTHS / SYSTEM

APOT-1 represents the time (in minutes) under which 90% of patients have their care transferred from EMS to hospital staff. **APOT-2** is the percentage of patients whose care is transferred from EMS to hospital staff by designated time frames (see graph key for time ranges). **APOT-3** represents the excess time (in hours) over 20 minutes (Min.) aggregate of patient transferred from EMS to hospital per month. Illustrated is the System Total Excess hours per month. *Example: if APOT in minutes is 184 minutes then 184-20 (APOT benchmark) = 164 minutes. Then 164/60 = 2.73 hours.* APOT >1 hour represents any transport with an APOT greater than one hour per hour range.









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> 5	10	17	12	8	71	5	4	7	7	37	30	8
4-5	21	12	18	20	56	13	10	7	15	36	43	21
3-4	86	74	52	84	187	48	35	29	84	103	94	36
2-3	248	252	154	277	441	104	109	111	263	278	266	198
1-2	986	953	703	1180	1237	591	706	584	1008	1083	1056	915

Completed by: Sacramento County Emergency Medical Services Agency (SCEMSA)
Updated: 9.7.2022

APOT 1 PER HOSPITAL & APOT 3 PER HOSPITAL & PROVIDER AGENCY FOR AUGUST - 2022

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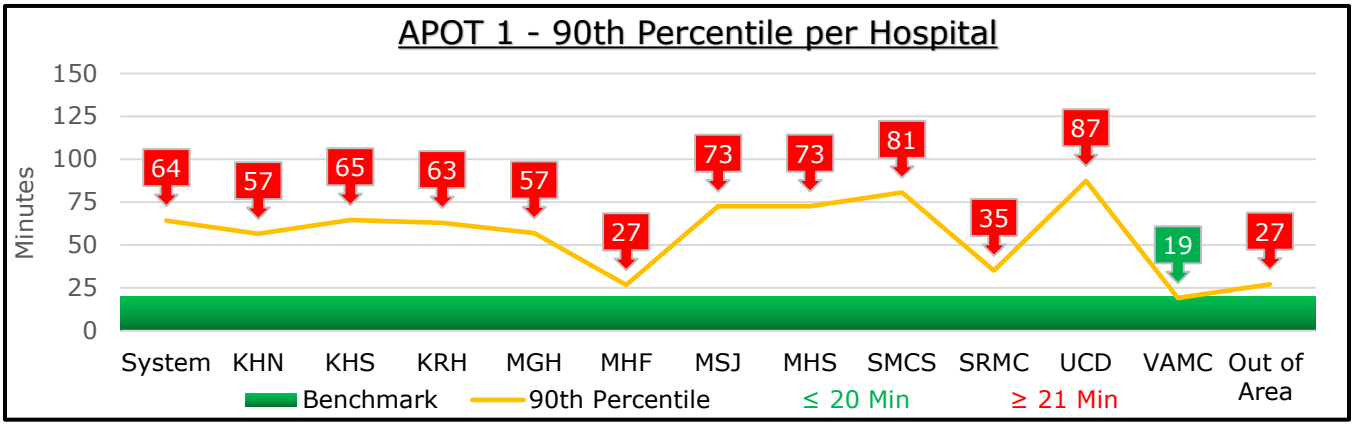
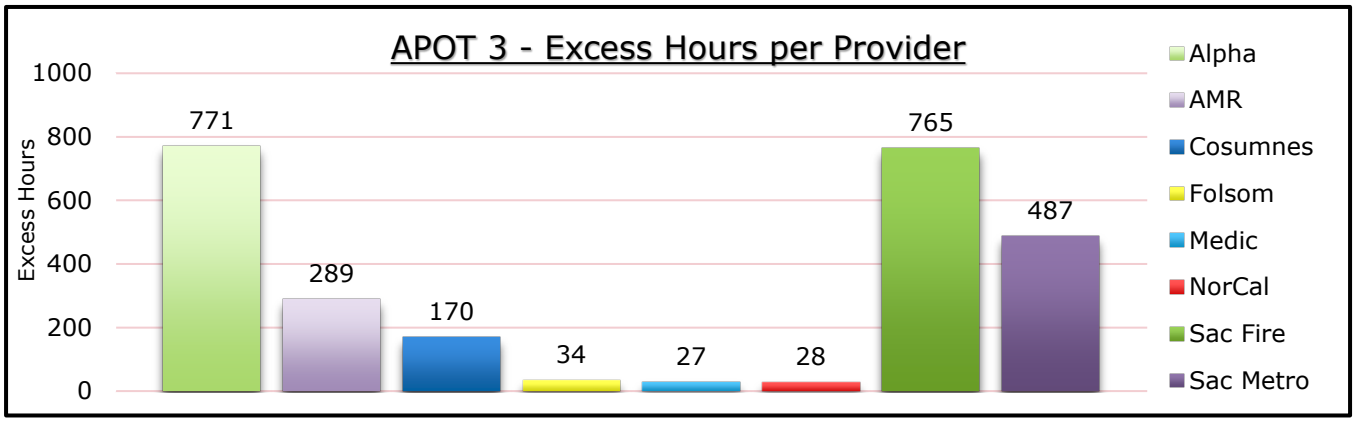
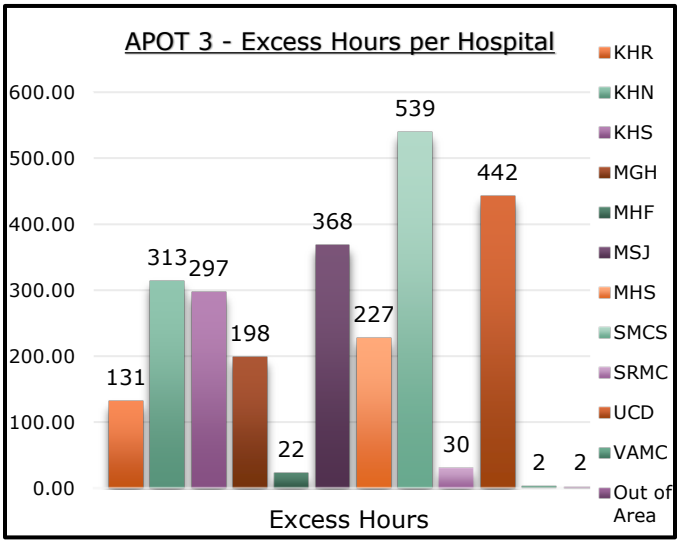




Excess Hours per Hour Range by Hospital (Over 1 Hour)					
Hour Range	**1-2**	**2-3**	**3-4**	**4-5**	**5+**
KHR	58	8			
KHN	121	11			
KHS	131	29	4		
MGH	70	7	1		
MHF	4				
MSJ	160	32	4	2	
MHS	84	16	2	2	
SMCS	206	47	5	1	
SRMC	7				
UCD	74	48	20	16	8
VAMC					



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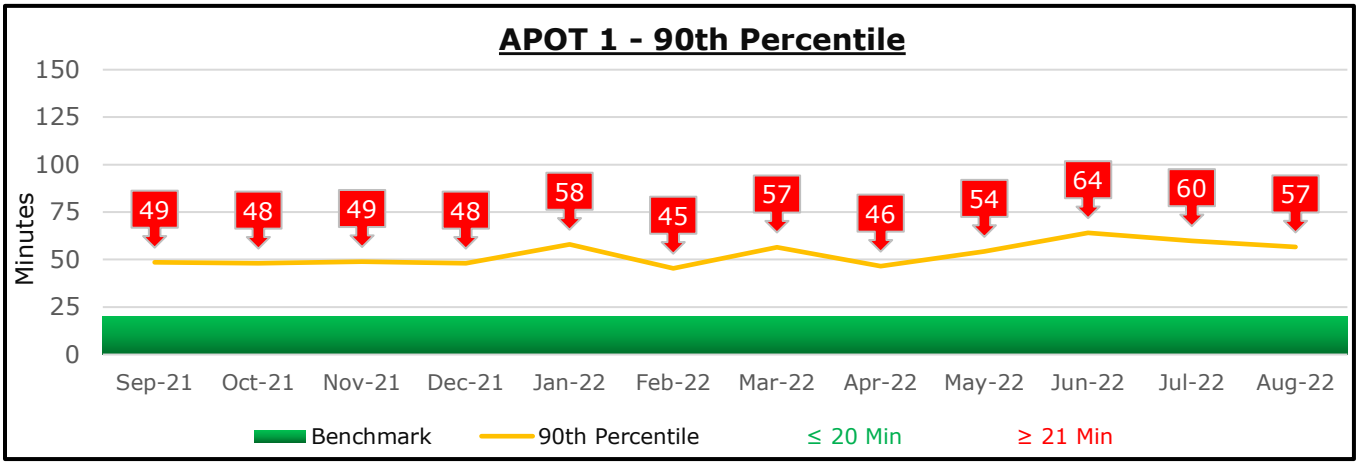
APOT Table - August 2022

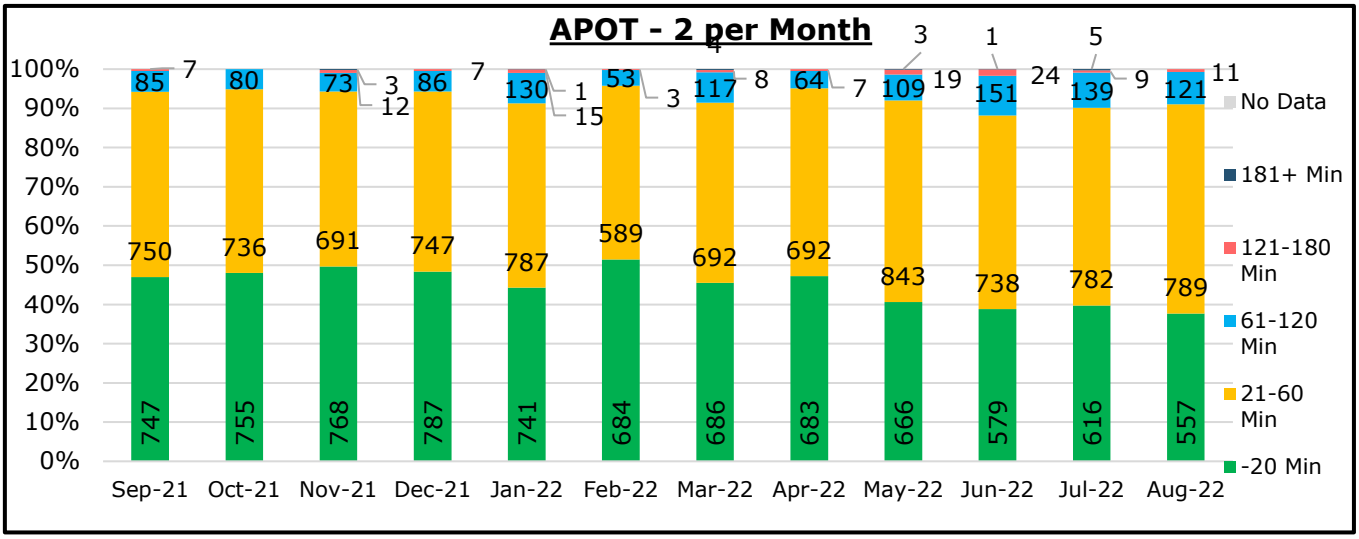
Key: Green Low /Best / Red Highest

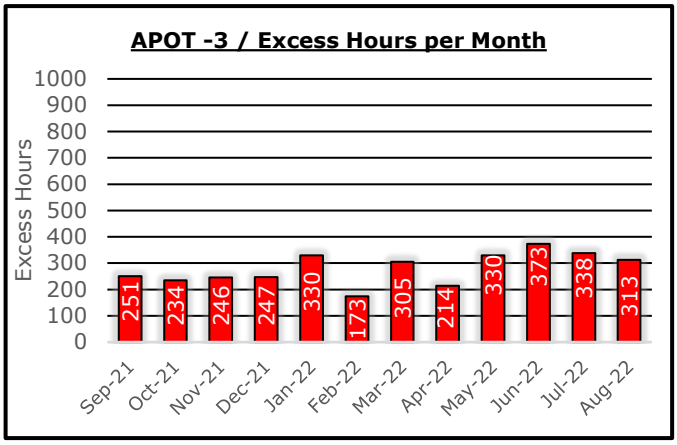
Hospital Names	Excess Hours	APOT 90TH Percentile in Minutes	Percentage of calls within 20 min	EMS Field to ED Patient count	Total Cost of Excess Hours to EMS Strike Team Rate $210.74/hour	Average Cost per 10 patients
KHR	130.82	1:02:59	49.06%	636	$27,569.71	$433.49
KHN	313.19	0:56:35	37.69%	1478	$66,001.91	$446.56
KHS	297.04	1:04:40	65.30%	1516	$62,599.16	$412.92
MGH	198.03	0:56:56	37.62%	909	$41,731.79	$459.10
MHF	22.00	0:27:45	82.30%	610	$4,637.09	$76.02
MSJ	367.91	1:12:33	52.62%	1393	$77,532.58	$556.59
MHS	226.87	1:12:36	30.26%	704	$47,809.60	$679.11
SMCS	**538.94**	1:20:36	**23.85%**	1409	**$113,575.69**	**$806.07**
SRMC	29.66	0:35:06	61.92%	428	$6,249.74	$146.02
UCD	442.12	**1:27:24**	50.58%	1212	$93,172.79	$768.75
VAMC	**2.34**	**0:19:08**	**91.21%**	182	**$493.38**	**$27.11**
Out of Area	2.14	0:27:06	77.78%	72	$449.97	$62.50
System	**2571**	**1:04:10**	**48.20%**	**10,549**	**$541,823.39**	**$513.63**

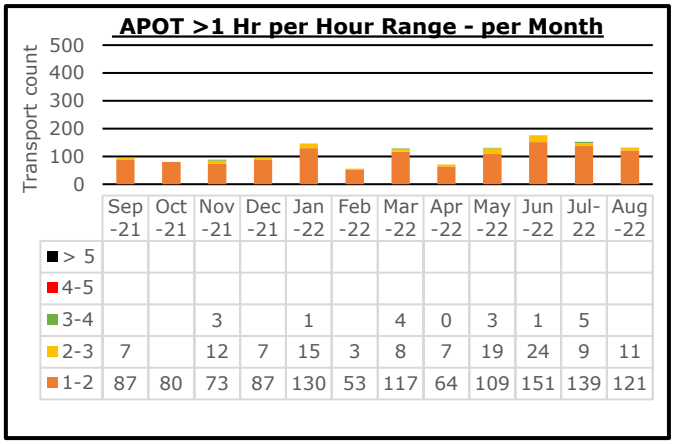
APOT 1, 2 & 3 - ROLLING 12 MONTHS / KAISER NORTH (KHN)

APOT-1 represents the time (in minutes) under which 90% of patients have their care transferred from EMS to hospital staff. **APOT-2** is the percentage of patients whose care is transferred from EMS to hospital staff by designated time frames (see graph key for time ranges). **APOT-3** represents the excess time (in hours) over 20 minutes (Min.) aggregate of patient transferred from EMS to hospital per month. Illustrated is the System Total Excess hours per month. *Example: if APOT in minutes is 184 minutes then 184-20 (APOT benchmark) = 164 minutes. Then 164/60 = 2.73 hours.* APOT >1 hour represents any transport with an APOT greater than one hour per hour range.









	Sep -21	Oct -21	Nov -21	Dec -21	Jan -22	Feb -22	Mar -22	Apr -22	May -22	Jun -22	Jul- 22	Aug -22
> 5												
4-5												
3-4			3		1		4	0	3	1	5	
2-3	7		12	7	15	3	8	7	19	24	9	11
1-2	87	80	73	87	130	53	117	64	109	151	139	121

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APOT 1, 2 & 3 - ROLLING 12 MONTHS / KAISER ROSEVILLE (KHR)

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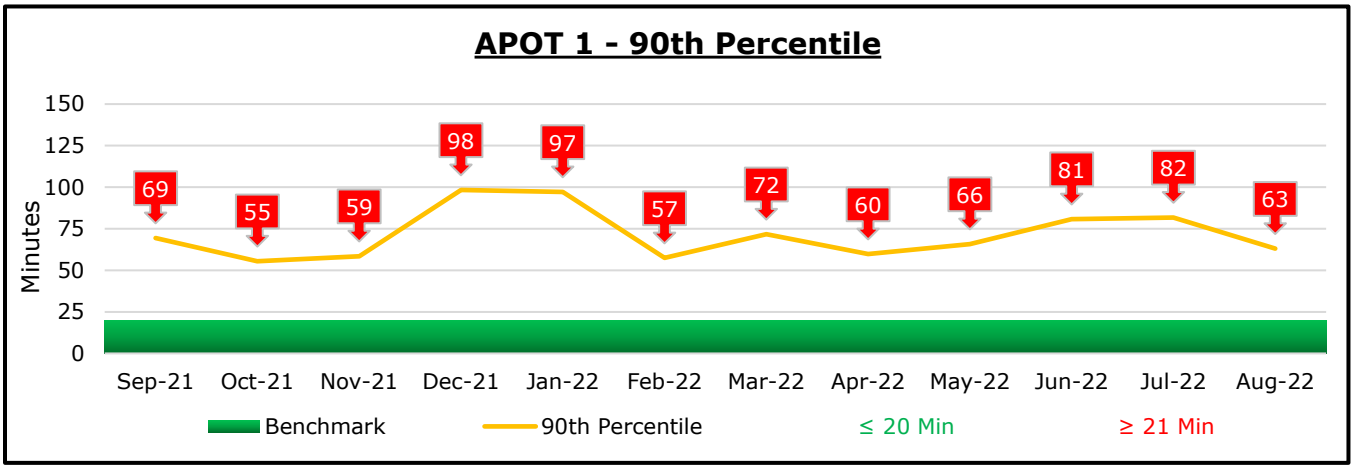

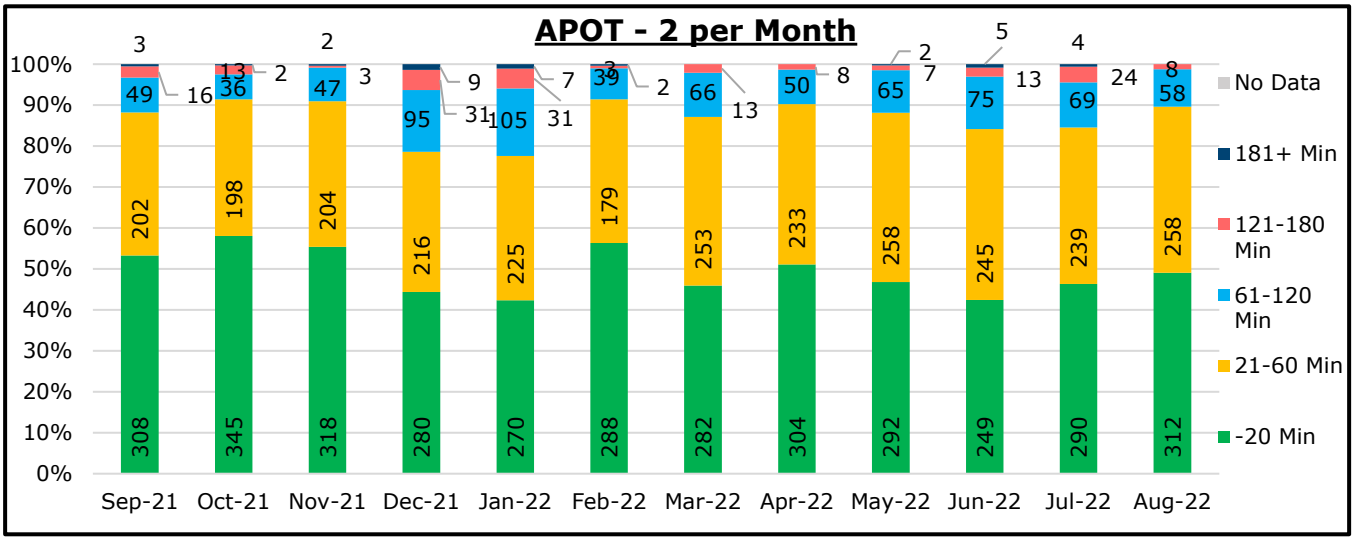

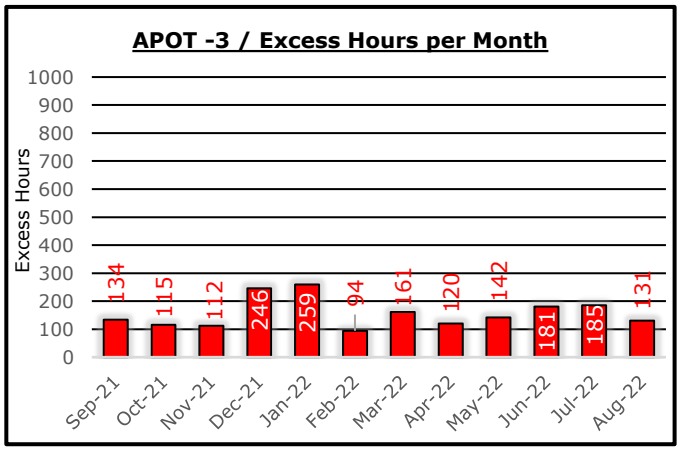

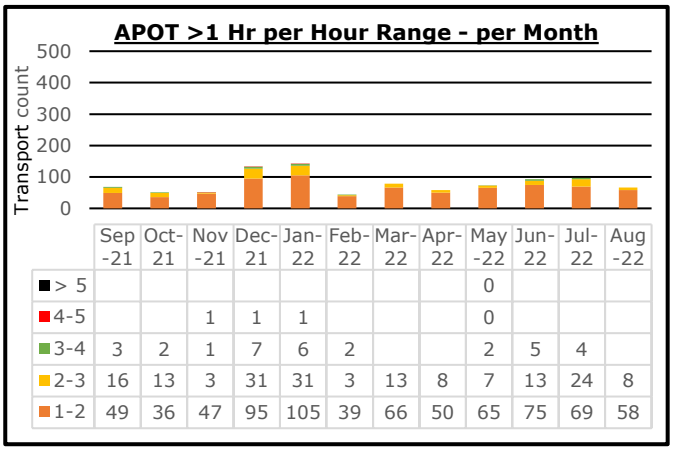

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> 5									0			
4-5			1	1	1				0			
3-4	3	2	1	7	6	2			2	5	4	
2-3	16	13	3	31	31	3	13	8	7	13	24	8
1-2	49	36	47	95	105	39	66	50	65	75	69	58

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APOT 1, 2 & 3 - ROLLING 12 MONTHS / KAISER SOUTH (KHS)

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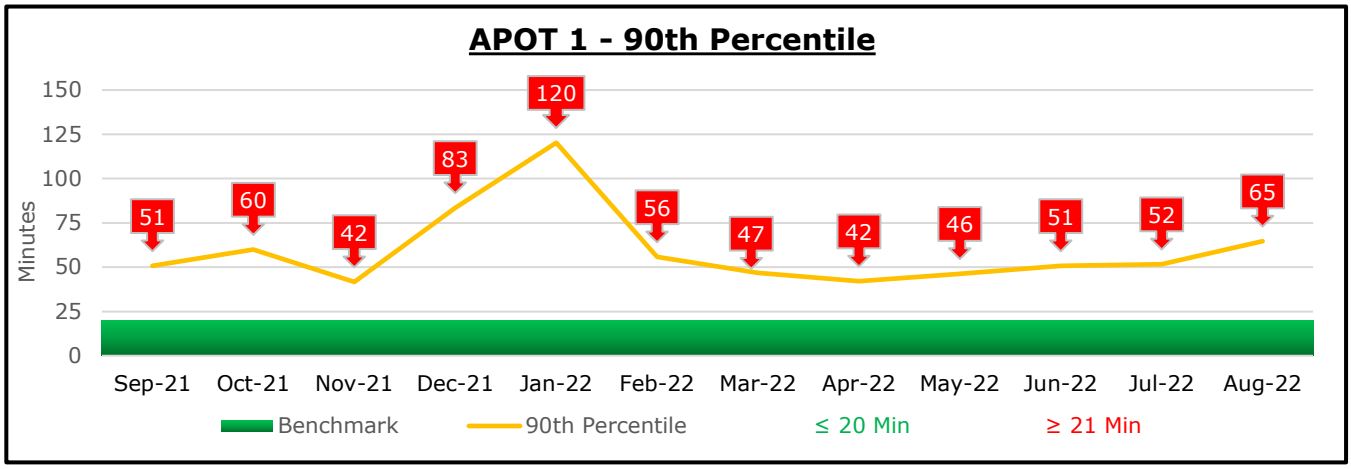

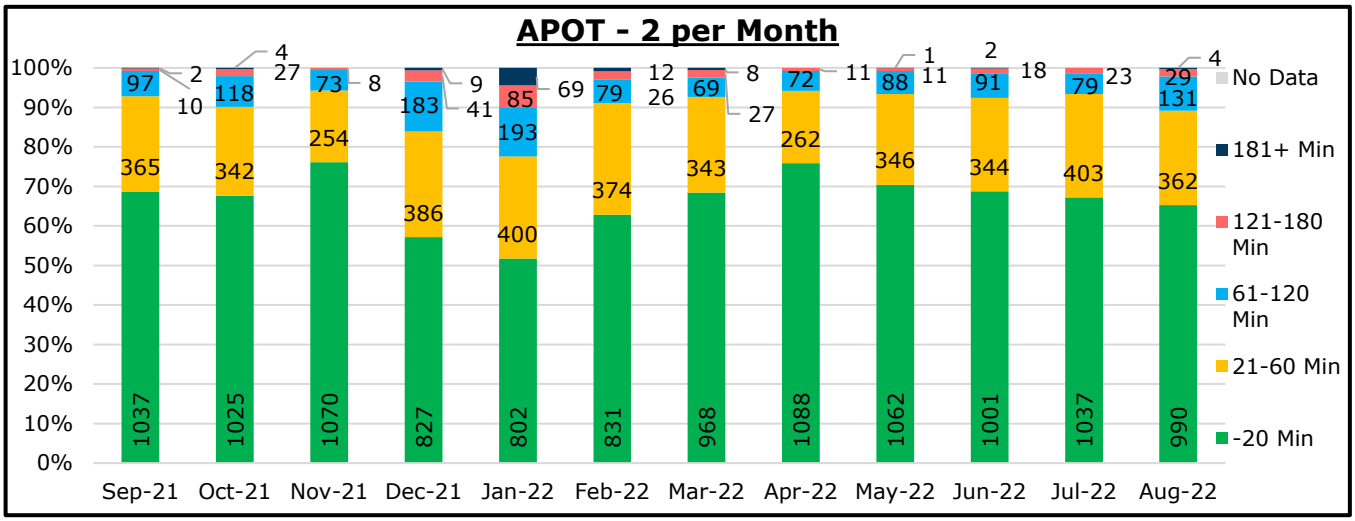

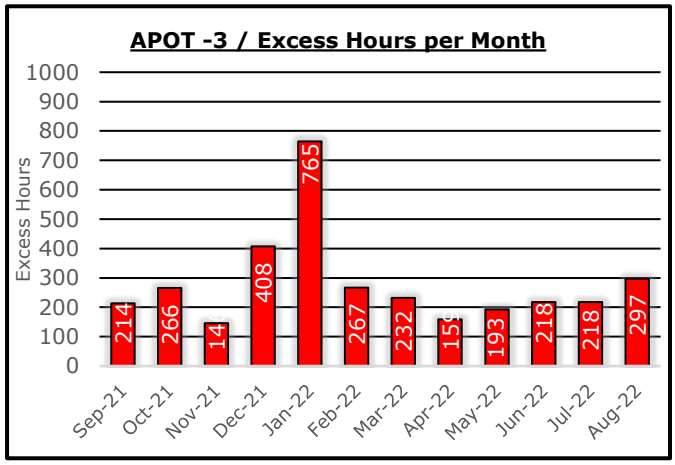

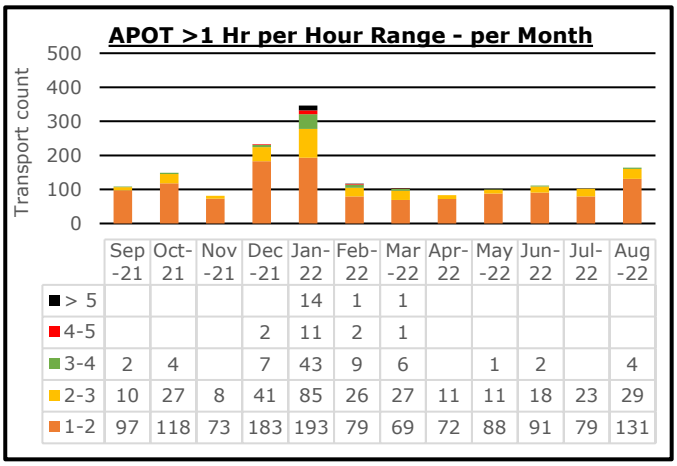

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> 5					14	1	1					
4-5				2	11	2	1					
3-4	2	4		7	43	9	6		1	2		4
2-3	10	27	8	41	85	26	27	11	11	18	23	29
1-2	97	118	73	183	193	79	69	72	88	91	79	131

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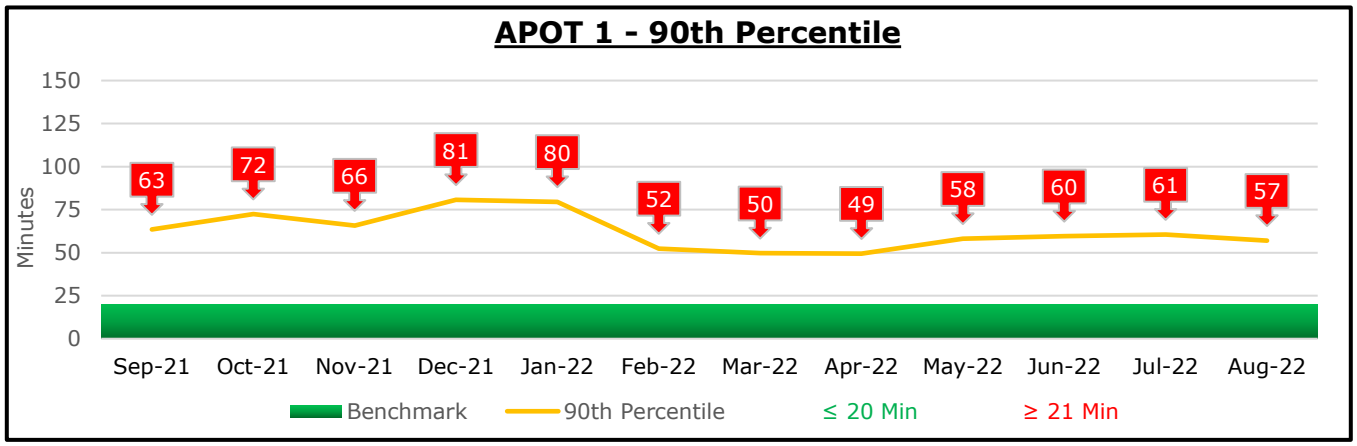
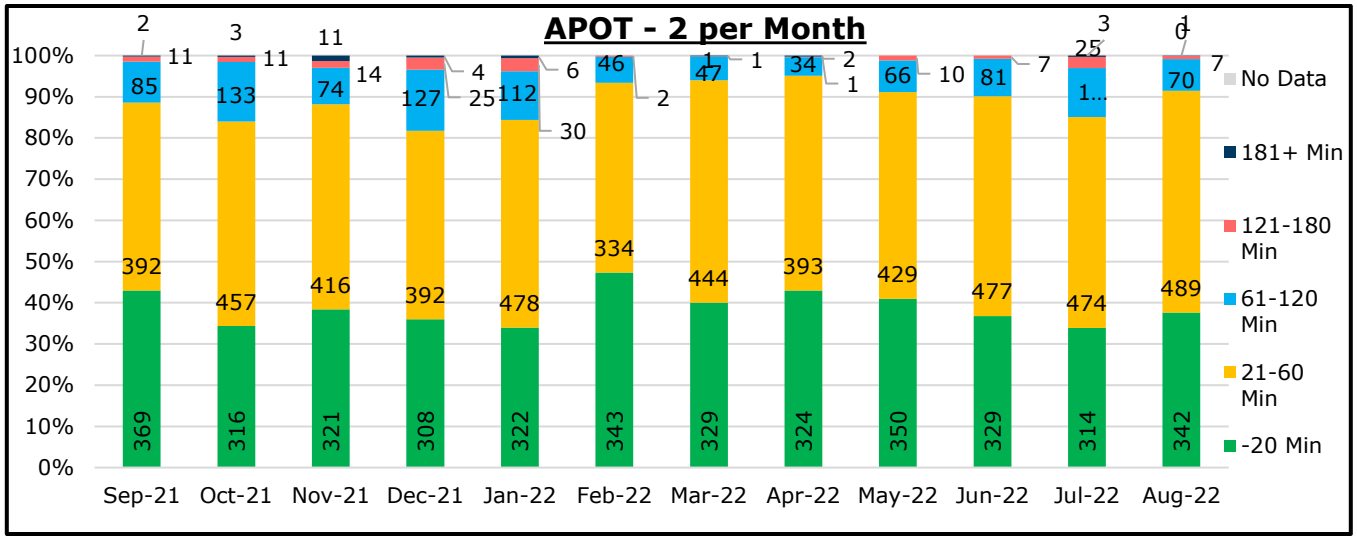
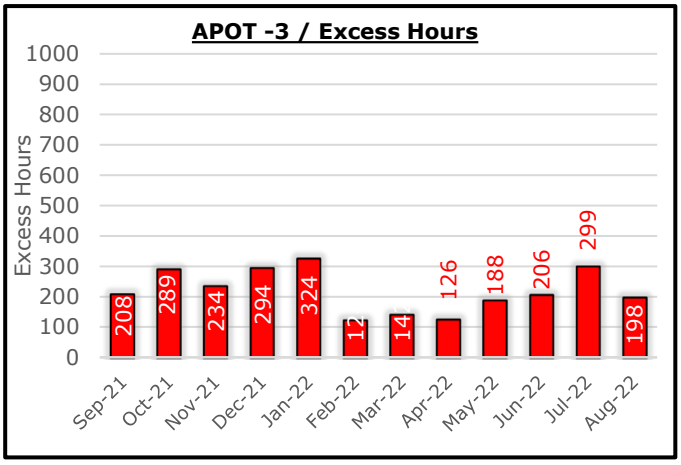
Updated: 9.7.2022

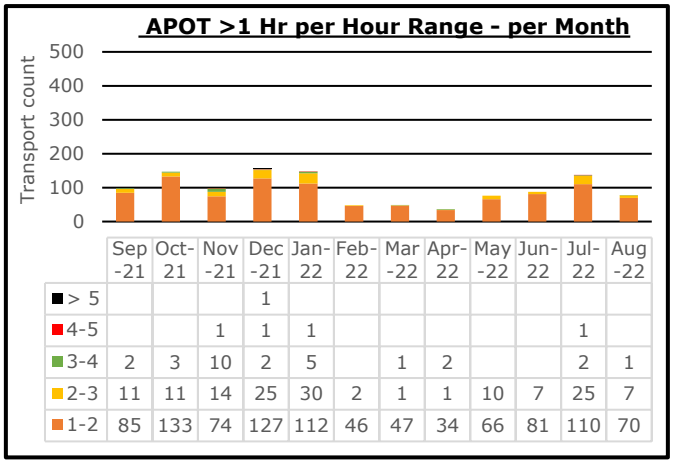
APOT 1, 2 & 3 - ROLLING 12 MONTHS / MERCY GENERAL (MGH)

APOT-1 represents the time (in minutes) under which 90% of patients have their care transferred from EMS to hospital staff. **APOT-2** is the percentage of patients whose care is transferred from EMS to hospital staff by designated time frames (see graph key for time ranges). **APOT-3** represents the excess time (in hours) over 20 minutes (Min.) aggregate of patient transferred from EMS to hospital per month. Illustrated is the System Total Excess hours per month. *Example: if APOT in minutes is 184 minutes then 184-20 (APOT benchmark) = 164 minutes. Then 164/60 = 2.73 hours.* APOT >1 hour represents any transport with an APOT greater than one hour per hour range.







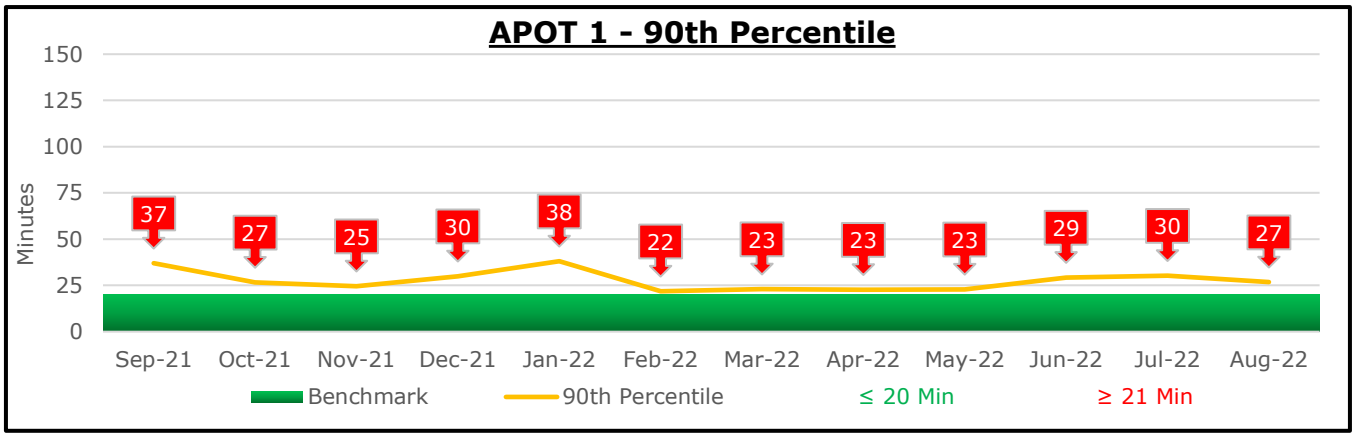


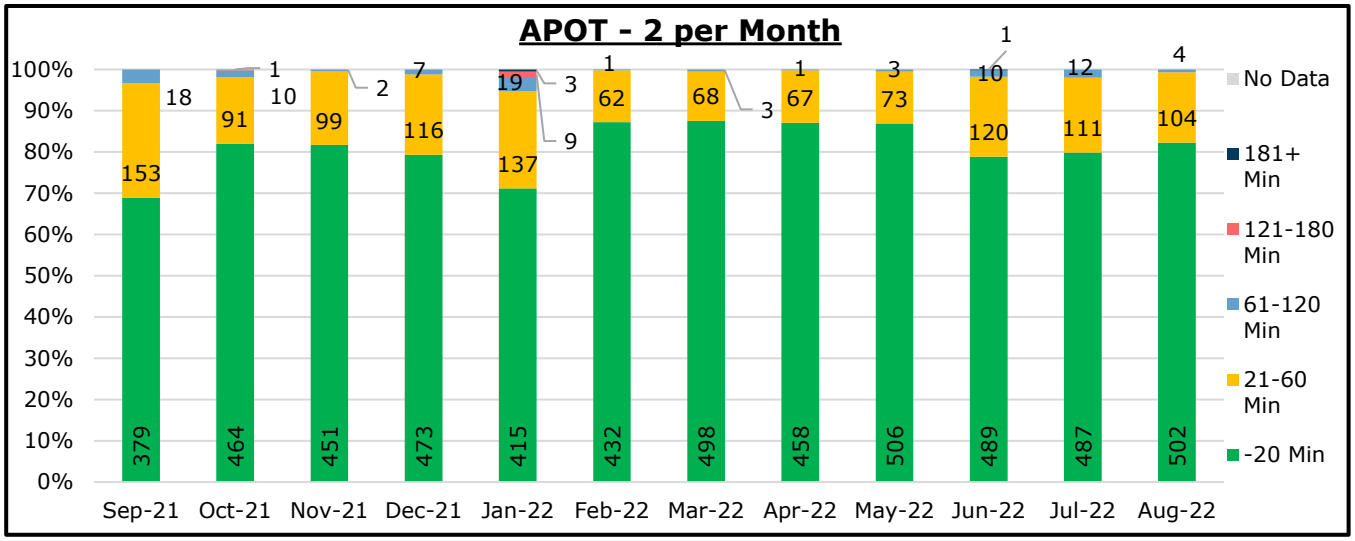
	Sep -21	Oct- 21	Nov -21	Dec -21	Jan- 22	Feb- 22	Mar -22	Apr- 22	May -22	Jun- 22	Jul- 22	Aug -22
> 5				1								
4-5			1	1	1						1	
3-4	2	3	10	2	5		1	2			2	1
2-3	11	11	14	25	30	2	1	1	10	7	25	7
1-2	85	133	74	127	112	46	47	34	66	81	110	70

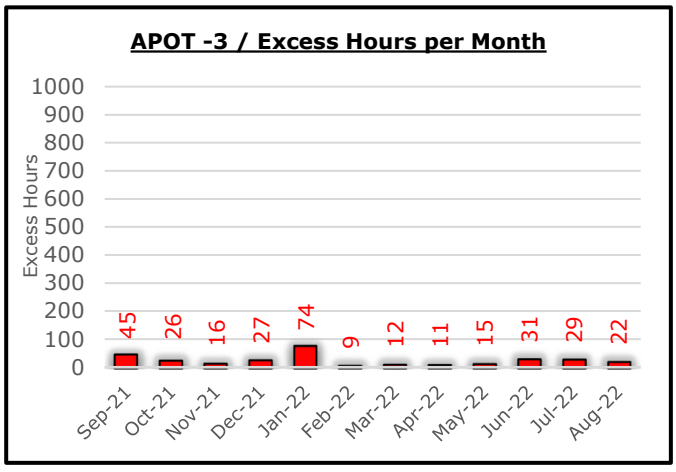
Completed by: Sacramento County Emergency Medical Services Agency (SCEMSA)
Updated: 9.7.2022

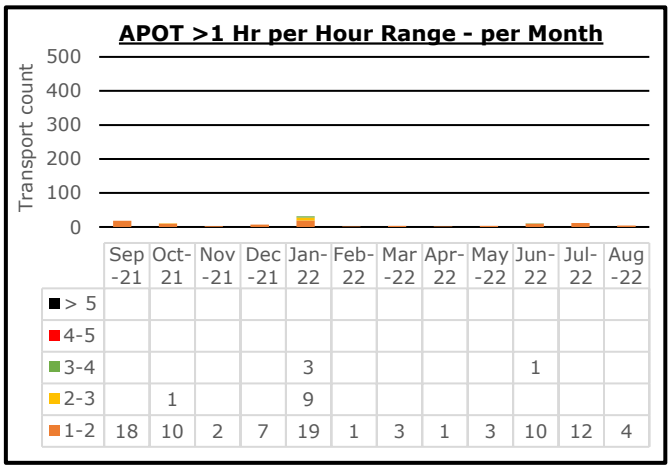
APOT 1, 2 & 3 - ROLLING 12 MONTHS / MERCY OF FOLSOM (MHF)

APOT-1 represents the time (in minutes) under which 90% of patients have their care transferred from EMS to hospital staff. **APOT-2** is the percentage of patients whose care is transferred from EMS to hospital staff by designated time frames (see graph key for time ranges). **APOT-3** represents the excess time (in hours) over 20 minutes (Min.) aggregate of patient transferred from EMS to hospital per month. Illustrated is the System Total Excess hours per month. *Example: if APOT in minutes is 184 minutes then 184-20 (APOT benchmark) = 164 minutes. Then 164/60 = 2.73 hours.* APOT >1 hour represents any transport with an APOT greater than one hour per hour range.







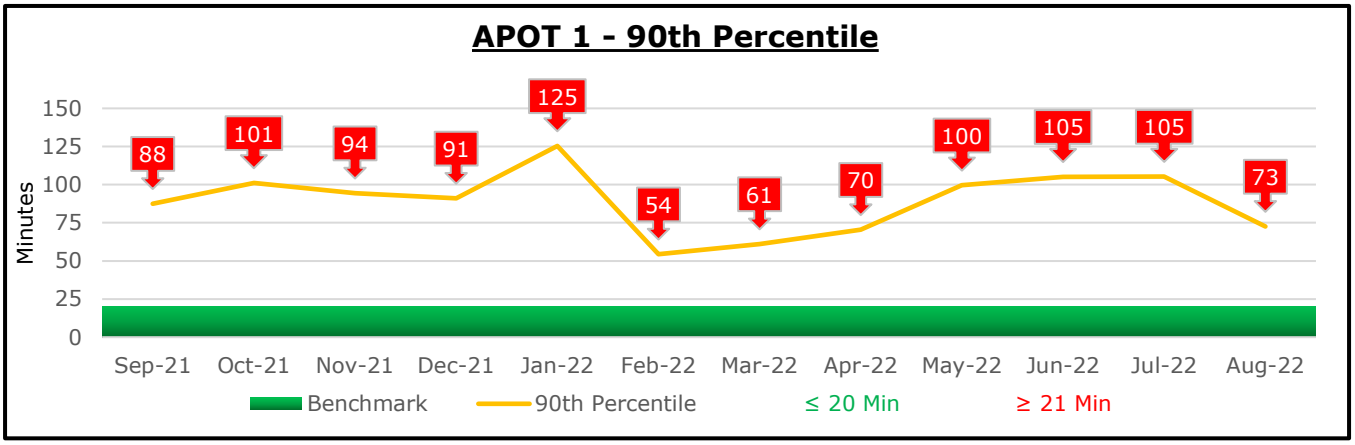


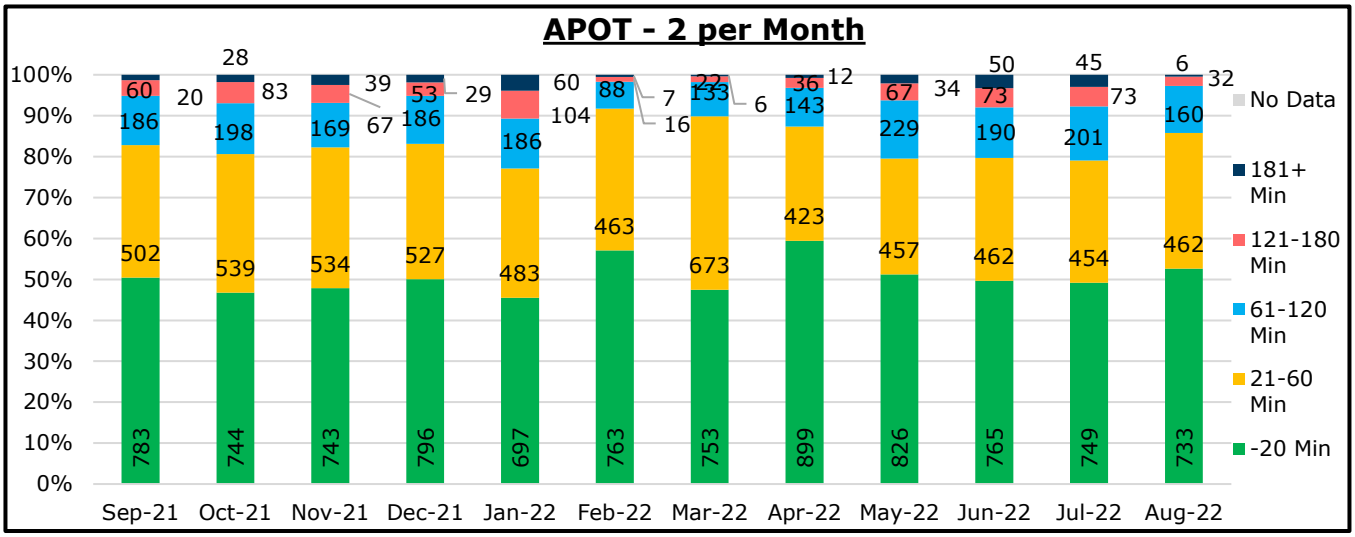
	Sep -21	Oct-21	Nov -21	Dec -21	Jan-22	Feb-22	Mar -22	Apr-22	May -22	Jun-22	Jul-22	Aug -22
> 5												
4-5												
3-4					3					1		
2-3		1			9							
1-2	18	10	2	7	19	1	3	1	3	10	12	4

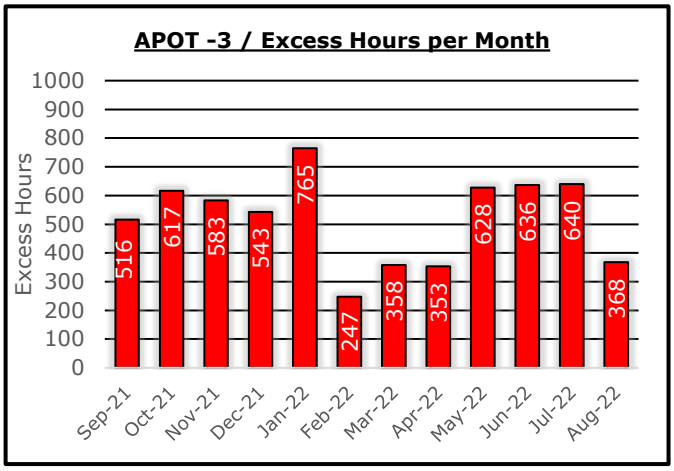
Completed by: Sacramento County Emergency Medical Services Agency (SCEMSA)
Updated: 9.7.2022

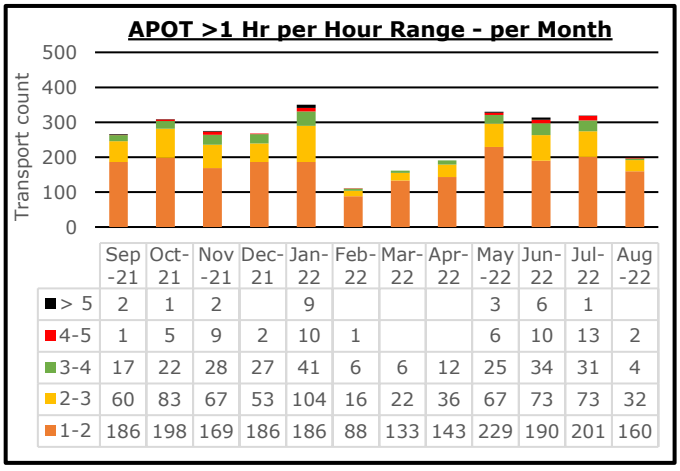
APOT 1, 2 & 3 - ROLLING 12 MONTHS / MERCY SAN JUAN (MSJ)

APOT-1 represents the time (in minutes) under which 90% of patients have their care transferred from EMS to hospital staff. **APOT-2** is the percentage of patients whose care is transferred from EMS to hospital staff by designated time frames (see graph key for time ranges). **APOT-3** represents the excess time (in hours) over 20 minutes (Min.) aggregate of patient transferred from EMS to hospital per month. Illustrated is the System Total Excess hours per month. *Example: if APOT in minutes is 184 minutes then 184-20 (APOT benchmark) = 164 minutes. Then 164/60 = 2.73 hours.* APOT >1 hour represents any transport with an APOT greater than one hour per hour range.







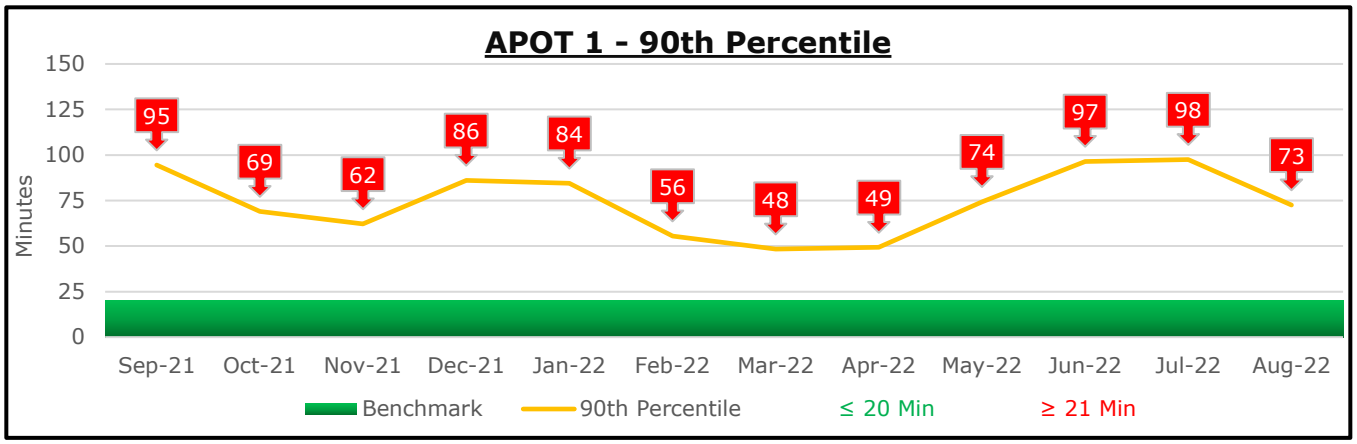


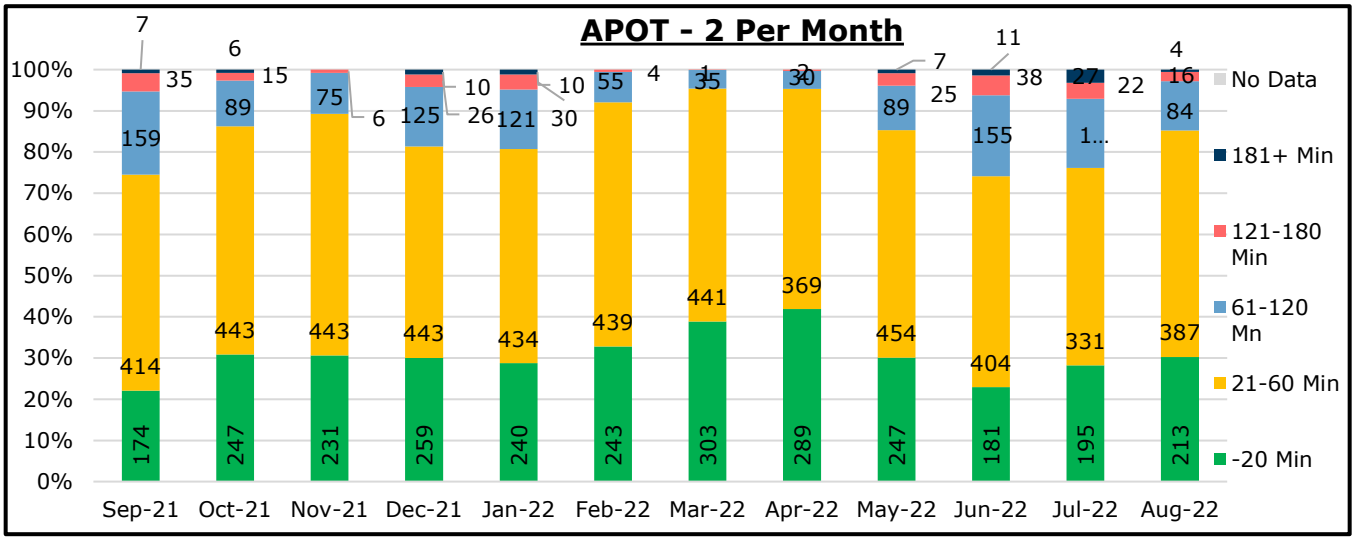
	Sep -21	Oct-21	Nov -21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May -22	Jun-22	Jul-22	Aug -22
> 5	2	1	2		9				3	6	1	
4-5	1	5	9	2	10	1			6	10	13	2
3-4	17	22	28	27	41	6	6	12	25	34	31	4
2-3	60	83	67	53	104	16	22	36	67	73	73	32
1-2	186	198	169	186	186	88	133	143	229	190	201	160

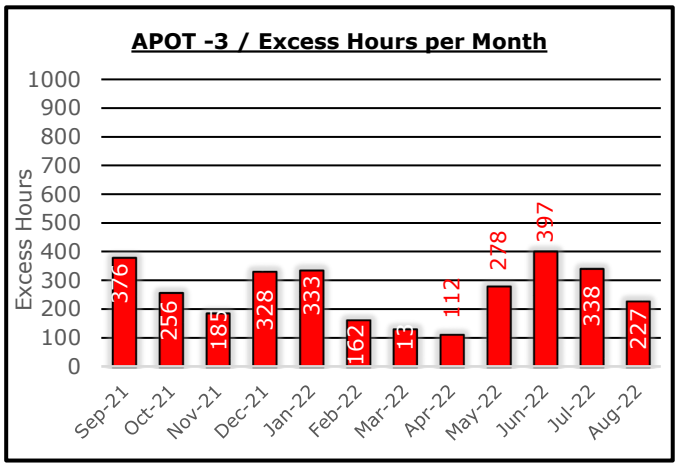
Completed by: Sacramento County Emergency Medical Services Agency (SCEMSA)
Updated: 9.7.2022

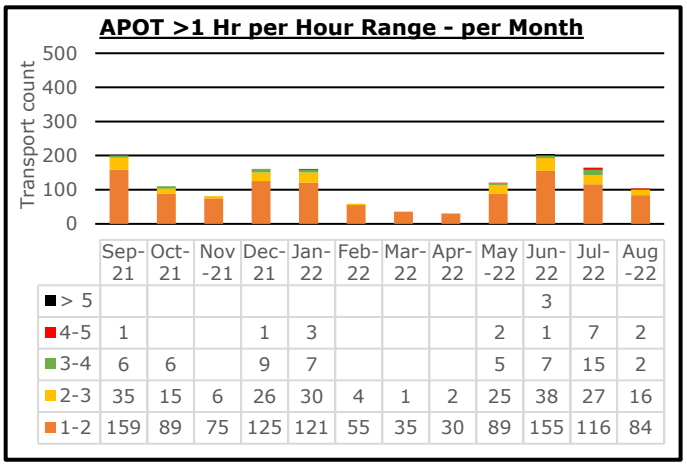
APOT 3 - ROLLING 12 MONTHS / MERCY METHODIST (MHS)

APOT-1 represents the time (in minutes) under which 90% of patients have their care transferred from EMS to hospital staff. **APOT-2** is the percentage of patients whose care is transferred from EMS to hospital staff by designated time frames (see graph key for time ranges). **APOT-3** represents the excess time (in hours) over 20 minutes (Min.) aggregate of patient transferred from EMS to hospital per month. Illustrated is the System Total Excess hours per month. *Example: if APOT in minutes is 184 minutes then 184-20 (APOT benchmark) = 164 minutes. Then 164/60 = 2.73 hours.* APOT >1 hour represents any transport with an APOT greater than one hour per hour range.







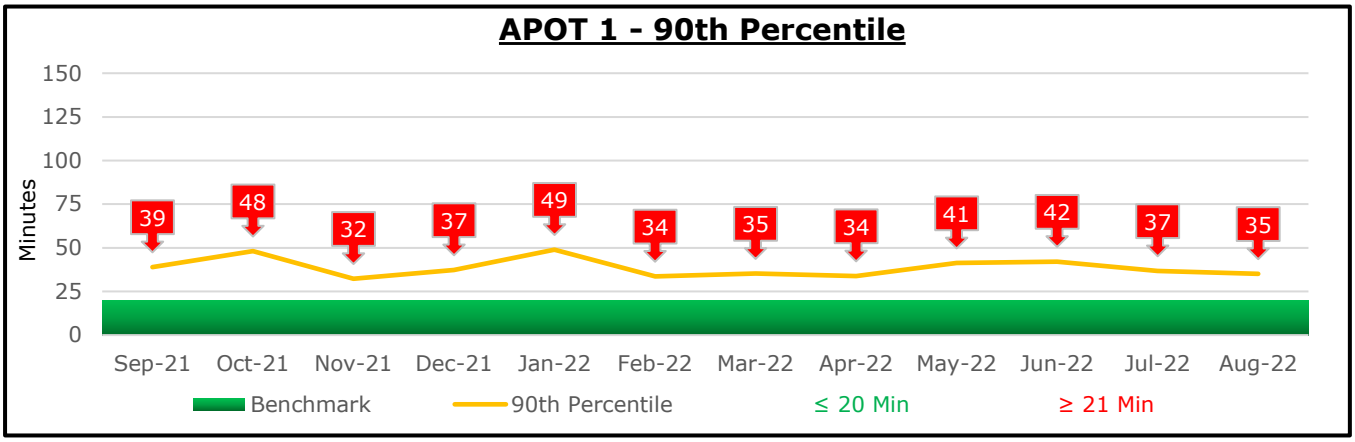


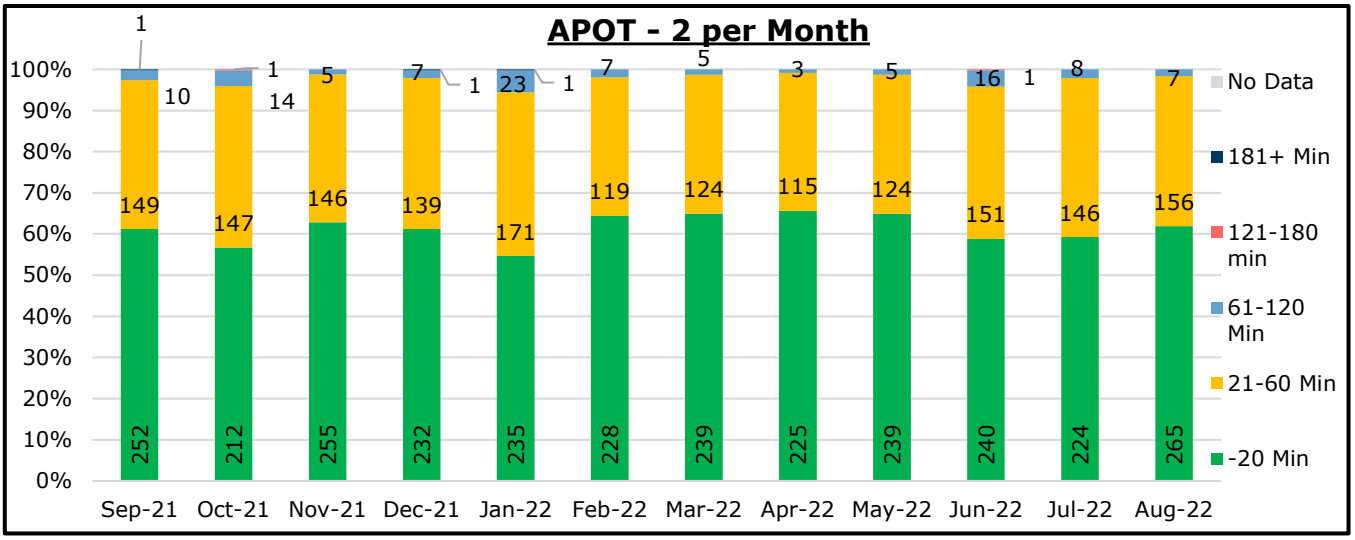
	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
> 5										3		
4-5	1			1	3				2	1	7	2
3-4	6	6		9	7				5	7	15	2
2-3	35	15	6	26	30	4	1	2	25	38	27	16
1-2	159	89	75	125	121	55	35	30	89	155	116	84

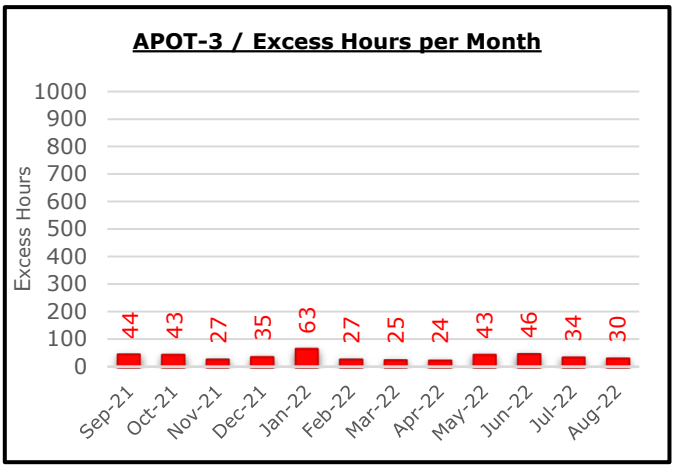
Completed by: Sacramento County Emergency Medical Services Agency (SCEMSA)
Updated: 9.7.2022

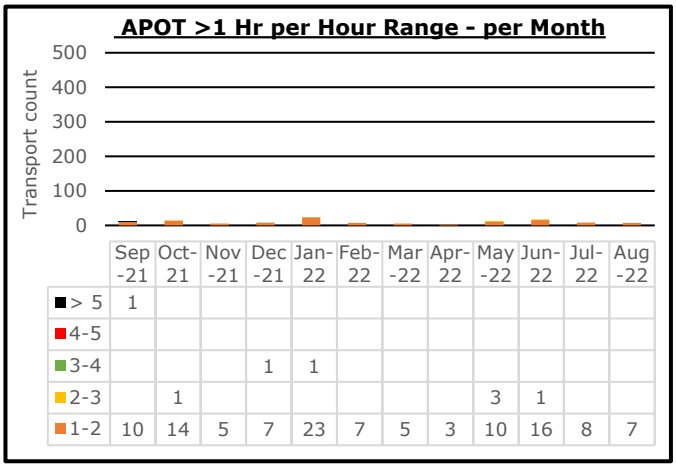
APOT 1, 2 & 3 - ROLLING 12 MONTHS / SUTTER ROSEVILLE (SRMC)

APOT-1 represents the time (in minutes) under which 90% of patients have their care transferred from EMS to hospital staff. **APOT-2** is the percentage of patients whose care is transferred from EMS to hospital staff by designated time frames (see graph key for time ranges). **APOT-3** represents the excess time (in hours) over 20 minutes (Min.) aggregate of patient transferred from EMS to hospital per month. Illustrated is the System Total Excess hours per month. *Example: if APOT in minutes is 184 minutes then 184-20 (APOT benchmark) = 164 minutes. Then 164/60 = 2.73 hours.* APOT >1 hour represents any transport with an APOT greater than one hour per hour range.









	Sep -21	Oct-21	Nov -21	Dec -21	Jan-22	Feb-22	Mar -22	Apr-22	May -22	Jun-22	Jul-22	Aug -22
> 5	1											
4-5												
3-4				1	1							
2-3		1							3	1		
1-2	10	14	5	7	23	7	5	3	10	16	8	7

Completed by: Sacramento County Emergency Medical Services Agency (SCEMSA)
Updated: 9.7.2022

APOT 1, 2 & 3 - ROLLING 12 MONTHS / SUTTER SACRAMENTO (SMCS)

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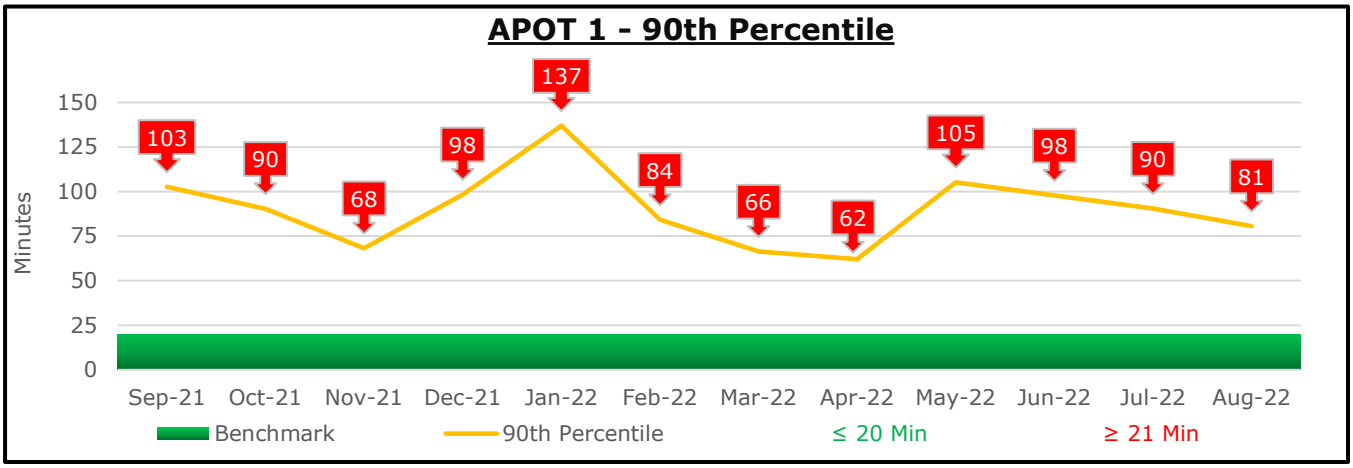

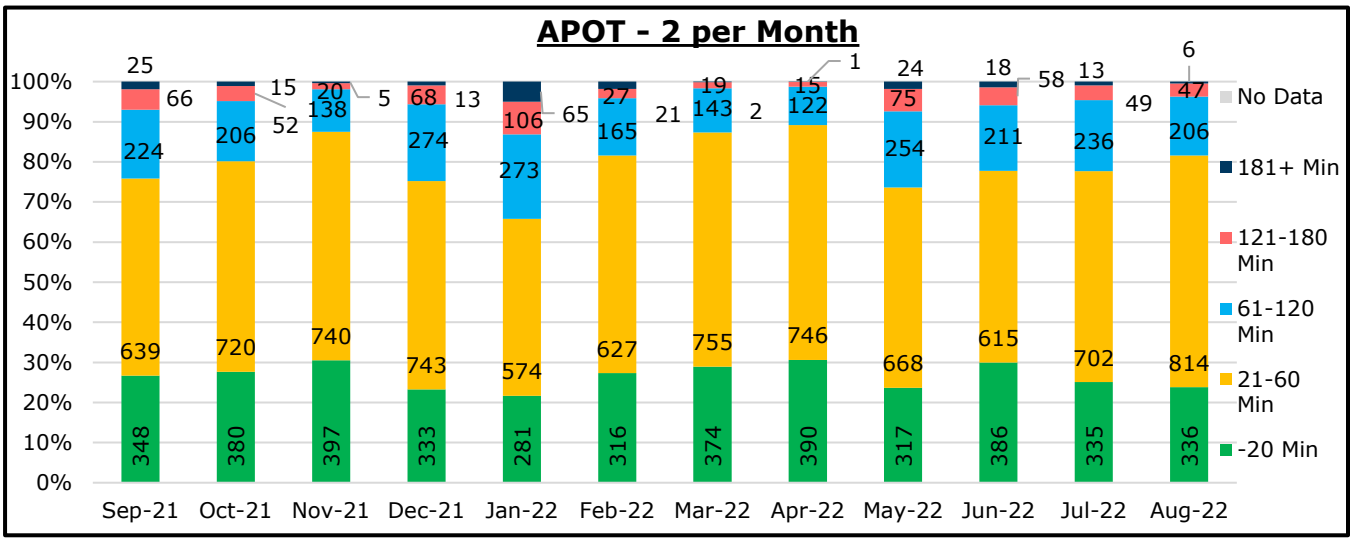

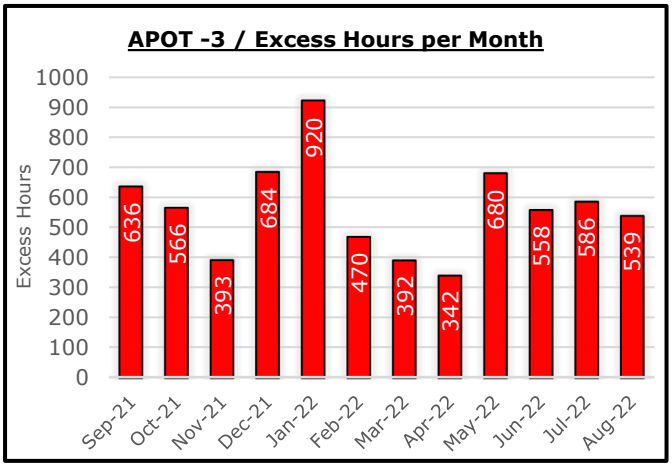

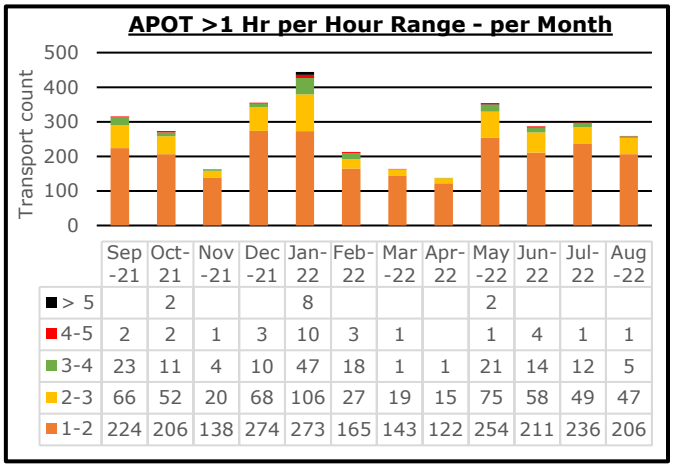

	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
> 5		2			8				2			
4-5	2	2	1	3	10	3	1		1	4	1	1
3-4	23	11	4	10	47	18	1	1	21	14	12	5
2-3	66	52	20	68	106	27	19	15	75	58	49	47
1-2	224	206	138	274	273	165	143	122	254	211	236	206

Completed by: Sacramento County Emergency Medical Services Agency (SCEMSA)
Updated: 9.7.2022

APOT 1, 2 & 3 - ROLLING 12 MONTHS / UC DAVIS (UCDMC)

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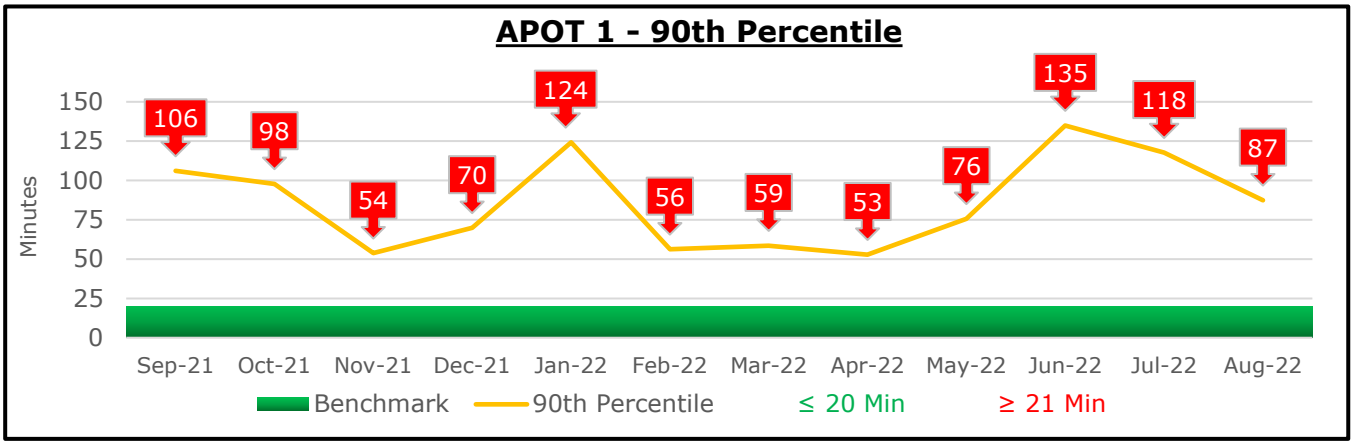
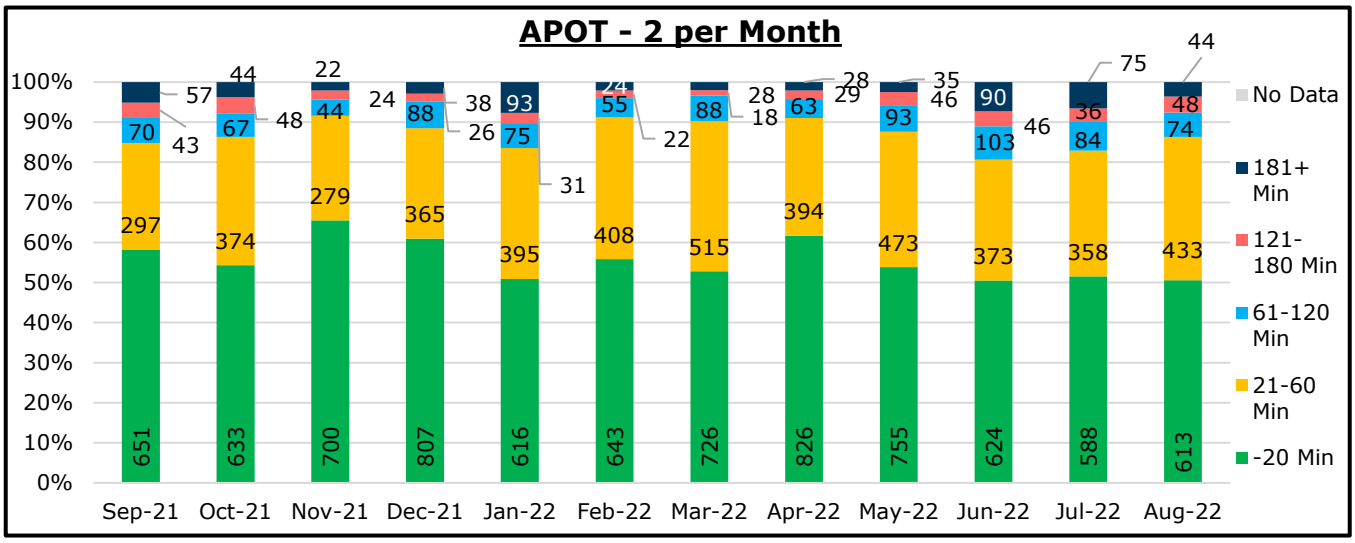
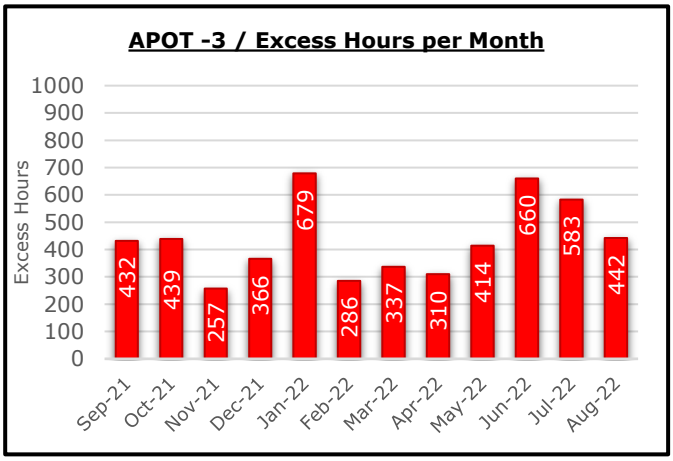
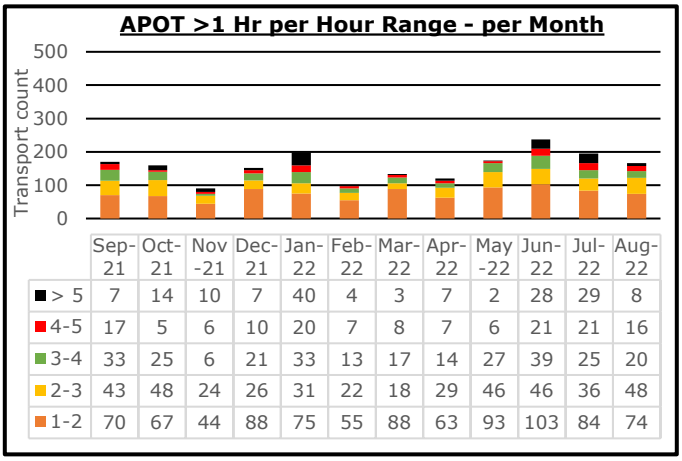






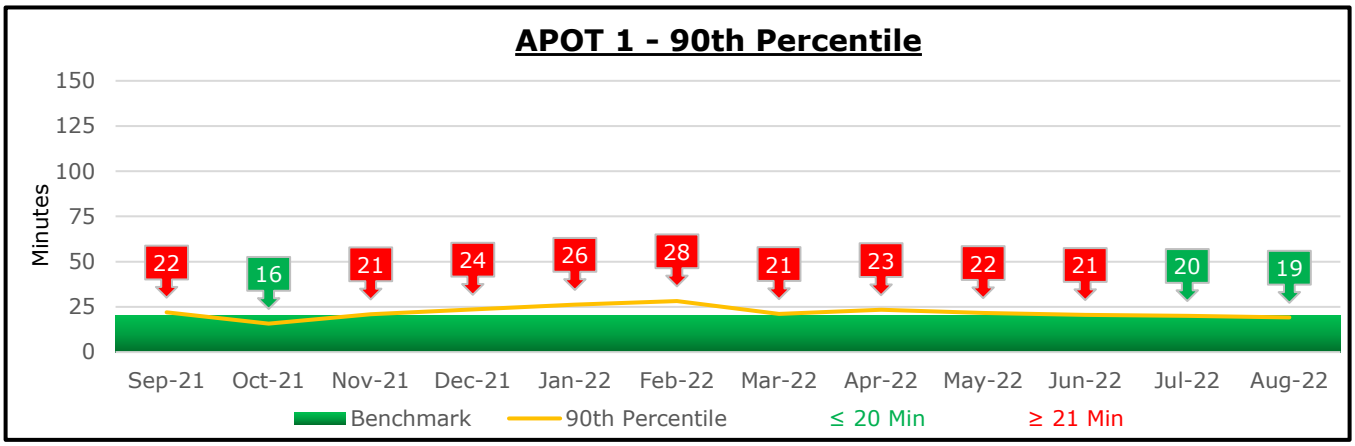


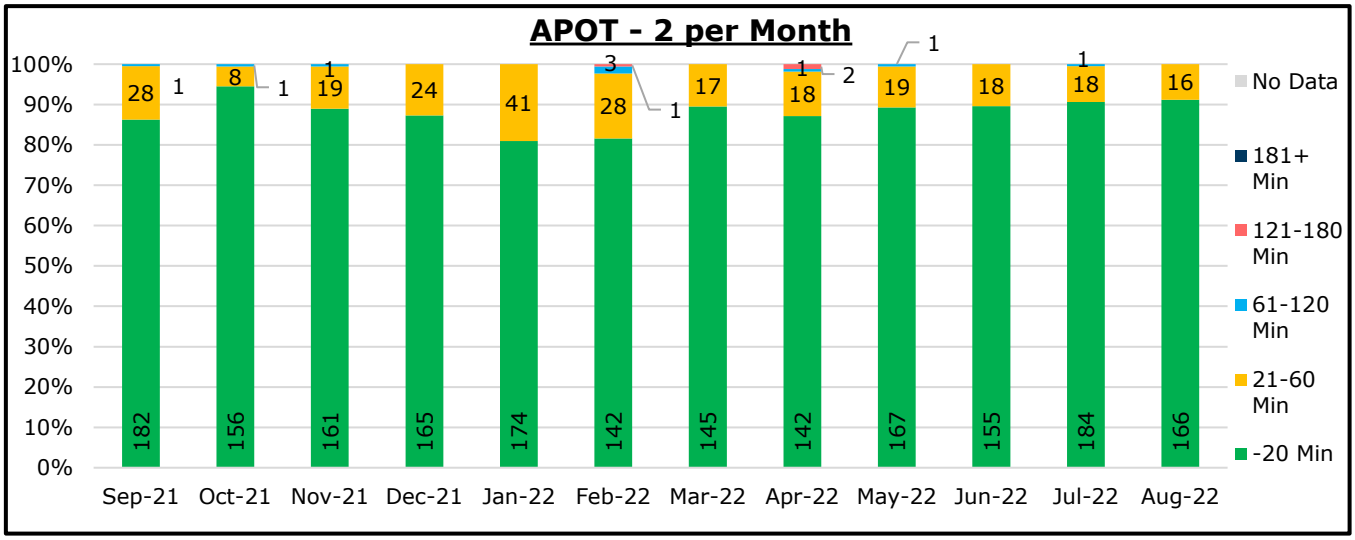
	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
> 5	7	14	10	7	40	4	3	7	2	28	29	8
4-5	17	5	6	10	20	7	8	7	6	21	21	16
3-4	33	25	6	21	33	13	17	14	27	39	25	20
2-3	43	48	24	26	31	22	18	29	46	46	36	48
1-2	70	67	44	88	75	55	88	63	93	103	84	74

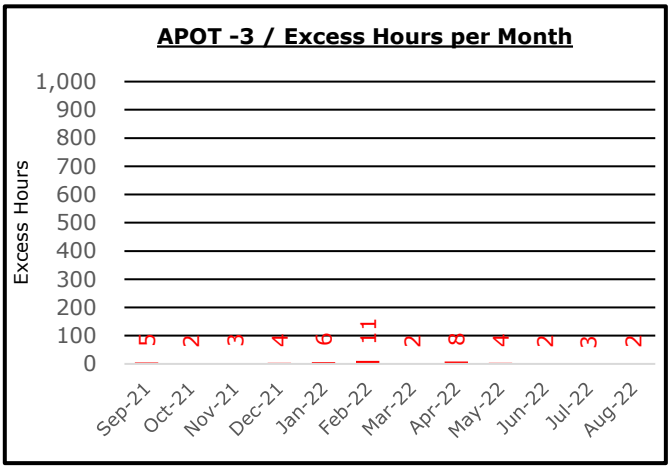
Completed by: Sacramento County Emergency Medical Services Agency (SCEMSA)
Updated: 9.7.2022

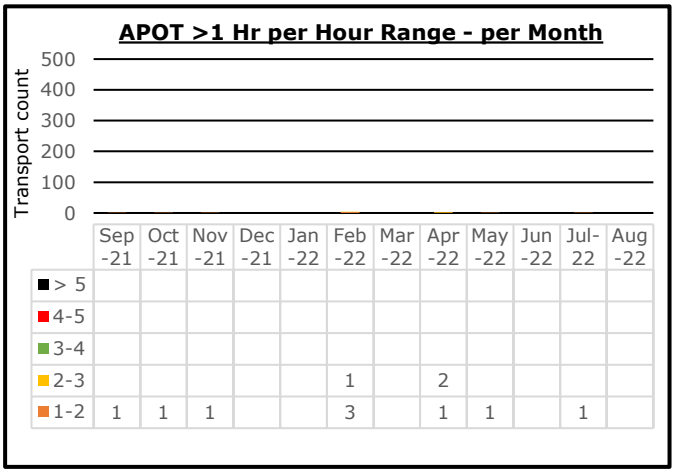
APOT 1, 2 & 3 - ROLLING 12 MONTHS / SACRAMENTO VA (VAMC)

APOT-1 represents the time (in minutes) under which 90% of patients have their care transferred from EMS to hospital staff. **APOT-2** is the percentage of patients whose care is transferred from EMS to hospital staff by designated time frames (see graph key for time ranges). **APOT-3** represents the excess time (in hours) over 20 minutes (Min.) aggregate of patient transferred from EMS to hospital per month. Illustrated is the System Total Excess hours per month. *Example: if APOT in minutes is 184 minutes then 184-20 (APOT benchmark) = 164 minutes. Then 164/60 = 2.73 hours.* APOT >1 hour represents any transport with an APOT greater than one hour per hour range.









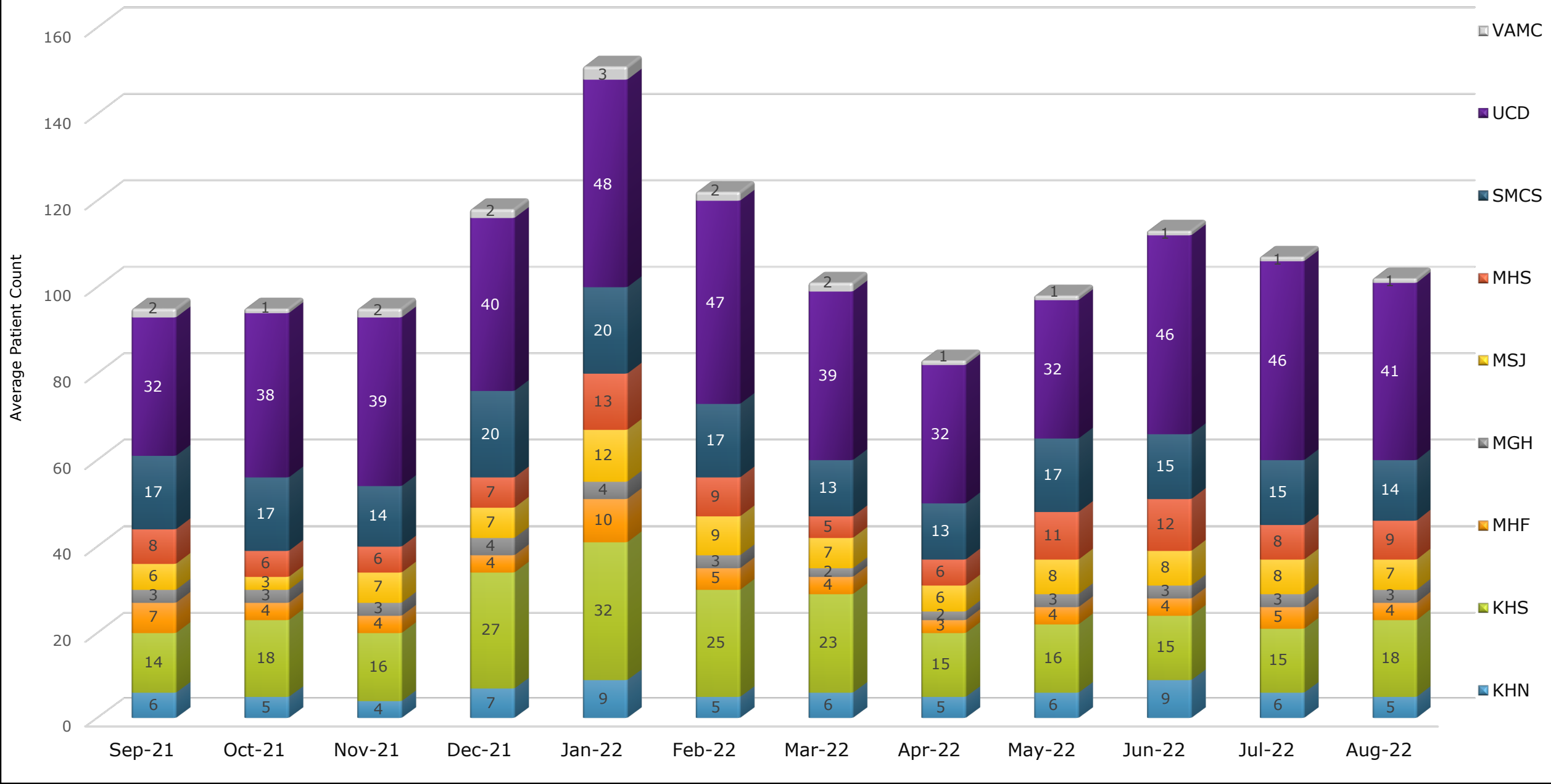
Completed by: Sacramento County Emergency Medical Services Agency (SCEMSA)
Updated: 9.7.2022

SCEMSA Quarterly Reports

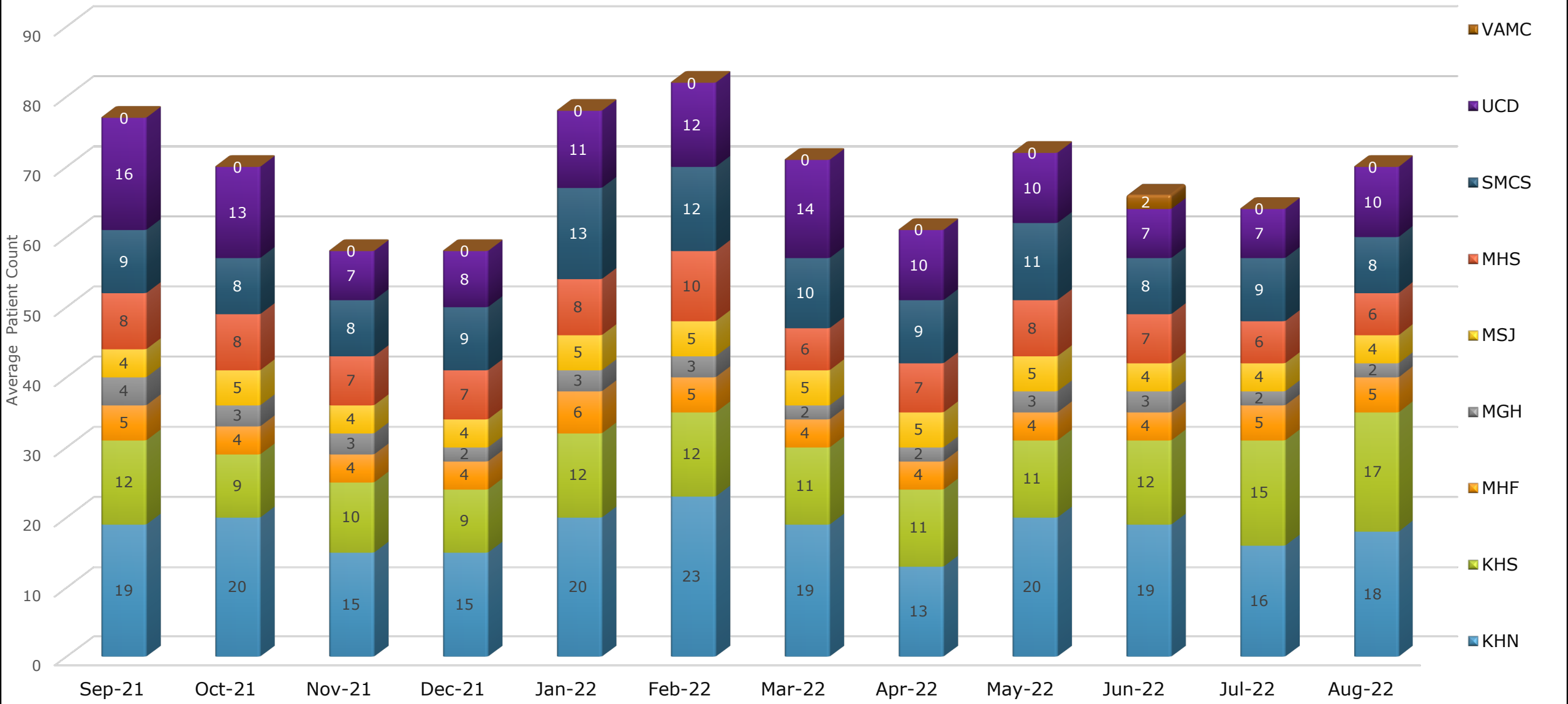
2022 - 2Quarter (April-June)

SCENE Calls (911-Response) – 2022- 2Quarter	Incident Count	Percentages	Notes
Total ePCRs received	75,662	100%	All records
Responses (911-Response)	59,908	79%	of total responses
Treated and Transported (of 911-Response)	**32,272**	**54%**	of 911 responses transported to the ED
Average Response Time of First Unit on Scene (PSAP to arrived scene)	0:12:23	N/A	
Average Response Time of First Unit on Scene (unit notified to arrived scene)	0:08:12	N/A	
Treated and Transferred Care or Assist (of 911-Response)	5,330	9%	
Transported By Law Enforcement (of 911-Response)	2	0%	
Dead at Scene (of 911-Response)	647	1%	
Cancelled (of 911-Response)	11,422	19%	No Patient found / No Contact / Prior to Arrival
RST -4 (Percentage of Response with Lights and Sirens)	37,928	63%	911 requests that included a lights and sirens response
RST -5 (Percentage of Transports with Lights and Sirens)	3,322	10%	911 request that included lights and sirens transport
IFT's	2936	4%	Treated & transported
Primary Impressions of Scene calls treated and transported	**Incident Count**	**Percentages**	
Traumatic Injury (T14.90)	4534	8%	
General Weakness (R53.1)	2900	5%	
Abdominal Pain / Problems (GI/GU) (R10.84)	2398	4%	
Behavioral / Psychiatric Crisis (F99)	2067	3%	
Non-Traumatic Body Pain (G89.1)	1702	3%	
No Medical Complaint (Z00.00)	1601	3%	
ALOC - (Not Hypoglycemia or Seizure) (R41.82)	1470	2%	
Respiratory Distress / Other (J80)	1453	2%	
Chest Pain - Suspected Cardiac (I20.9)	1197	2%	
Pain / Swelling - Extremity - non-traumatic (M79.60)	1191	2%	
Nausea/Vomiting (R11.2)	1041	2%	
Seizure - Post (G40.909)	921	2%	
Syncope / Near Syncope (R55)	921	2%	
Stroke / CVA / TIA (I63.9)	867	1%	
Sepsis (A41.9)	652	1%	
AMA/ Released / Refused / No Treatment of Scene Calls	**Incident Count**	**Percentages**	
AMA's	4,748	8%	
Patient Refused Evaluation / Care (without transport)	4,470	7%	
Patient Treated, Released (per protocol)	887	1%	
Total : AMA/ Released / Refused / No Treatment of Scene Calls	**10,105**	**17%**	

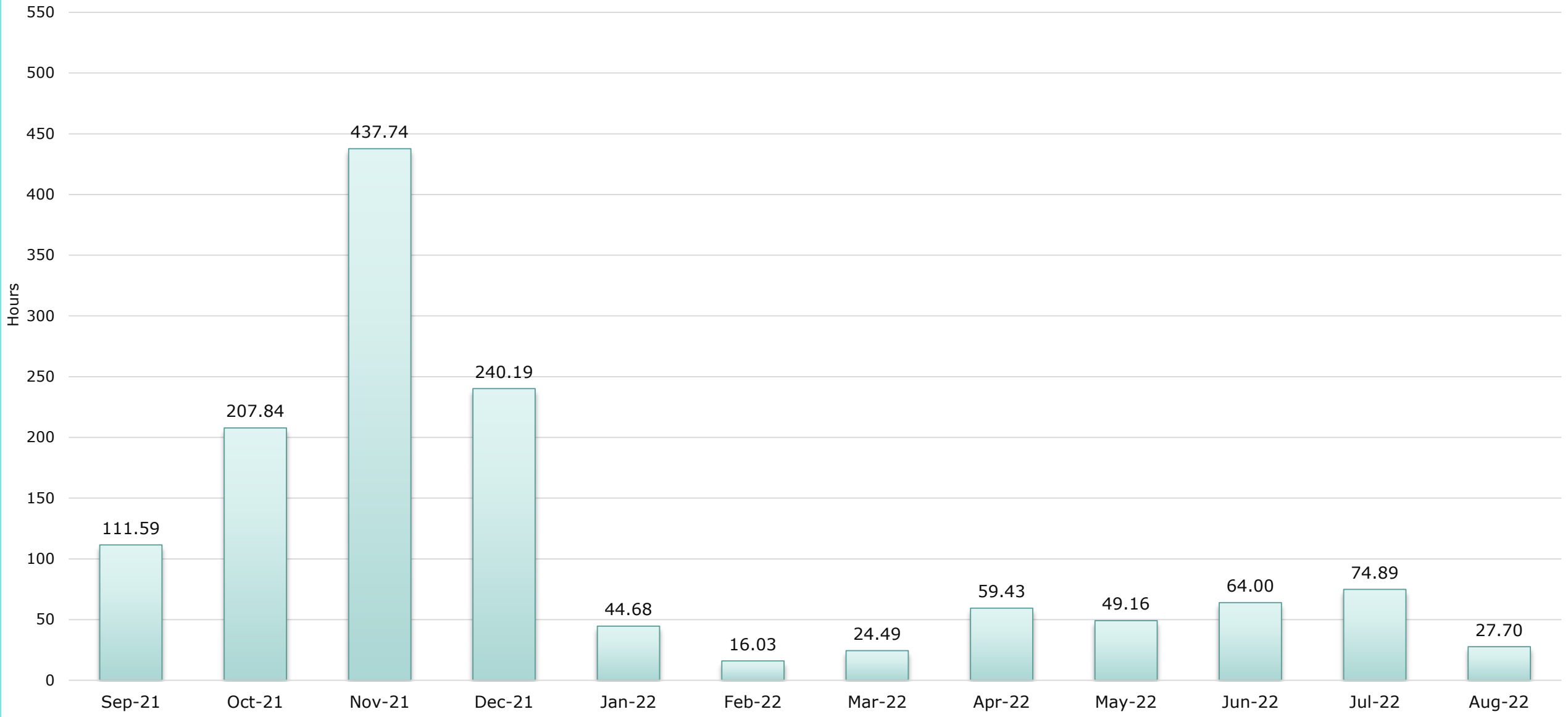
EMS: Patients on Medical Hold per Local Hospital Emergency Department



EMS: Patients Awaiting Placement into Psychiatric Facility per Local Hospital Emergency Department

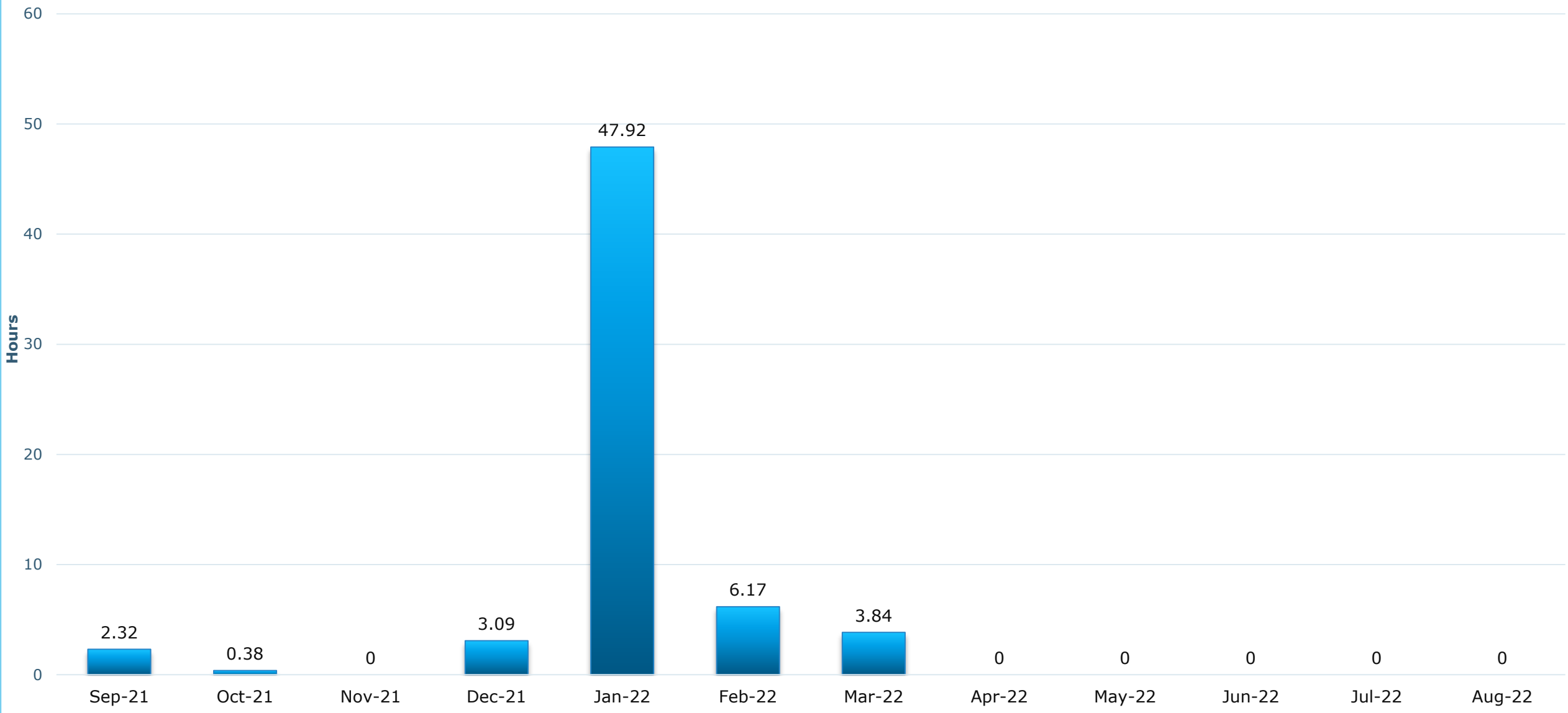


Total Advisory Hours per Month



Advisory Status Represents: CT or STEMI services unavailable / Power outage / Main power outage, using auxiliary power.

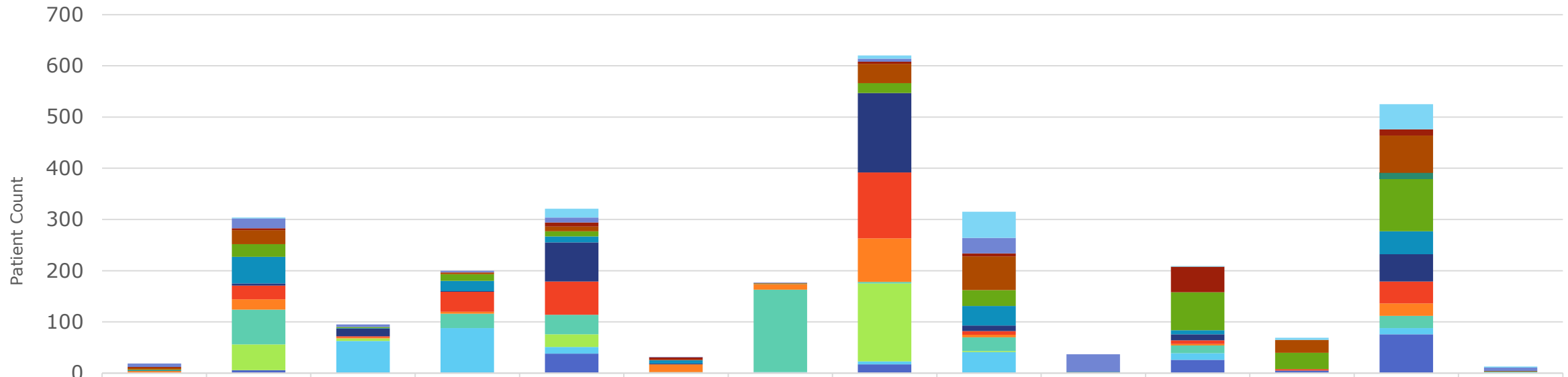
Total Internal Disaster Hours per Month



Internal Disaster Status: Damaged infrastructure Hazardous materials incident / Sheltering in place / Loss of main and auxiliary power / Loss of water supply / On campus fire or explosion / On campus security threat other event requiring hospital evacuation.

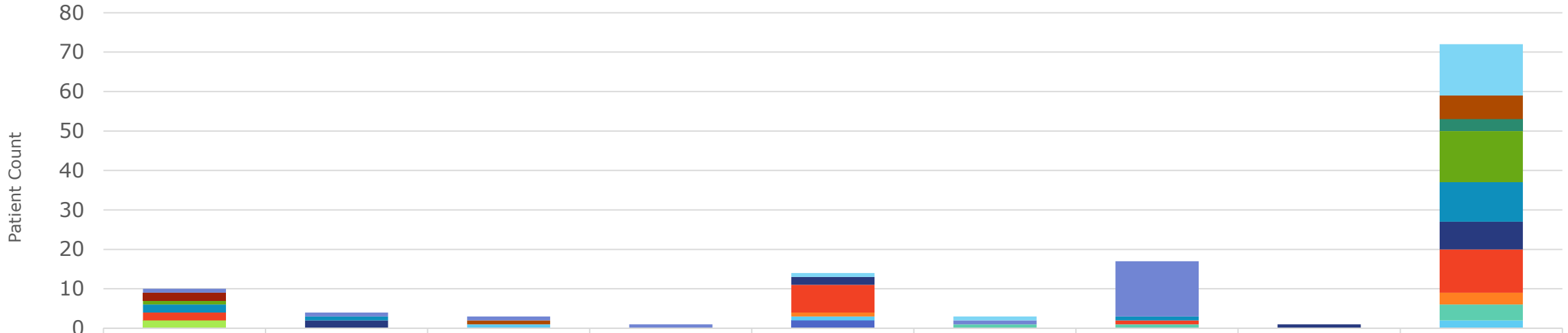
Interfacility Transports

Interfacility Transfers (IFTs) 2022-2Q - EMS Data



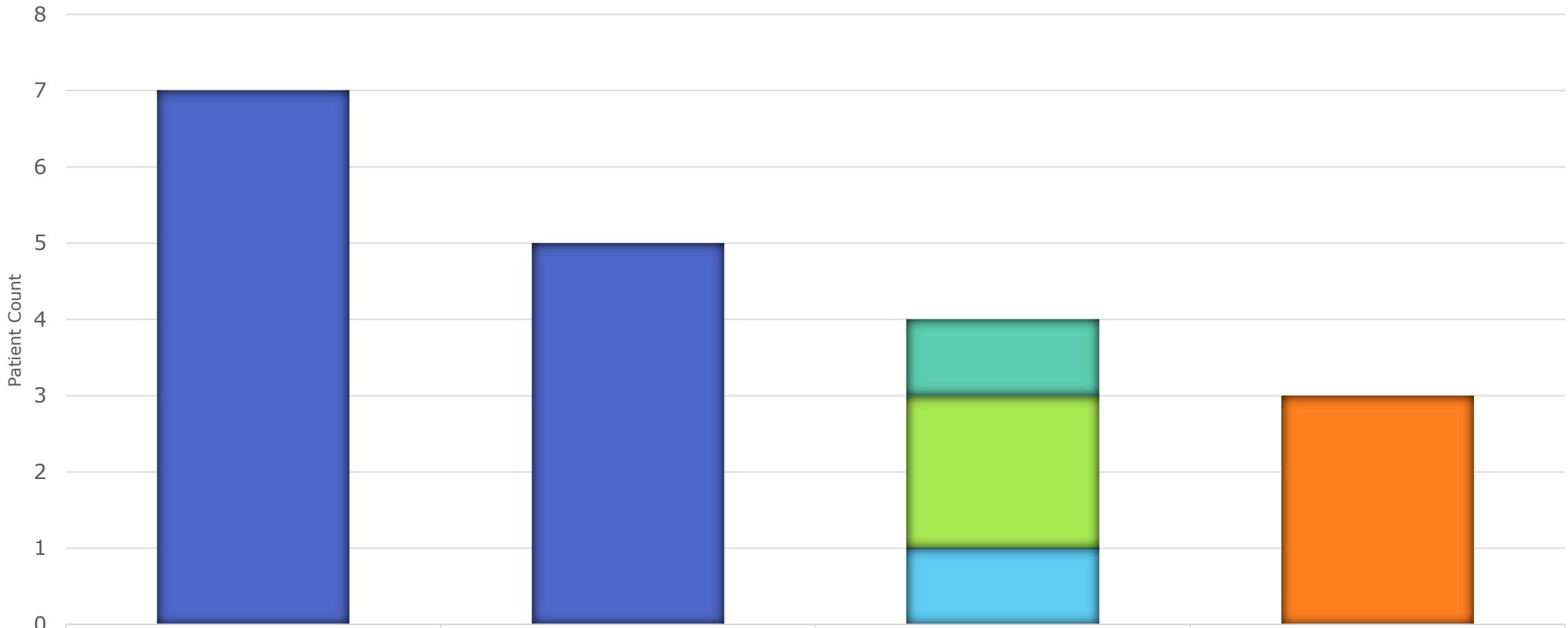
	Air	KHN	KHS	KRH	MGH	MHF	MHS	MSJ	OOA	Shriners	SMCS	SRMC	UCD	VAMC
VAMC- Send		2			17			6	51		1	4	49	2
UCD- Send	7	19	5	3	10	1	1	6	30	34				7
SRMC- Send	1	4		1	8	5	1	4	6		50		12	
SMCS- Send	4	27		3	9	1		38	66			25	73	1
Shriners- Send													12	
OOA- Send	1	25	2	13	10		1	19	31		74	32	102	
MSJ- Send	2	52	1	20	12	6			38	1	8		45	
MHS- Send		4	15	1	76	2		155	11		12		53	
MHF- Send		27	2	39	65		1	129	7	1	7	3	43	
MGH- Send	4	20	2	4		15	10	85	5		3		24	
KHS- Send		68		28	38	1	161	3	27	1	15		24	2
KHR- Send		50	5		25			152	2					
KHN- Send			63	87	13	1	1	6	40		13		12	
Air- Send		6		1	38		1	17	1		26	5	76	1

2022-2Q – Interfacility Transfers with Primary Impression of Trauma- EMS Data



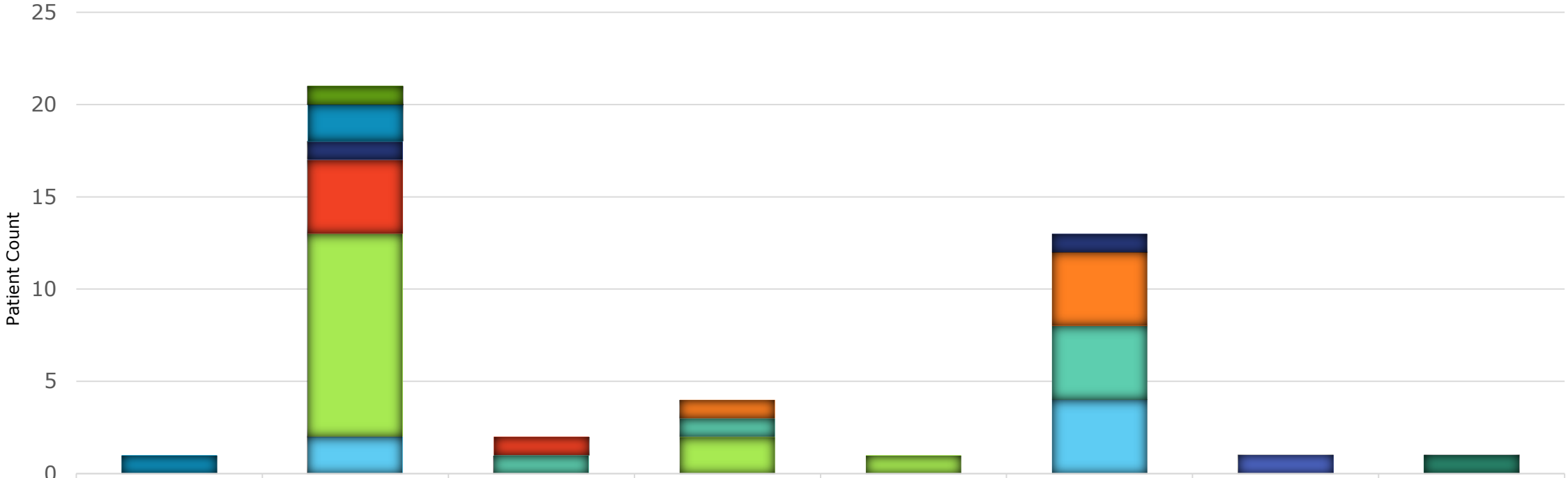
	KHN	KHS	KRH	MGH	MSJ	OOA	Shriners	SMCS	UCD
VAMC- Send					1	1			13
UCD- Send	1	1	1	1		1	14		
SRMC- Send	2								
SMCS- Send			1						6
Shriners- Send									3
OOA- Send	1								13
MSJ- Send	2	1					1		10
MHS- Send		2			2			1	7
MHF- Send	2				7		1		11
MGH- Send					1				3
KHS- Send						1	1		4
KHR- Send	2								
KHN- Send			1		1				2
Air- Send					2				

2022-2Q Interfacility Transfers with Primary Impression of STEMI - EMS Data



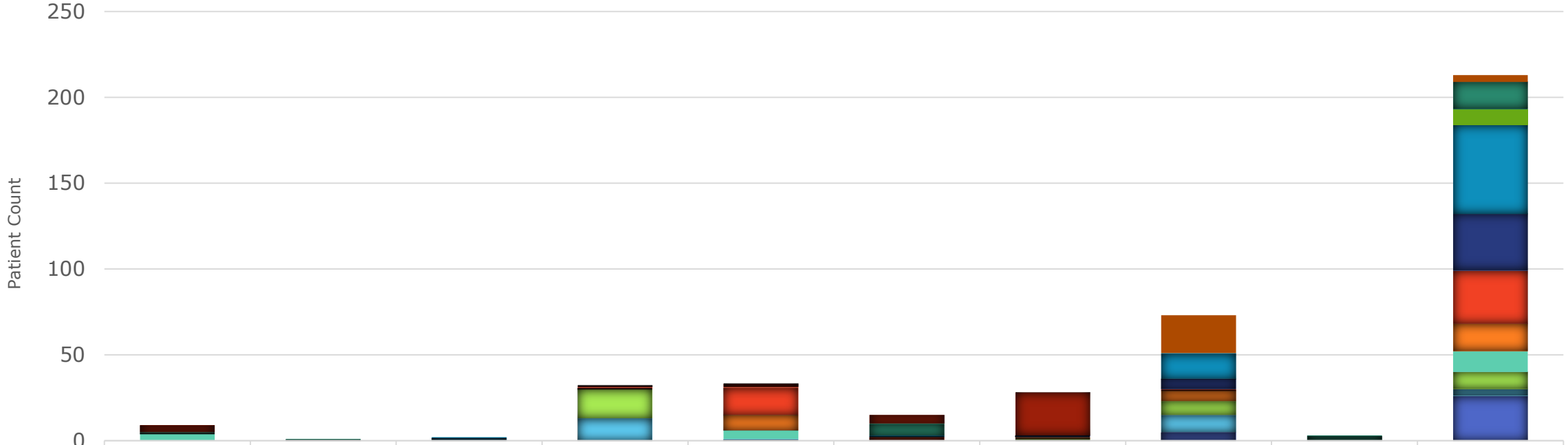
	KHS	KRH	MGH	UCD
VAMC- Send				3
MHS- Send			1	
MHF- Send			2	
KHS- Send			1	
KHN- Send	7	5		

2022-2Q Interfacility Transfers with Primary impression of Stroke – EMS Data



	Air	KHN	KRH	MGH	MHS	MSJ	SMCS	UCD
VAMC- Send								1
UCD- Send		1						
SMCS- Send	1	2						
OOA- Send		1				1		
MSJ- Send		4	1					
MHS- Send				1		4		
MHF- Send			1	1		4		
KHS- Send		11		2	1			
KHR- Send		2				4		
Air- Send							1	

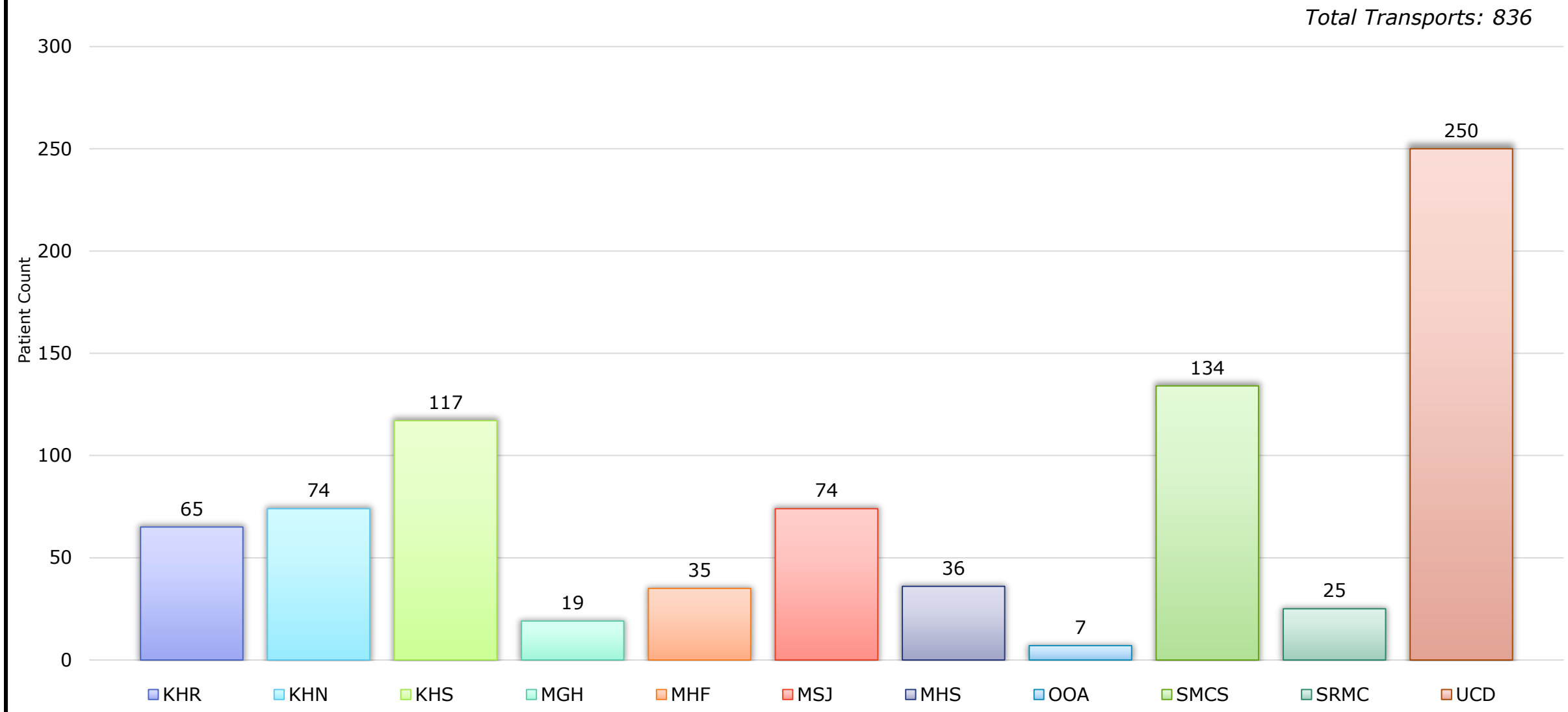
2022-2Q Interfacility Transfers Patients <15 Years Old - EMS Data



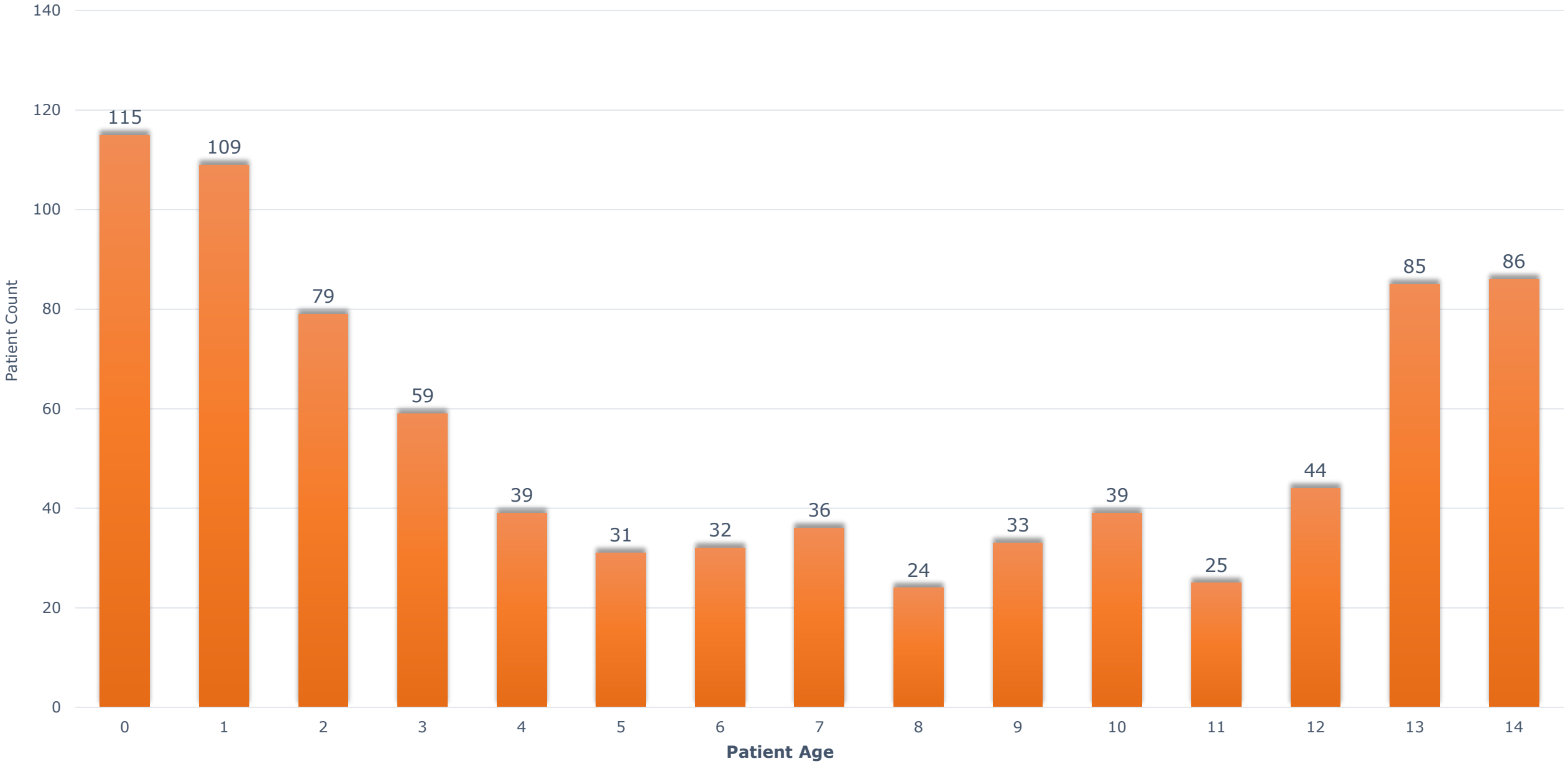
	Air	KHN	KHS	KRH	MSJ	OOA	Shriners	SMCS	SRMC	UCD
UCD- Send	4			1	2	5	25			
SRMC- Send								22		4
SMCS- Send	1	1				7			3	16
Shriners- Send										9
OOA- Send			2			1		15		52
MSJ- Send							1	6		33
MHS- Send				1	16	2		1		31
MHF- Send					9		1	6		16
MGH- Send	4				5					12
KHS- Send				17			1	8		10
KHN- Send				13	1			10		4
Air- Send								5		26

Pediatrics

Distribution of Scene Pediatric Patients to ED 2022-2Q - EMS Data



Count of 911 Response (Despite Outcome) per Patient Age <15
2022-2Q - EMS Data



Top 25 Primary Impressions for Transported Pediatric Patients 2022-2Q - EMS Data

Number	Primary Impression	Counts
1	Traumatic Injury	172
2	Seizure - Post	164
3	Behavioral/Psychiatric Crisis	50
4	Respiratory Distress/Other	45
5	General Weakness	36
6	No Medical Complaint	33
7	Fever	32
8	Nausea/Vomiting	32
9	Syncope/Near Syncope	29
10	Allergic Reaction	28
11	Overdose/Poisoning/Ingestion	26
12	Seizure - Active	23
13	Respiratory Distress/Bronchospasm	20
14	ALOC - (Not Hypoglycemia or Seizure)	17
15	Cold/Flu Symptom	17
16	Abdominal Pain/Problems (GI/GU)	13
17	Newborn	13
18	ALTE (BRUE)	11
19	Burn	8
20	Cardiac Arrest -Non-traumatic	8
21	Non-Traumatic Body Pain	8
22	Anaphylaxis	8
23	Airway Obstruction	4
24	Submersion/Drowning	3

STEMI

STEMI Dashboard - EMS Data

STEMI	System Total 2021 - 3Q	System Total 2021 – 4Q	System Total 2022- 1Q	System Total 2022- 2Q
Total transported patients with primary impression of STEMI	139	144	168	139
Total number of patients that received ASA or pertinent negative present	125	137	153	117
90% Scene time	0:31:41	0:16:26	0:16:59	00:16:52
Patient with eVitals.03 or eDevice.08 documenting ECG of STEMI (started monitoring 2022-1Q)	-	-	70	58
Percentage of STEMI primary impressions with a STEMI ECG	-	-	42%	42%
Patients with a pre-arrival notification (of STEMI ECG)	139	138	66	52
% Pre-arrival notification	100.00%	95.83%	94%	90%
90th % Time to First ECG (from arrival at scene to device)	0:14:33	0:20:00	-	-
90th % ECG to hospital notification	0:18:20	0:14:48	-	-

STEMI Core Measures - EMS Data

Core Measure	Definition	2021-3Q		2021-4Q		2022-1Q		2022-2Q	
		Patient Count	%	Patient Count	%	Patient Count	%	Patient Count	%
ACS-01	Number of patients 35 and older treated and transported to ED with a Primary (*or*) Secondary Impression of **STEMI** or **Chest Pain Suspected Cardiac** that received **ASA**	1,437	78.98%	1,532	70.89%	1,533	66.34%	1527	70.99%
ACS-04	Number of patients with Primary (*or*) Secondary Impression of **STEMI** or ECG of STEMI - transported to a PCI capable hospital that had a STEMI alert	161	90.06%	197	82.74%	215	82.33%	183	85.79%
ACS-03	90th Percentile in **minutes** of Unit Arrived on Scene to Patient Arrived at Destination (Primary Impression of STEMI)	141	0:31	144	0:33	173	0:34	140	00:32:33
ACS-06	90th Percentile in **minutes** of Unit Arrived on Scene to First ECG (Primary Impression of STEMI)	141	0:14	144	0:14	173	0:13	140	00:14:22

STEMI Primary Impression for Treated and Transported Patients

Hospital Name	2021- 3Q	2021- 4Q	2022-1Q	2022-2Q
KHR	7	9	11	8
KHN	0	1	0	0
KHS	34	35	54	30
MHF	0	0	1	0
MGH	23	24	24	22
MSJ	41	38	43	35
SMCS	15	17	17	24
SRMC	6	3	7	5
UCD	13	17	11	13
Totals	**139**	**144**	**168**	**137**

CARES Data

No New Data

STROKE

Stroke Core Measure – EMS Data

Core Measure	Definition	2021- 3Q		2021- 4Q		2022- 1Q		2022-2Q	
		Patient Count	**%**	**Patient Count**	**%**	**Patient Count**	**%**	**Patient Count**	**%**
STR-01	Prehospital Screening for Stroke Patients	971	96.70%	900	95.00%	1,011	95.84%	993	95.67%
STR-02	Glucose Testing for Suspected Stroke Patients	971	94.95%	875	97.22%	860	96.60%	993	93.76%
STR-04	Advanced Hospital Notification for Stroke Patients with positive Stroke Scale	551	95.10%	584	94.00%	94.01%	602	600	93.33%

Stroke Dashboard - EMS Data

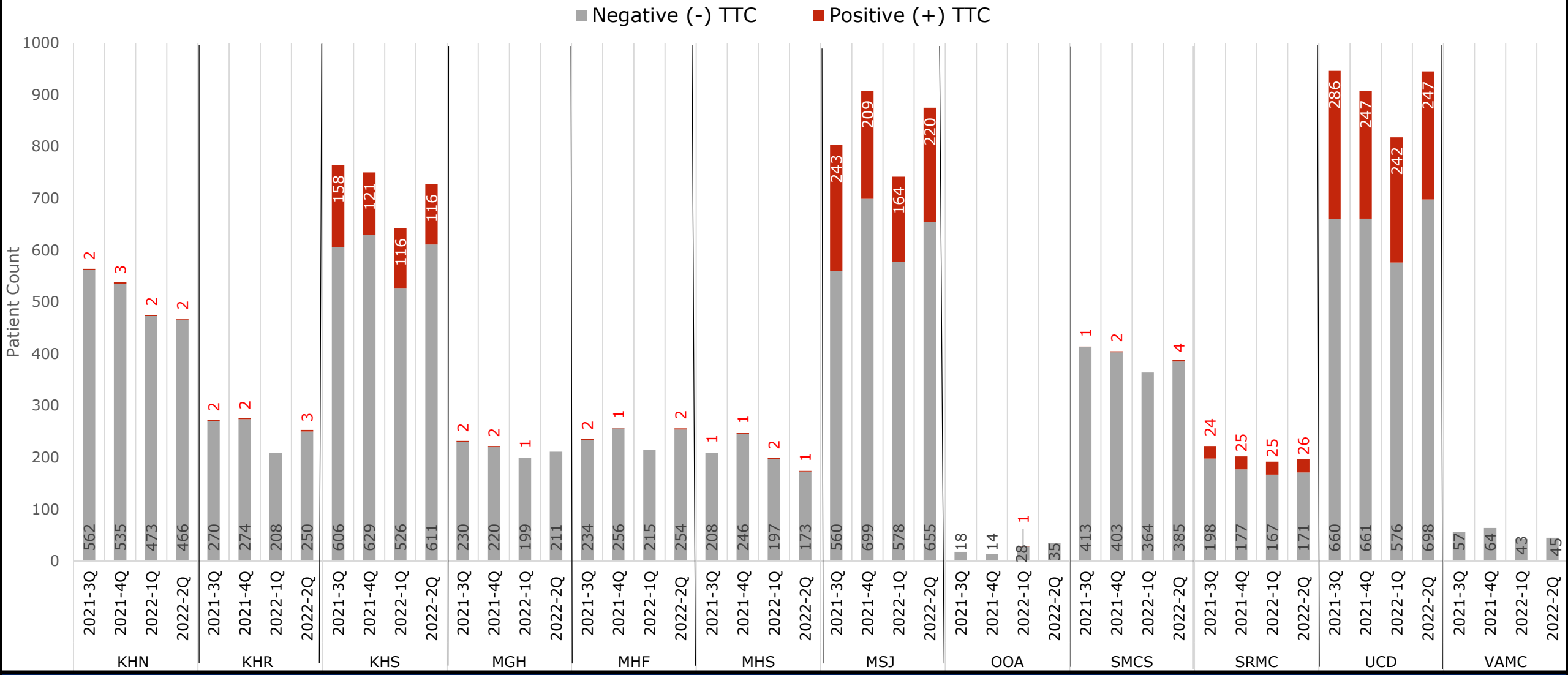
Stroke	System Total 2021- 3Q	System Total 2021- 4Q	System Total 2022- 1Q	System Total 2022-2Q
Total transported patients with Primary impression of Stroke	839	900	887	866
Number of patients with documented Stroke Screen	825	855	851	847
% of patients with documented Stroke Screen	98.33%	95.00%	95.94%	97.81%
Documented Glucose	816	875	860	865
% of documented Glucose	97.26%	97.22%	96.96%	99.88%
Patients with a Stroke pre-arrival notification	743	805	795	771
% of Stroke pre-arrival notification	88.56%	89.44%	89.63%	89.03%

Stroke Primary Impression for Treated and Transported Patients - EMS Data

Hospital Name	2021- 3Q	2021- 4Q	2022-1Q	2022-4Q
Kaiser Antioch	1	0	1	0
KHR	35	47	38	41
KHN	126	173	147	162
KHS	167	153	176	150
Lodi	1	0	1	0
MGH	48	37	42	38
MHF	41	66	72	45
MSJ	180	164	171	184
MHS	73	95	76	84
VAMC	2	0	0	
SMCS	75	76	81	74
SRMC	24	17	20	29
UCD	66	72	62	59
Total	**839**	**900**	**887**	**866**

Trauma

Transported Patients with a Primary Impression of Trauma per Quarter – EMS Data



Scene Time for Patients with +TTC 2022-2Q

90th Percentile - 00:15:00
Average - 00:10:39

13.58% of Trauma had +TTC
99.29% of patients with +TTC were taken to a trauma center