

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



**9616 Micron Ave. Suite 960
Sacramento, CA. 95827
September 14, 2023**

| Agency | Representative | Agency | Representative |
|------------------------------|------------------------|-----------------------------------|------------------|
| American Medical Response | Mark Mendenhall | Sutter Medical Center, Roseville | Rose Colangelo |
| American Medical Response | Paul Harper | 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 | Dave Buettner |
| Folsom Fire Department | Mark Piacatini | Sutter Health | Zach Rucker |
| Sacramento City Fire | Brian Pedro | Kaiser Sac | Rich M. |
| UC Davis Medical Center | Samantha Brown, M.D. | UC Davis Medical Center | Jeremy Veldstra |
| Mercy San Juan/Alpha One | Nathan Beckerman, M.D. | Alpha One | Nige Coibian |
| NorCal Ambulance | Nic Scher | Alpha One | Matt Burruel |
| EDC ESA | Christy Jorgensen | Mercy San Juan | Amelia Hart |
| SCEMSA | Kevin Mackey, M.D. | Methodist Hospital | Krystyna Ongjoco |
| Sacramento Metropolitan Fire | John Rudnicki | Medic Ambulance | Brian Meader |
| Sacramento Metropolitan Fire | David Sutton | Medic Ambulance | Lisa Curlee |
| Sacramento Metropolitan Fire | Adam Blitz | American Medical Response | Jack Wood, D.O. |
| Reach/Calstar | Corey Collier | Kaiser | Sarah Henry |
| Cosumnes Fire | Robert Kasparian | Kaiser Sacramento | Greg Smith, M.D. |
| Sutter Health | Karen Scarpa, M.D. | Alpha One | Nick Coibain |
| SCEMSA Staff | All | Sutter Roseville | Heather Garcia |

| ITEM | DETAILS | ACTION |
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| Welcome and Introductions | NONE | NONE |
| Public Comment | NONE | NONE |
| Minutes Review | September 14, 2023 | Approved: Dr. Naik and Dr. Rose |
| SCEMA Updates | Dave Magnino: CEMSIS Update – October 1, 2023, CEMSIS 3.5 goes live. That gives one quarter to work out all of the issues for our different providers before 3.4 is gone. Please talk to your vendors ASAP because the provider's data will not be accepted into CEMSIS once 3.4 is gone. 3.4 will be turned off at 23:59 on December 31, 2023. If providers are having problems with their vendors, please reach out to Dave, and he will make a phone call to the State to get the issue resolved. If your agency is ready to go live with 3.5, go live with it. CEMSIS will | None |

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| | <p>accept it now. Data may be a little skewed while Dorthy and Yvonne figure out the collection of both 3.4 and 3.5.</p> <p>Ben Merin: Admin edit has been made to PD#5060 – Hospital Diversion (Edits can be seen below under New Business). This has been done to accommodate procedural changes in EMS Resource regarding Advisories.</p> | |
| <p>APOT/Wall Time Reports</p> | <p>Sacramento County is seeing general worsening in the month of August with Covid increasing again. Conversation has taken place with stakeholders regarding PD# 5050, and Dr. Kann has decided to push the policy out early to help with wall times that are currently worsening. The policy went live on September 5th with the expectation that crews will be trained on this policy by November 1st.</p> <p>Dr. Kann explained the importance of the patient being delivered to the hospital where they normally receive care due to the length of time it takes to transfer the patient to their appropriate hospital. This excludes STEMI, Stroke, and Trauma patients. Getting patients to the right hospital and their in-network hospital equates to APOT. The problem lies with the “pipe” from the ED to in-house hospital beds and in-house hospital beds to home/SNF. This is a problem for APOT. If the “pipe” can be made bigger by getting the patients to the right hospital the first time this will directly impact APOT times.</p> <p>Dr. Rose discusses the success of the Quick Care Program that Alpha-One has implemented. The patient that can be treated on the EMS gurney stays on the EMS gurney, is treated by the ED doctor, and is transported home by the same crew.</p> | <p>All Reports Attached to Minutes</p> |

| Old Business | | |
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| <p>PD# 8004 – Suspected Narcotic Overdose</p> | <p>Approved with Edits: Language removed under BLS: 3. 2mg dose may be repeated x 1 for a max dose of 4 mg. 6. If trauma is suspected, assess for traumatic injury per PD# 8015. 7. Spinal motion restriction when indicated per PD# 8044. 8. Perform blood glucose determination. 9. If the patient is seizing, protect the patient from further injury.</p> <p>Language added under BLS: 3. May repeat every 5 minutes, as needed, until the patient is breathing spontaneously. 5. Perform blood sugar determination. Refer to PD# 8002 – Diabetic Emergencies.</p> <p>Language removed under ALS: 2. a. Can also be given IM when IV or IN is difficult or impossible. • up to 6mg, IN or IM. If IN Naloxone cannot be titrated, it should be given per the manufacturer-specified direction. 3. If blood glucose ≤ 60 mg/dl, refer to PD# 8002 Diabetic Emergencies. (this is stated in the BLS section.) Cross Reference: PD# 8015 – Trauma PD# 8044 – Spinal Motion Restriction (SMR)</p> <p>Language added under ALS: 2. a. • May repeat every 5 minutes, as needed, titrate to adequate respiratory status.</p> <p>Additional language added: Naloxone Leave Behind Kit: Indication: A. History of illicit substance use or active prescriptions for opioids. B. History of physical exam findings consistent with IV drug use – needle marks, abscesses at injection sites. C. Physical environment suggestive</p> | <p>Julie Carrington would like to know why the Naloxone Leave Behind Kit is included in this policy when it is a policy on its own already. She also feels that the information in this policy is more specific than the information in the Naloxone Leave Behind policy. Dr. Kann states he will take a look at it and make a decision whether to leave this information in this policy.</p> |

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| | <p>of illicit substance use – paraphernalia opioid pill bottles present at the scene. BLS or ALS: A. If respiratory distress or altered mental status, refer to appropriate county policy. B. Provide Naloxone Leave Behind Kit. C. Review indications for Naloxone use with a bystander, friend, or family member. D. Review instructions for use with a bystander, friend, or family member. E. Review the DHS opioid resource information sheet. Cross Reference: PD# 2002 – Naloxone Leave Behind</p> | |
| New Business | | |
| PD# 2002 – Narcan Leave Behind – NEW POLICY | Approved with no edits | <p>Dr. Kann states that this policy is the framework for our providers to leave Narcan behind. Julie Carrington would like to know if this program is going to be “volunteer program” for agencies. Dr. Kann states this is a Sacramento County driven program, and they can provide training and phone numbers for follow up resources to the patients that the medics have left Narcan behind. Sacramento County is way behind in starting this program. A link will be provided for at a later date for Agencies to obtain the Narcan for this program.</p> |
| PD# 2003 – BLS Tiered Response System – NEW POLICY | Approved with no edits or comments | <p>Dr. Brown would like the paramedics to document in the transporting agencies narrative what they performed. Dr. Sloane suggests creating a sub-committee to discuss this. One speaker states documentation of the paramedic’s assessment/treatment is already being done.</p> |

PD# 2004 – Patient Privacy
– NEW POLICY

PD# 2030 – Advanced Life
Support Inventories

PD# 2033 – Determination of
Death

PD# 5060 – Hospital
Diversion

**Approved with no edits or
comments.**

Approved with edits:
Language added under Policy:
A. Providers may choose to carry **only
one narcotic analgesic (Fentanyl or
Ketamine*)** and only one non-
narcotic analgesic (Acetaminophen
or Ketorolac) for pain control.
***Note: Although Ketamine is not a
narcotic, it will be considered an
option in lieu of Fentanyl if providers
choose not to carry both.**
Language removed under
medications:
**D50 OR
D10% OR both**
Language added under medications:
Dextrose: **D50, D25, and D10**

Approved with edits: Language
added under Determination of Death
Paramedic Only A.3.
“Wide complex”

**Administrative Edits. In Effect on
the Website September 15, 2023:**
Language removed under Procedure:
**D. ADVISORY - Partial closure based
on temporary limited service:**
1. CT scanner unavailable:
Prehospital personnel will transport a
patient to the next most appropriate
facility with CT services if the patient
has any of the following signs or
symptoms:
**a. Any patient with a Cincinnati
Prehospital Stroke Scale (CPSS) > 0.**
**b. Sudden onset of “worst headache
of their life.”**
**c. Unexplained new altered level of
consciousness: [Glasgow Coma Scale
(GCS) <12] without response to
glucose, Glucagon, or Naloxone.**
d. Head injuries with GCS < 14, any

head injury on anticoagulants, or any penetrating head injury.

2. Cath Lab unavailable: Prehospital personnel will transport a patient to the next most appropriate facility if the patient has any of the following signs or symptoms:

a. ECG indicating acute STEMI.

E. Trauma Diversion- Trauma centers that cannot provide critical trauma services due to equipment failure or staffing or operating room availability may request temporary trauma diversion.

a. The trauma services medical director or designee shall determine when the facility is unable to care for additional trauma patients.

b. Prehospital personnel will transport all critical trauma patients to the next most appropriate facility.

Language added under Definitions C.:

1. The trauma services medical director or designee shall determine when the facility is unable to care for additional trauma patients.

2. Prehospital personnel will transport all critical trauma patients to the next most appropriate facility.

D. STEMI Diversion – STEMI receiving centers may divert suspected STEMI patients under one of the following circumstances:

1. Critical diagnostic/treatment equipment failure or scheduled maintenance.

2. The STEMI services medical director/designee determines their hospital is unable to care for additional STEMI patients.

E. Stroke Diversion - Stroke receiving centers may divert suspected stroke patients under one or more of the following circumstances:

1. There is no CT capability at the intended receiving facility.

2. The intended receiving facility is

PD# 8001 – Allergic Reaction/Anaphylaxis

experiencing an unusually high number of stroke patients and is at capacity to provide timely and optimal care.

Approved with edits

Language Removed Under BLS:

- 2. Secure Airway
- 5. Use the lowest concentration and flow rate of O₂ as possible.

Language Added Under BLS Allergic Reaction:

- 1. Assess C-A-B
- 4. Position of comfort, reduce anxiety
- 5. SPO₂ with supplemental O₂ as necessary to maintain SP0₂ ≥ 94%
- 6. Suction as Needed

Language Removed Under ALS:

NOTE: Epinephrine should be used cautiously in patients > 35 years old or with a history of CAD or HTN.

The new language added regarding Bradykinin Mediated Angioedema and Histamine Induced Angioedema has not been an accepted change and is removed.

Julie Carrington would like it to be recognized that this policy is being pulled out of turn, and updates to this policy only went into effect on May 1, 2023.

Dr. Kann responds by stating that TXA for the treatment of Bradykinin Mediated Angioedema can reduce the time of a hospital stay, helping to reduce APOT times. If there is a "Best Practice," we should incorporate it and not wait a year to implement it.

Julie states her challenge is getting her medics to go through the process of pulling, mixing, and administering it. She is still working on getting them on board to do this. She agrees Best Practices are wonderful, and we must move that way. She is asking for consistency due to the challenge of bringing these back out of order and updating them again when it was just done. She asks if there is a compelling reason to bring this out of turn unless we see a lot of Bradykinin Angioedema.

Dr. Rose asks if there is evidence that shows administering TXA 20 minutes prior to arrival at the ED makes a significant difference. He states that Bradykinin Angioedema and Histamine induced Angioedema is difficult for him to dx sometimes. He has never seen the data that changes the outcome if TXA is administered by the medics prior to

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| <p>PD# 8020 – Respiratory Distress-Airway Management-Respiratory Failure</p> <p>PD# 8025 – Burns</p> | <p>Approved with edits New language regrading nebulized TXA removed.</p> <p>Approved with edits Language removed under BLS: ABC's/Routine Medical Care: Stop the burning process. Administer supplemental O₂ as necessary to maintain SpO₂ ≥ 94%. Be prepared to support ventilation with appropriate airway adjuncts. Check for associated injuries and apply dry sterile dressings to burned areas. Inhalation Injury: Assess for: a. Burns around face and neck.</p> | <p>arriving at the ED. It adds one more task for the medics and what I really want is for them to get them to the hospital quickly and does it really make giving it in the field decrease wall times. Dr. Kann does not have that data. Dr. Rose also states that currently, in the protocol, the dose for Epi states "use with caution greater than 35 years", but the current allergy society states there are no contraindications for the use of Epi in acute Anaphylaxis or impending airway issues. Dr. Mackey states that Bradykinin and Histamine induced Angioedema are not broken down and trained on in Paramedic schools, causing a heavy lift to educate Paramedics in the field. He would also like to wait for a bigger study to be released to support this change. Dr. Kann made the decision to remove the new edits regarding Bradykinin and Histamine induced Angioedema.</p> <p>Proposed language regarding treatment of Hemoptysis with nebulized TXA is not accepted in this policy. It will be added for oral bleeding/Epistaxis with base contact to the Hemorrhage protocol.</p> |
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- b. Singed nasal hairs.
- c. Soot around nose and mouth.
- d. Chemical inhalation.
- 6. Remove the source of the burn. Wash with copious amounts of water.
- 7. Electrical burns are potentially severe injuries not apparently visible from the surface wound that require further treatment in the hospital.
- 10. Transport.

Language added under BLS:

- 2. Perform ABCs.
- 3. Assess for inhalation injury (singed nasal hairs, hoarse voice or stridor, oral or facial burns) and administer supplemental O2 as necessary to maintain SpO2 ≥ 94%. Be prepared to support ventilation with appropriate airway adjuncts.
- 4. Estimate the size of the burn (see below).
- 5. For burns < 30% TBSA AND no inhalation injury, stop the burning process by applying COOL RUNNING WATER (CRW) over the burn. The goal is cumulative (bystander and first responder) application of CRW for 20 minutes.
- 6. Apply CRW over the burn for 20 minutes.
- 8. Avoid hypothermia by isolating and cooling only the burned area. Keep unaffected body parts warm by covering them as much as possible and use the heater in the passenger compartment.
- 9. After cooling the burn, apply a covering to the burn (dry non-stick gauze, loose plastic wrap, etc).

Approved with edits

Language Removed:

Definitions:

A. Mild Distress - The patient is able to speak full sentences; the patient may have an elevated pulse and blood pressure; the patient may be

Dr. Naik states the dispatch is also giving these instructions.

If you want more information you can go to: <https://www.20crw.org/>

PD# 8026 – Respiratory Distress

diaphoretic and weak; mental status is unaffected; no cyanosis is present.
B. Moderate Distress - The patient is able to speak a few words; the patient may have an elevated pulse and blood pressure; the patient may be diaphoretic and weak; mental status is unaffected; mild cyanosis of lips and digits may be present.
C. Severe Distress - The patient is unable to speak; the patient may have decreased/elevated pulse and/or decreased/elevated blood pressure; mental status is altered; more central and profound cyanosis is present.

Under Caveats Language Removed:

A. Patients may have several disease processes together, producing shortness of breath. Wheezing may occur in diseases other than asthma, and peripheral edema may occur in settings other than congestive heart failure (CHF). Assessment should usually yield a single treatment plan. Commit yourself to a single assessment - you may modify this assessment based on response to therapy and as additional information becomes available, modify the treatment plan.

B. Patients may have diseases producing shortness of breath that cannot be relieved with any prehospital treatments. Some patients will present to the prehospital personnel so far in respiratory failure that maintenance/establishment of an airway together with expeditious transport are the only treatments possible.

B. Hemoptysis (common causes):

1. Malignancy
2. Bronchiectasis
3. Infection:
 - a. Lung abscess
 - b. Necrotizing pneumonia

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| <p>PD# 8065 – Hemorrhage</p> | <p>c. Fungal infection d. Tuberculosis e. Septic pulmonary embolism f. Vasculitis g. Iatrogenic causes:</p> <ul style="list-style-type: none"> • Tracheoinnominate fistula • Post-biopsy • Bronchoscopic procedure <p>D. Continuous Positive Airway Pressure (CPAP) and Bi-PAP are highly effective at improving respiratory distress and should be attempted if available in all patients with moderate and severe respiratory distress. In general, one provider should monitor and manipulate CPAP leaving the primary provider to focus on the overall condition of the patient.</p> <p>Language Added: Policy BLS:</p> <ol style="list-style-type: none"> 1. Assess C-A-B. 3. Position of comfort, reduce anxiety. 4. SpO2 with supplemental O2 as needed. 5. Suction as needed. 6. CPAP for severe dyspnea. 7. Airway adjuncts as needed. <p>Language Added: Policy ALS:</p> <ol style="list-style-type: none"> 1. Cardiac monitoring and ETCO2 measurement as available. 2. Vascular access, but do not delay airway management. 3. Consider intubation for significant hypoxia, dyspnea, or impending airway loss. <p>Approved with edits Language added under Notes: F. Epistaxis Language added: Epistaxis BLS:</p> <ol style="list-style-type: none"> 1. Assess C-A-B. 2. Secure airway. 3. Position of Comfort, reduce anxiety. 4. Suction as needed. | <p>Treatment with TXA for Epistaxis/oral bleeding will be added with base consult. Also, other September edits to this policy will be reviewed and brought back to December MAC/OAC for approval.</p> |
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| <p>PD# 8067 – Sepsis/Septic Shock</p> <p>PD# 8837 – Pediatric Airway Management</p> <p>PD# 9004 – Pediatric Burns</p> | <p>5. Apply ice and direct pressure across the bridge of the nose.</p> <p>6. SpO2 with supplemental O₂ as needed.</p> <p>ALS:</p> <ol style="list-style-type: none"> 1. Cardiac monitoring and ETCO₂ measurement as available. 2. Vascular access, but do not delay airway management for suspected posterior hemorrhage. 3. Consider Prepare for intubation for significant hypoxia, dyspnea, or impending airway loss. 4. For stable patients, encourage vigorous nose blowing to remove clotted blood. 5. Soak 500 mg of TXA on a cotton pledget and insert into the bleeding nostril. <p>Under ALS treatment flow chart: TXA IV/IO dose changed from 1g to 2g Flow chart for ALS Epistaxis added. Flow chart for ALS For Traumatic Hemorrhage changed to clearly identify For Traumatic Hemorrhage.</p> <p>Approved with edits Language added under ALS: 3. PRESSURE BAG ALL SALINE BOLUSES</p> <p>Approved with edits Language added under Procedure/ALS: E. 6. Inadequate oxygenation and ventilation with an iGel device on the 4th attempt will constitute a failed airway and trigger diversion and a FAILED AIRWAY PRE-ALERT to the closest ED for airway management.</p> <p>Approved with edits Language removed under BLS: 1. ABC's/Routine Medical Care: a. Stop the burning process. Remove the patient from the source of the burn. Remove burning or smoldering clothing and remove</p> | <p>The discussion was brought up regarding paramedics carrying LR for Sepsis. It was decided that it would be left as NS bolus. It will be addressed if there is an NS shortage.</p> |
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jewelry. Administer supplemental O₂ as necessary to maintain SpO₂ ≥ 94%. Be prepared to support ventilation with appropriate airway adjuncts. Check for associated injuries and apply dry sterile dressings to burned areas.

2. Inhalation Injury: Assess for:
 - a. Burns around face and neck.
 - b. Singed nasal hairs.
 - c. Soot around nose and mouth.
 - d. Chemical inhalation.
3. Caustic and Chemical Burns: Wear protective clothing and gloves and consider the presence of hazardous materials. Remove the source of the burn. Remove all clothing. Wash with copious amounts of water. Do not scrub.
4. Electrical Burns: Electrical burns are potentially severe injuries not apparently visible from the surface wound that require further treatment in the hospital. Check for and dress all entrance and exit wounds.
5. Transport: Any patient with the following shall be transported to UCDMC Burn Center:
 - a. Partial thickness > 9% of the body surface.
 - b. Any electrical or chemical burn.
 - c. Evidence of possible inhalation injury.
 - d. Any burn to face, hands, feet, genitalia, perineum or major joints.
6. Transport.

Language added under BLS:

1. Remove the patient from the source of the burn, then remove burning or smoldering clothing and remove jewelry
2. Perform ABCs
3. Assess for inhalation injury (singed nasal hairs, hoarse voice or stridor, oral or facial burns) and administer supplemental O₂ as necessary to maintain SpO₂ ≥ 94%. Be prepared to support ventilation with

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| <p>PD# 2530 – Trauma Center Designation – NEW POLICY</p> | <p>appropriate airway adjuncts. 4. Estimate the size of the burn (see below) 5. Stop the burning process by applying cool running water over the burn. The goal is cumulative (bystander and first responder) application of cool running water for 20 minutes. 6. Caustic and Chemical Burns: Wear protective clothing and gloves and consider the presence of hazardous materials. Remove the patient’s clothing. Apply cool running water over the burn for 20 minutes. Do not scrub. 7. Electrical Burns: Check for and dress all entrance and exit wounds. 8. Avoid hypothermia by isolating and cooling only the burned area. Keep unaffected body parts warm by covering them as much as possible, and use the heater in the passenger compartment. 9. After cooling the burn, apply a covering to the burn (dry non-stick gauze, loose plastic wrap, etc.).</p> <p>Approved with no edits or comments.</p> | |
| <p>Scheduled Policy Updates</p> | | |
| <p>PD# 2010 – Medical Advisory Committee</p> <p>PD# 2020 – Operational Advisory Committee</p> <p>PD# 2500 – EMS Aircraft Designation Requirements</p> <p>PD# 2510 – Designation Requirements for Ground-Based Advanced Life Support (ALS) Service Providers</p> | <p>Approved with no edits or comments.</p> <p>Approved with no edits or comments.</p> <p>Approved with no edits or comments.</p> <p>Approved with no edits or comments.</p> | |

PD# 2520 – Hospital
Emergency Service
Downgrade or Closure Impact
Evaluation Report

**Approved with no edits or
comments.**

PD# 4003 – Emergency
Medical Services Liaison
Officer (ELO)

**Approved with no edits or
comments.**

PD# 4050 – Certification-
Accreditation Review Process

Approved with edits.

Language removed:

Definitions:

- A. Certificate or License: A specific document issued to an individual denoting competence in the named area of prehospital service.
- B. EMT: A person who is trained in all facets of basic life support according to the California Code of Regulations, Title 22, Division 9, Chapter 2, and who has a valid certificate issued by SCEMSA or other Local Emergency Medical Services Agency (LEMSA).
- C. EMR: A person who is trained to provide immediate lifesaving care to critical patients under the medical oversight of SCEMSA and has a valid and current certificate issued by SCEMSA.
- D. Paramedic: An individual whose scope of practice to provide advanced life support according to California Code of Regulations, Title 22, Division 9, Chapter 4 and has a valid license issued by California Emergency Medical Services Authority (EMSA) and a valid accreditation issued by SCEMSA.
- E. MICN: A registered nurse who is functioning pursuant to Section 2725 of the Business and Professions Code and who has been authorized by the medical director of SCEMSA as qualified to provide prehospital

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| <p>PD# 4055 – Criminal Background Checks</p> <p>PD# 4302 – Continuing Education Provider</p> <p>PD# 4303 – EMR Program Requirements and Approval</p> <p>PD# 8032 – Traumatic Cardiac Arrest</p> | <p>advanced life support or to issue instructions to prehospital emergency medical care personnel within Sacramento County according to standardized procedures developed by SCEMSA consistent with statewide guidelines established by EMSA.</p> <p>F. Medical Director: The Medical Director of SCEMSA</p> <p>G. Relevant Employer: Those ambulance services permitted by the Department of the California Highway Patrol or a public safety agency that the certificate holder works for or was working for at the time of the incident under review, as an EMT, EMR or Paramedic either as a paid employee or a volunteer.</p> <p>Language added under Procedure: B. The California Emergency Medical Services Authority. C. Sacramento County Emergency Medical Services Agency.</p> <p>Language added under Due Process: C. within twenty-one (21) days</p> <p>Grammatical changes also made to protocol.</p> <p>Approved with no edits or comments.</p> <p>Approved with Edits Language added under Protocol: 5. SCEMSA shall approve or disapprove the request for a CE course within sixty (60) calendar days of receipt of the completed request.</p> <p>a. Submit a course summary FORM for each CE course being offered prior to teaching.</p> <p>Approved with no edits or comments.</p> <p>Approved with Edits Language removed under Protocol E.: Epinephrine will not correct arrest</p> | |
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caused by a tension pneumothorax, cardiac tamponade, or hemorrhagic shock.

Language added under BLS 2.:

Apply tourniquets as necessary.

Language removed under BLS 4.:

Chest compressions should be performed, when possible, without delaying transport or other treatments.

Language added under BLS 4.:

Chest compressions/high-quality CPR for any rhythm other than Wide Complex PEA < 40 bpm or Asystole.

Language added under BLS:

5. The use of a Mechanical CPR Device should be omitted if it will cause a delay in transport.

6. Expedite transport to the closest Trauma Center.

Language Removed under ALS:

1. Optimize Oxygenation/Ventilation

- Advanced airway as needed per policy.

- Advanced airway placement shall be confirmed with an ETCO₂ detection device or waveform Capnography.

2. Correct potential obstructive shock - Maintain high Index of suspicion for tension pneumothorax, Bilateral needle thoracostomy per PD# 8015 – Trauma

3. Treat potential exsanguination

- Obtain two (2) large-bore IV or IO access.

- 1 Liter normal saline bolus simultaneously via each IV/IO.

- Utilize a pressure bag for rapid fluid administration.

- Reassess lung sounds after each Liter.

- Repeat IV fluid during arrest until SBP>90 or a maximum of 4 liters is administered.

4. Treat Cardiovascular Collapse

- High-quality CPR.

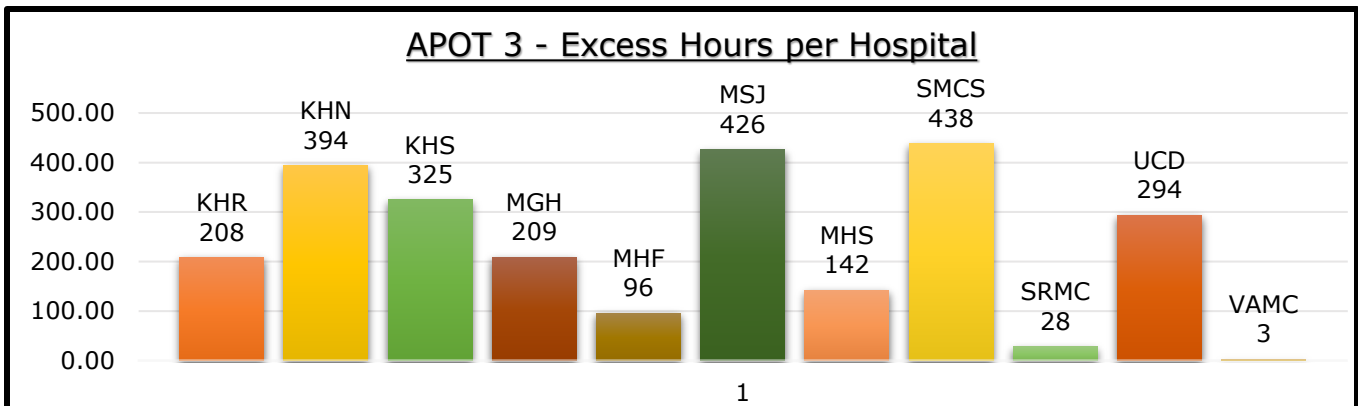
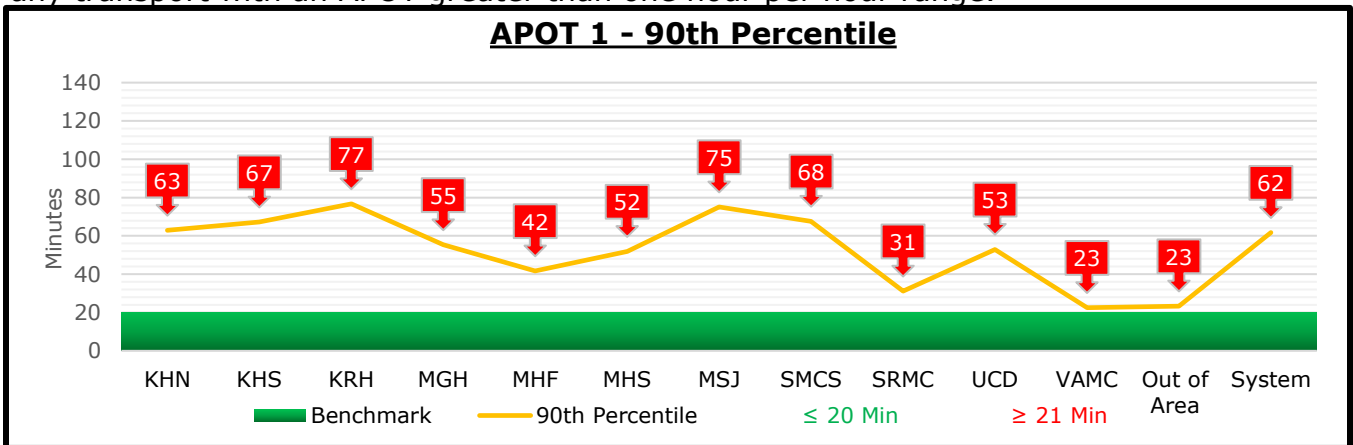
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| <p>PD# 9006 – Pediatric Medical Cardiac Arrest</p> <p>PD# 9007 – Pediatric Diabetic Emergencies</p> | <ul style="list-style-type: none"> • ECG monitoring and appropriate defibrillation per PD# 8031 – Non-Traumatic Cardiac Arrest. <p>Language added under ALS:</p> <ol style="list-style-type: none"> 1. Continue transport with BLS airway if adequate ventilation/chest rise is achieved. Advanced airway as needed per policy. 2. Correct potential obstructive shock – maintain a high index of suspicion for tension pneumothorax. Bilateral needle thoracostomy per PD# 8015 – Trauma. 3. Obtain large-bore IV or IO access. Give 1 liter of Normal Saline bolus by pressure bag infusion. 4. Cardiac monitoring – defibrillate shockable rhythms. <p>Approved with no edits or comments.</p> <p>Approved with Edits</p> <p>Language removed under BLS:</p> <ol style="list-style-type: none"> 5. Bullet point: <ul style="list-style-type: none"> • 50% Dextrose (no longer option for oral administration) <p>Language removed under ALS:</p> <ol style="list-style-type: none"> 3. Bullet points: <ul style="list-style-type: none"> • Dextrose 0.5 gm/kg IV/IO up to 12.5 gm. • 14 plus years old: D50, 50 ml preload – full adult dose. 5. Bullet points: <ul style="list-style-type: none"> • Dextrose 0.5 gm/kg IO as per dosages above. • 0.5 gm/kg for a maximum dose of 1 gm/kg. 6. Bullet point <ul style="list-style-type: none"> • In the event of a glucometer failure, administer 0.5 gm/kg for a maximum dose of 1 gm/kg of Dextrose based on age above or 0.5 mg of Glucagon IM based on clinical assessment. <p>Language added under ALS:</p> | <p>D10 is the best practice for pediatric patients. It is also a safety factor for children. D50 and D25 have been kept in policy due to shortages on D10. D10 can be given to all patients if they choose not to carry D50 or D25.</p> |
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| <p>PD# 9008 – Pediatric Seizures</p> <p>PD# 9009 – Pediatric Neonatal Resuscitation</p> <p>PD# 9011 – Pediatric Overdose</p> <p>PD# 9021 – Pediatric Behavioral Crisis-Restraint</p> | <p>3. Bullet points</p> <ul style="list-style-type: none"> • Under 2 years old: D10, 5 ml/kg. • 2-14 years old: D25, 2 ml/kg or D50 1 ml/kg. <p>NOTE: if blood glucose remains < 60 mg/dl a repeat dose may be given.</p> <p>Approved with Edits – Grammatical Only, no change to the protocol.</p> <p>Approved with no edits or comments.</p> <p>Approved with no edits or comments.</p> <p>Approved with Edits Language Added/Removed Under BLS:</p> <p>1. a. Bullet Points:</p> <ul style="list-style-type: none"> • Contact the chain of command to respond to the scene. • Contact the base hospital to discuss and consult about the situation if needed. and possible need for law enforcement evaluation for a 5150 application. <p>7. Bullet Points:</p> <ul style="list-style-type: none"> • Law enforcement personnel are responsible for the Capture, detention, and restraint of assaultive or potentially assaultive patients. • Law enforcement agencies Retain primary responsibility for the safe transport of patients under arrest. <p>Language removed under Precautions:</p> <p>F. Patients under arrest or on psychiatric detention shall be searched thoroughly by law enforcement for weapons and contraband prior to placement in the ambulance.</p> | |
|--|---|--|

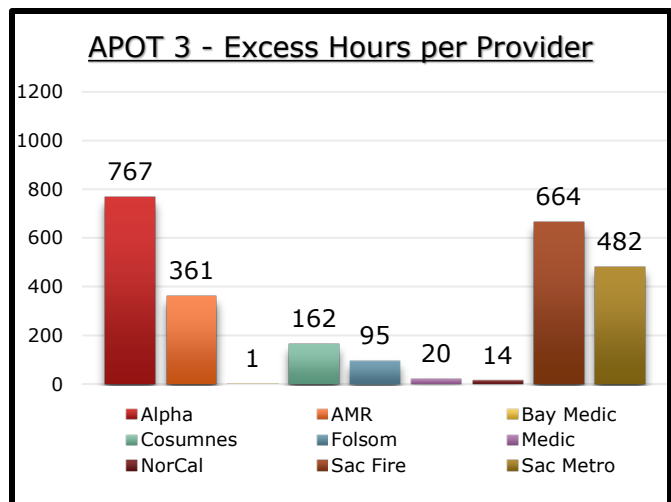
| Roundtable | <p>Julie Carrington: If scientific studies will be used in the future to determine changes to protocols, please include a link to those studies in the agenda.</p> <p>An unknown speaker would like policy 5100 to be reviewed at the December MAC/OAC meeting. He is looking to have SCEMSA adopt ALS being able to use transport vents, blood, and other medications. Dr. Kann agrees that this will be placed on the December agenda.</p> | |
|------------|---|--|

APOT 1 PER HOSPITAL & APOT 3 PER HOSPITAL & PROVIDER AGENCY FOR AUGUST - 2023

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.



| Excess Hours per Hour Range by Hospital (Over 1 Hour) | | | | | |
|---|-----|-----|-----|-----|----|
| Hour Range | 1-2 | 2-3 | 3-4 | 4-5 | 5+ |
| KHR | 102 | 11 | 1 | | |
| KHN | 136 | 34 | 4 | | |
| KHS | 143 | 29 | 4 | | |
| MGH | 73 | 11 | | | |
| MHF | 23 | 3 | 1 | | 2 |
| MSJ | 184 | 33 | 10 | 3 | 1 |
| MHS | 38 | 7 | | | |
| SMCS | 197 | 12 | 1 | | |
| SRMC | 6 | | | | |
| UCD | 61 | 23 | 17 | 7 | 7 |
| VAMC | | | | | |



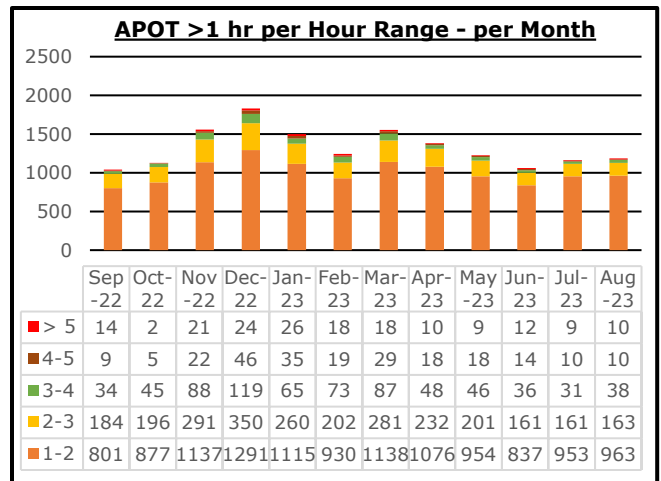
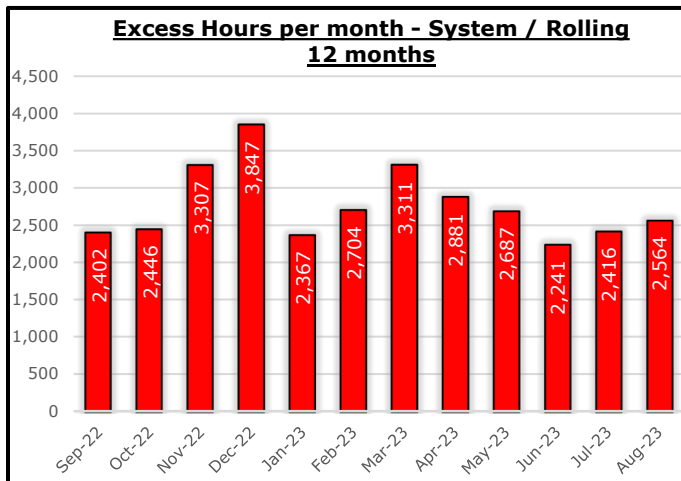
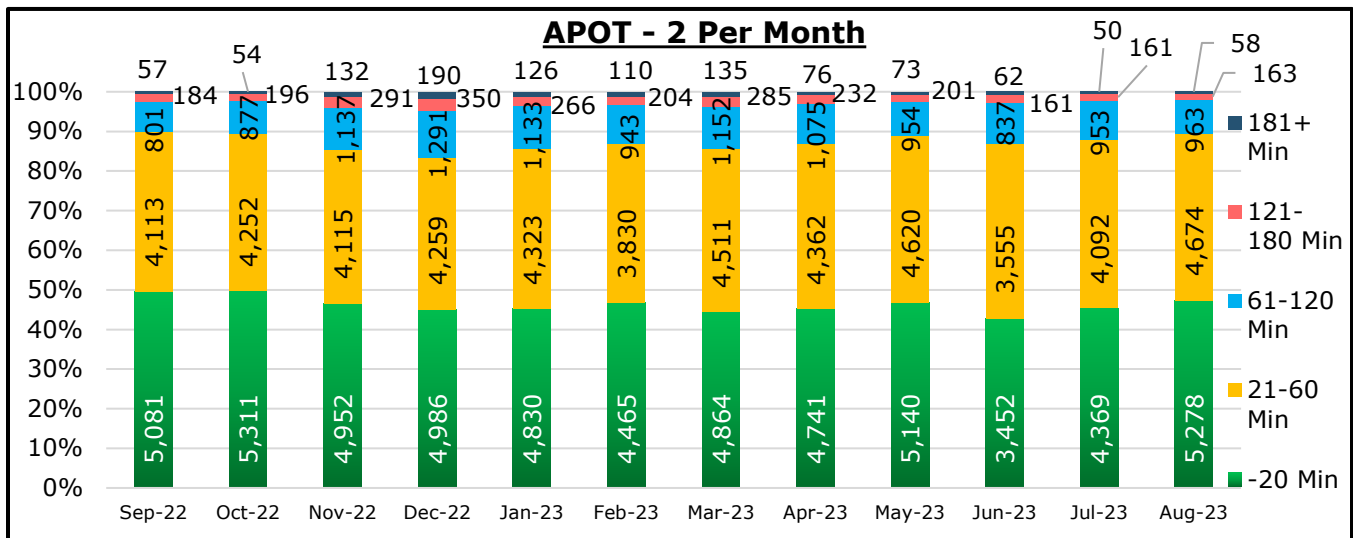
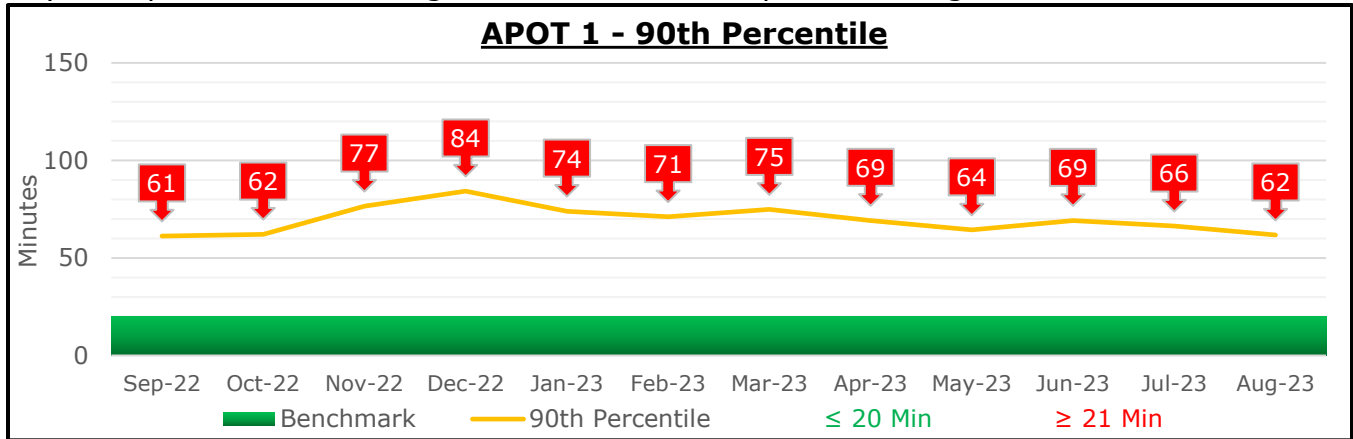
APOT Estimated Cost Table - August 2023

Key: **Green Low / Best / Red Highest**

| Hospital Names | Excess Hours | APOT - 1 in Minutes | Percentage within 20 min | EMS Field to ED Patient count | Average Cost of Excess Hours to EMS Strike Team Rate \$210.74hr | Average Cost per 10 patients |
|----------------|--------------|---------------------|--------------------------|-------------------------------|--|------------------------------|
| KHR | 208.47 | 1:16:44 | 33.80% | 648 | \$43,933.64 | \$677.99 |
| KHN | 394.13 | 1:02:55 | 39.67% | 1573 | \$83,059.38 | \$528.03 |
| KHS | 324.63 | 1:07:11 | 60.65% | 1517 | \$68,412.03 | \$450.97 |
| MGH | 208.65 | 0:55:19 | 36.01% | 933 | \$43,970.66 | \$471.28 |
| MHF | 95.91 | 0:41:42 | 54.27% | 597 | \$20,212.99 | \$338.58 |
| MSJ | 425.93 | 1:15:04 | 47.06% | 1513 | \$89,760.98 | \$593.26 |
| MHS | 142.06 | 0:51:50 | 31.34% | 787 | \$29,937.06 | \$380.39 |
| SMCS | 438.25 | 1:07:36 | 27.82% | 1492 | \$92,357.47 | \$619.02 |
| SRMC | 28.03 | 0:31:08 | 66.28% | 516 | \$5,907.39 | \$114.48 |
| UCD | 293.96 | 0:52:57 | 64.60% | 1305 | \$61,948.39 | \$474.70 |
| VAMC | 2.63 | 0:22:31 | 86.81% | 182 | \$554.56 | \$30.47 |
| Out of Area | 1.45 | 0:23:22 | 83.56% | 73 | \$305.57 | \$41.86 |
| System | 2564 | 1:01:42 | 47.40% | 11,136 | \$540,360.12 | \$485.24 |

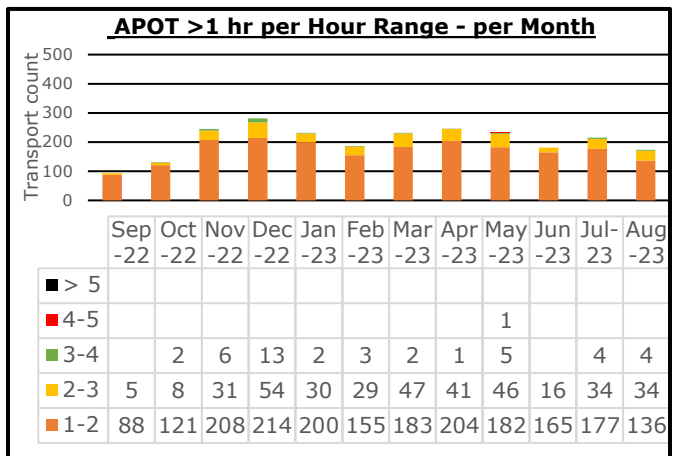
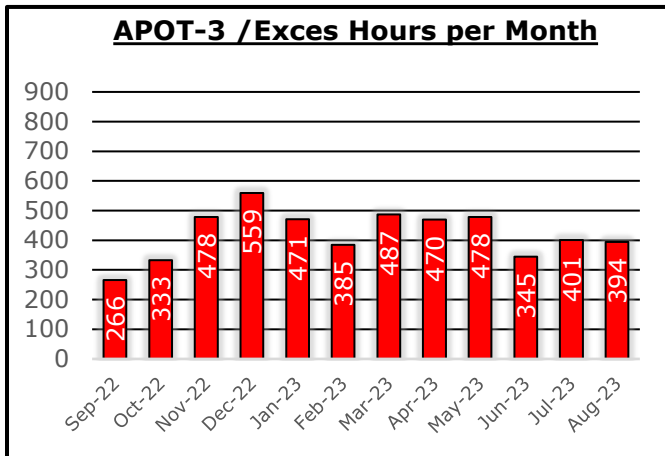
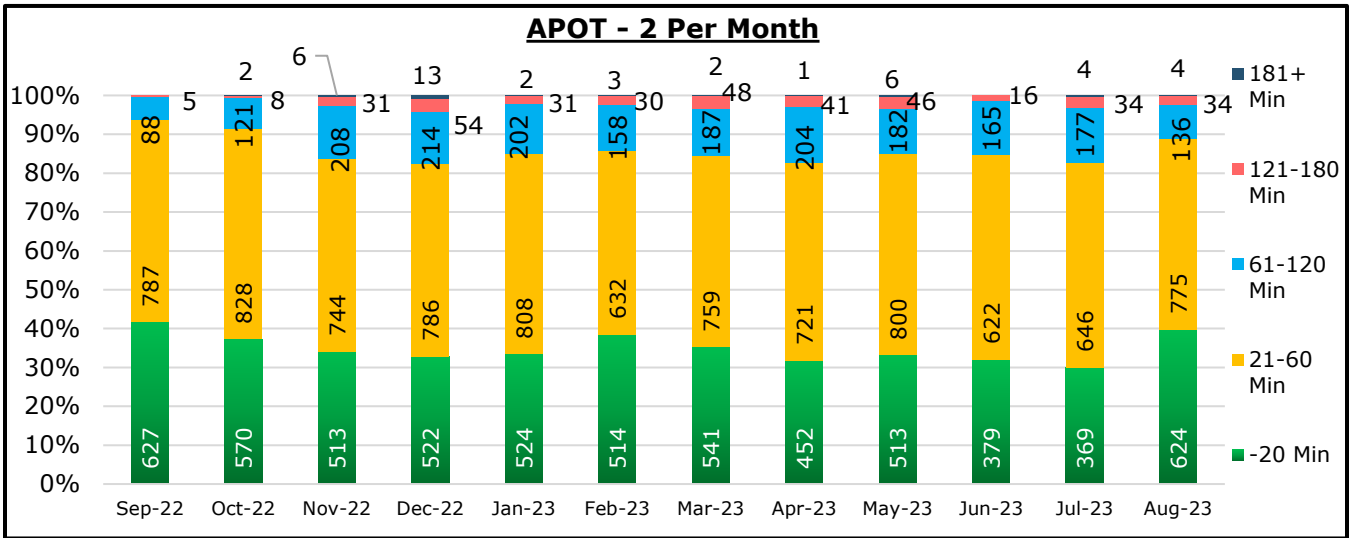
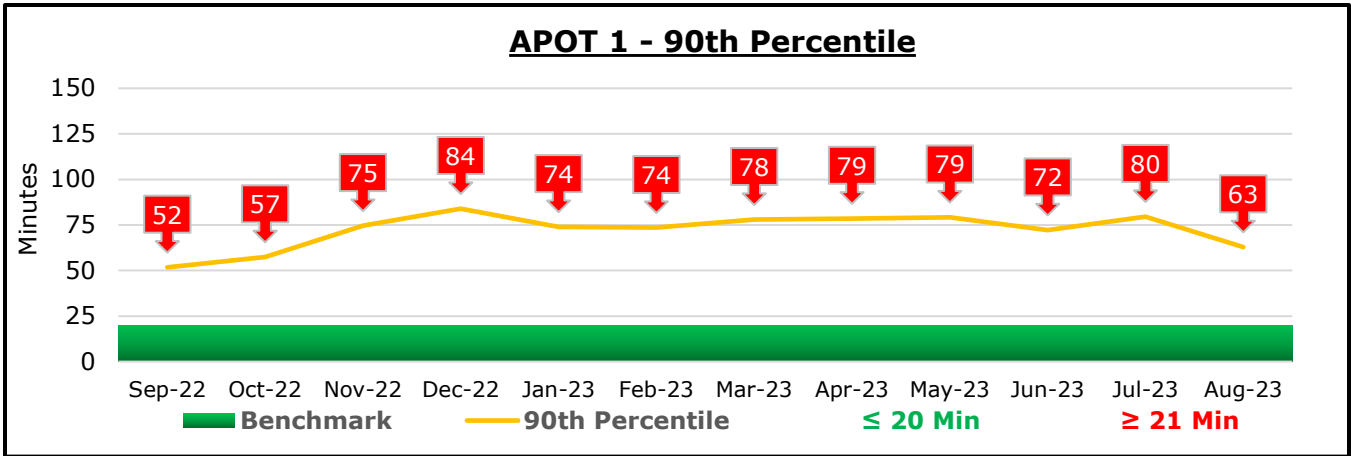
APOT 1, 2 & 3 - ROLLING 12 MONTHS / SYSTEM

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.



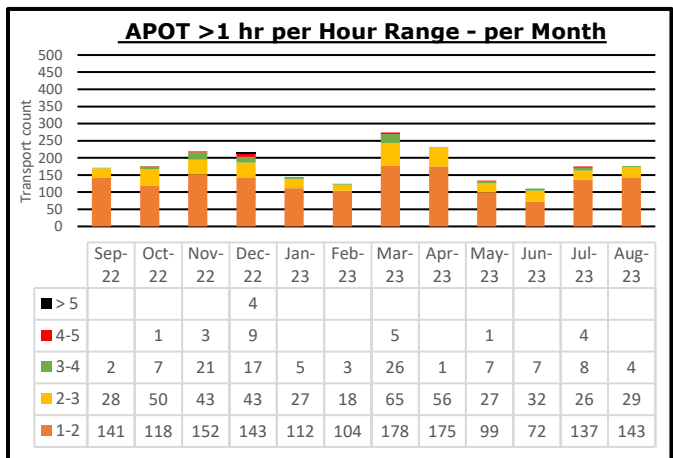
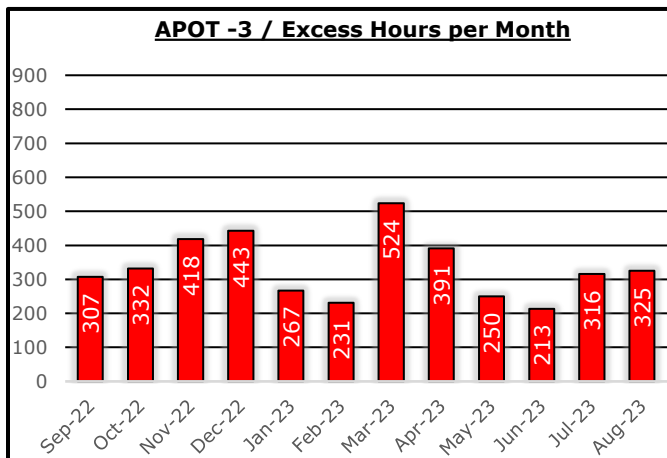
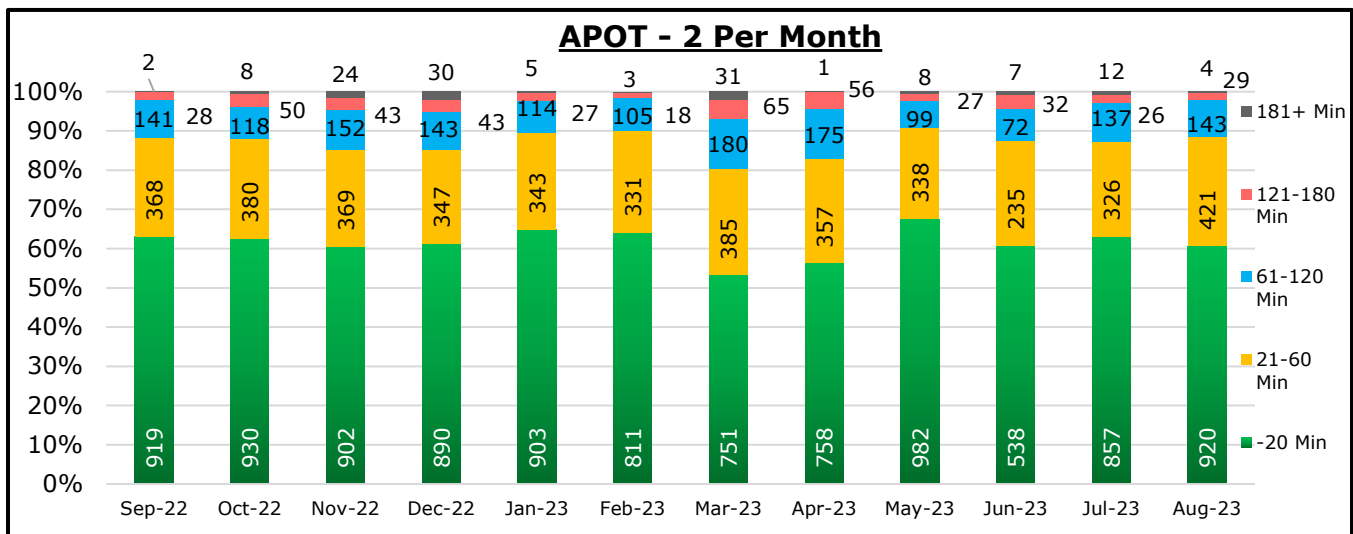
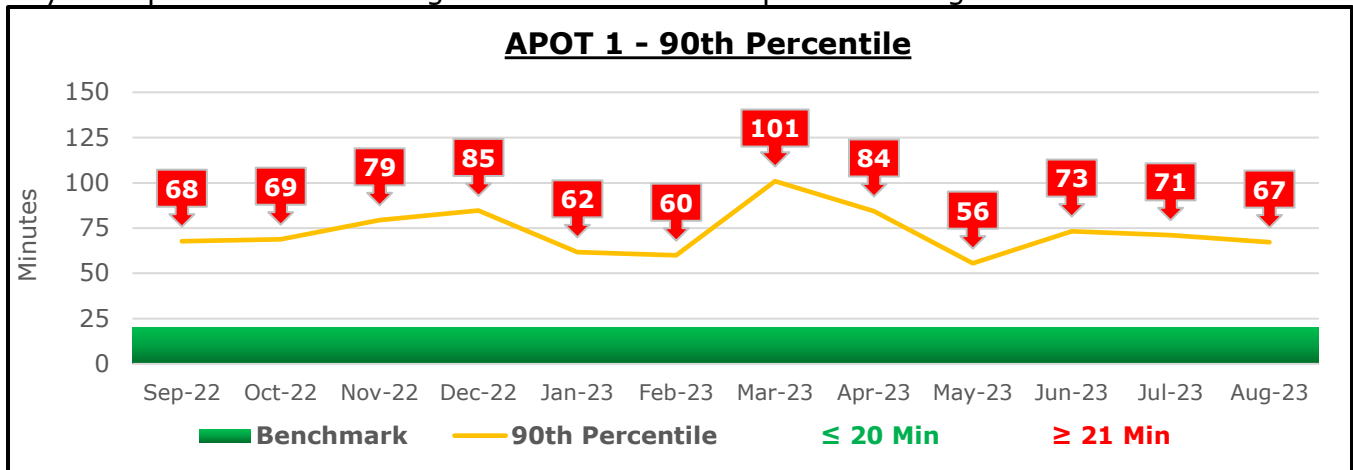
APOT 1, 2 & 3 - ROLLING 12 MONTHS / KAISER NORTH (KHN)

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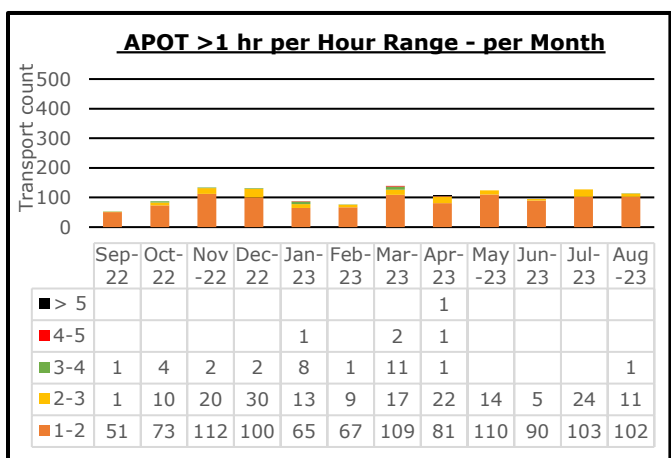
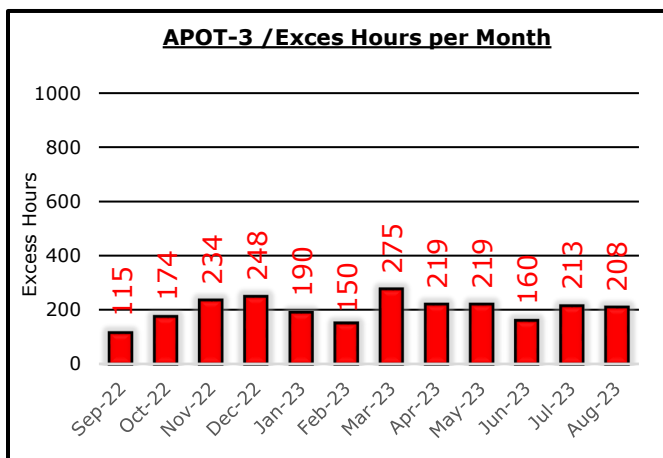
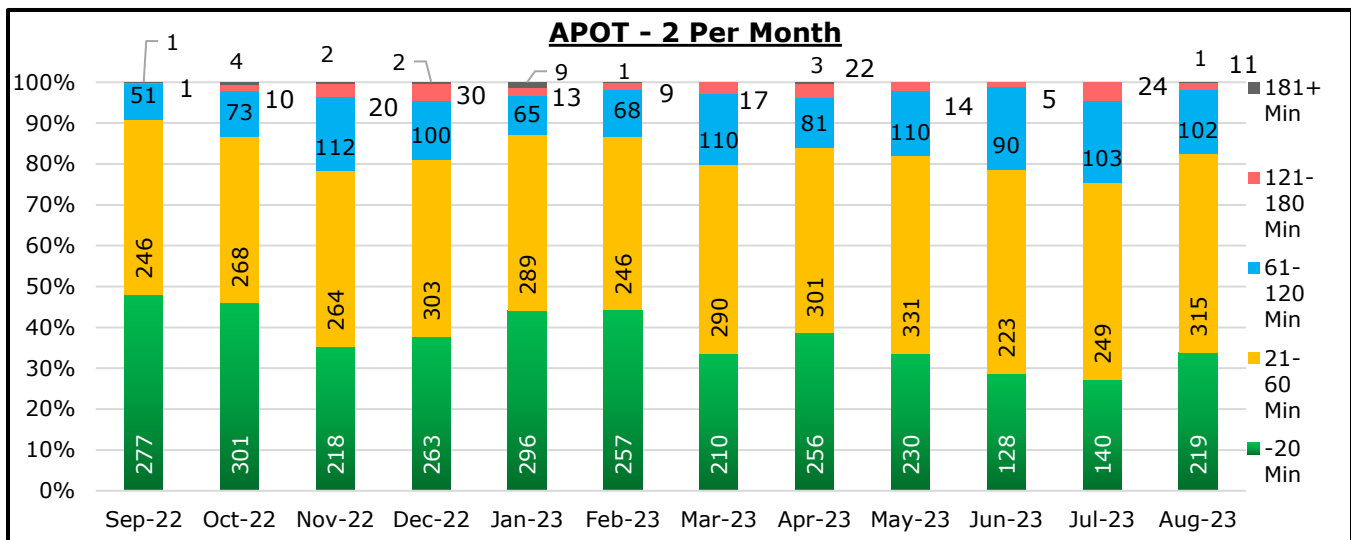
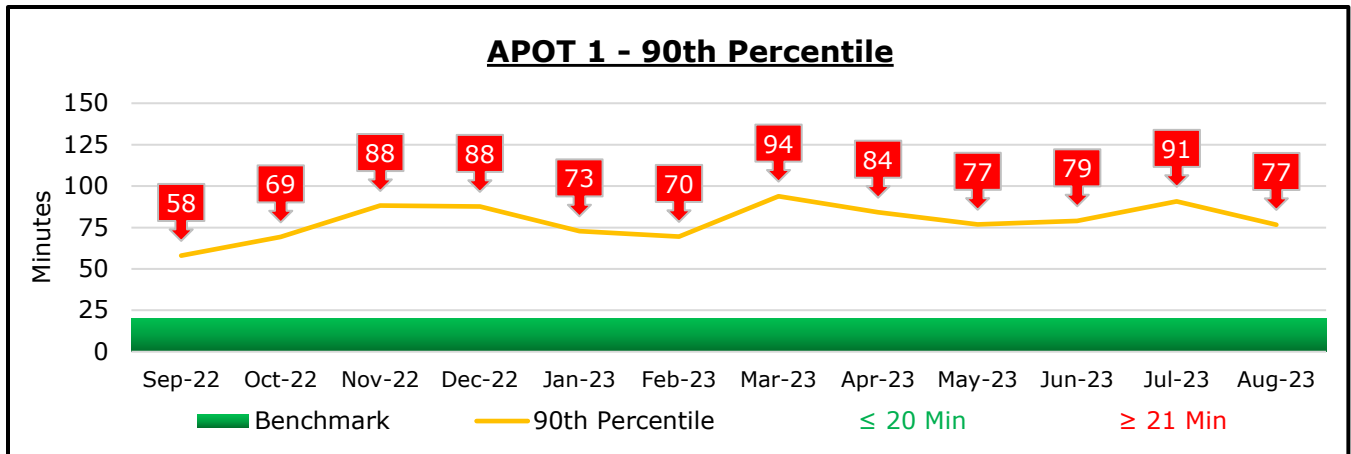
APOT 1, 2 & 3 - ROLLING 12 MONTHS / KAISER SOUTH (KHS)

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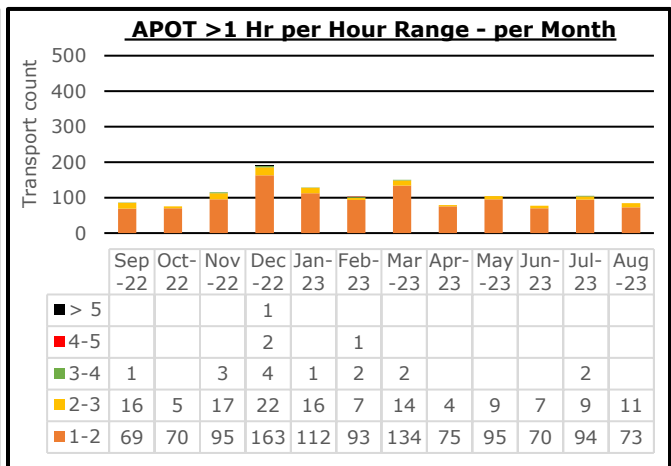
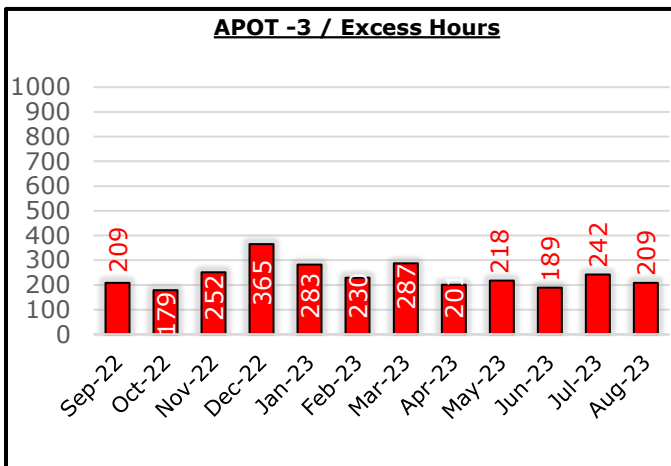
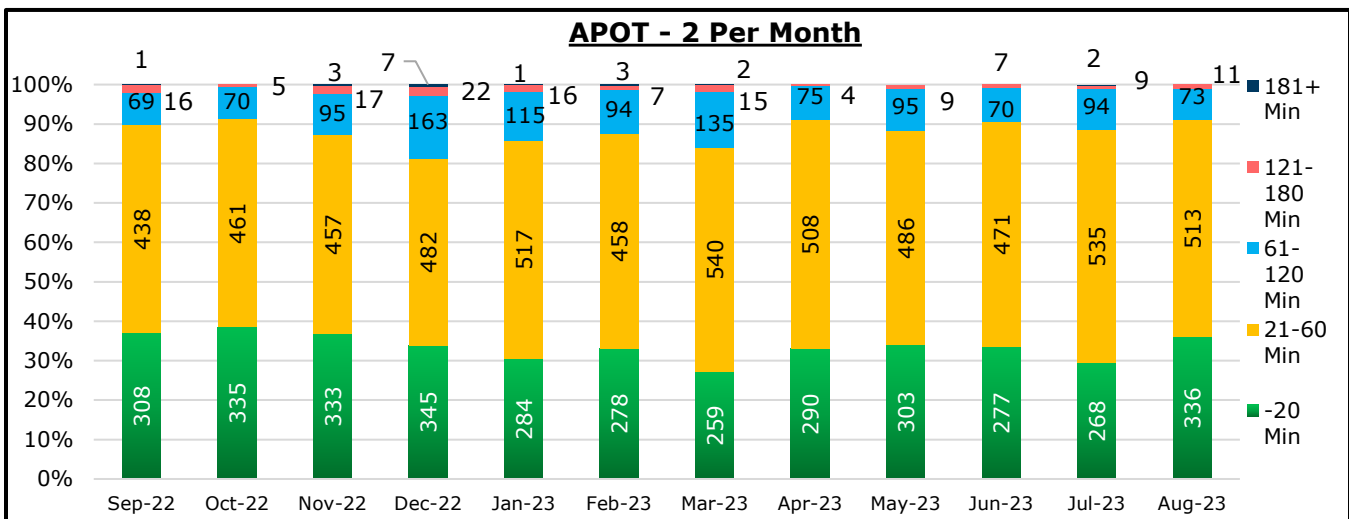
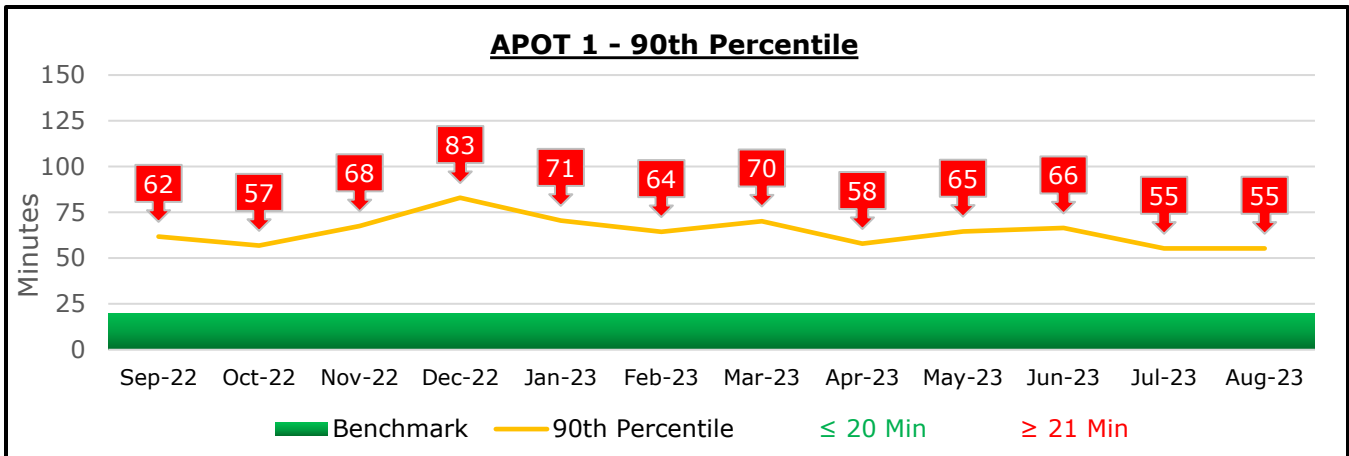
APOT 1, 2 & 3 - ROLLING 12 MONTHS / KAISER ROSEVILLE (KHR)

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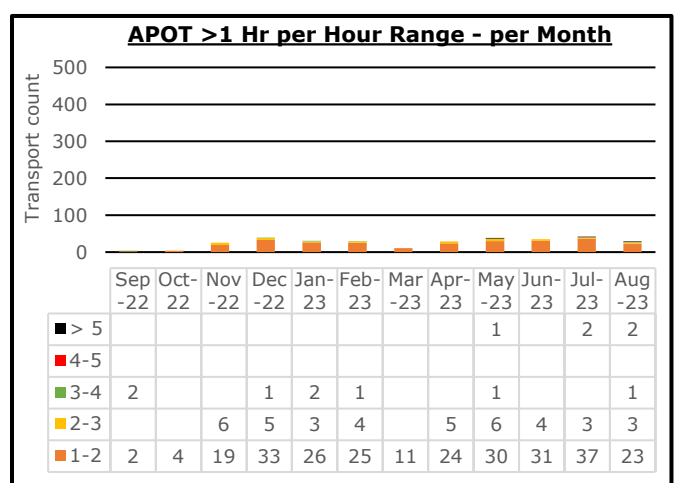
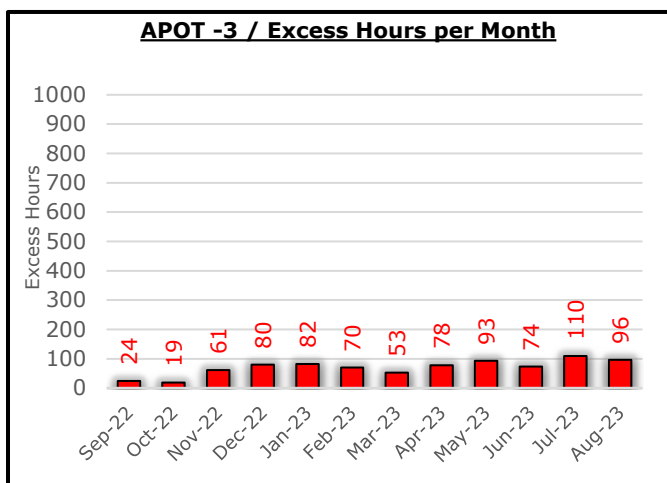
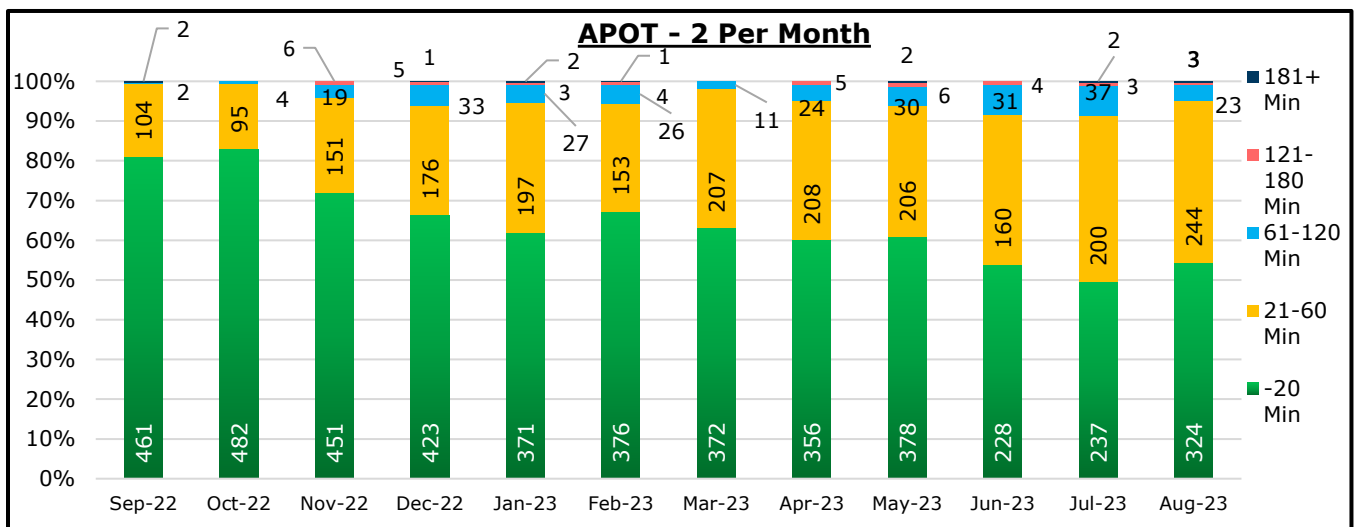
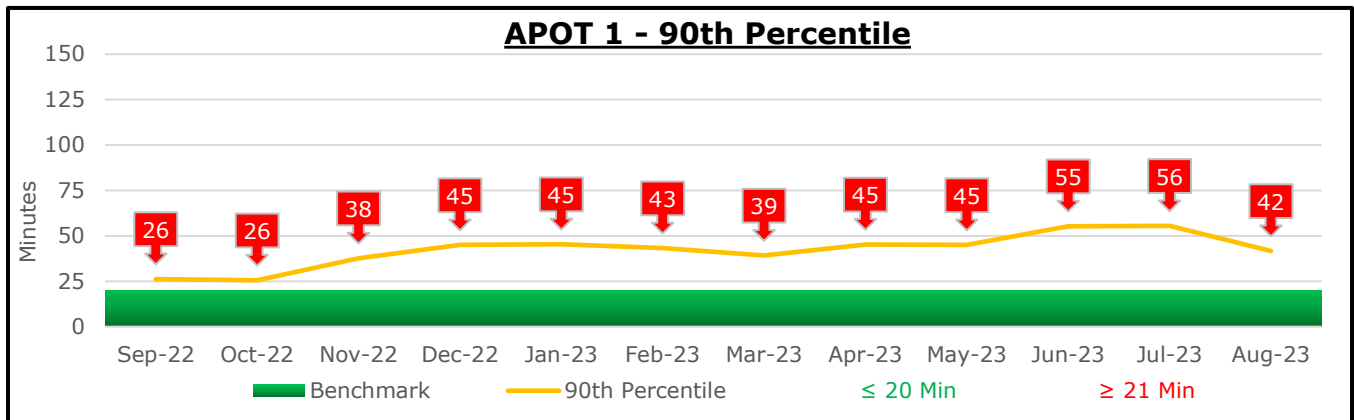
APOT 1, 2 & 3 - ROLLING 12 MONTHS / MERCY GENERAL (MGH)

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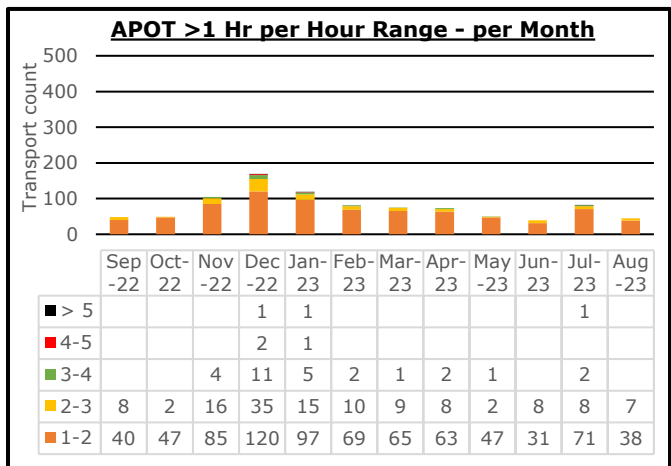
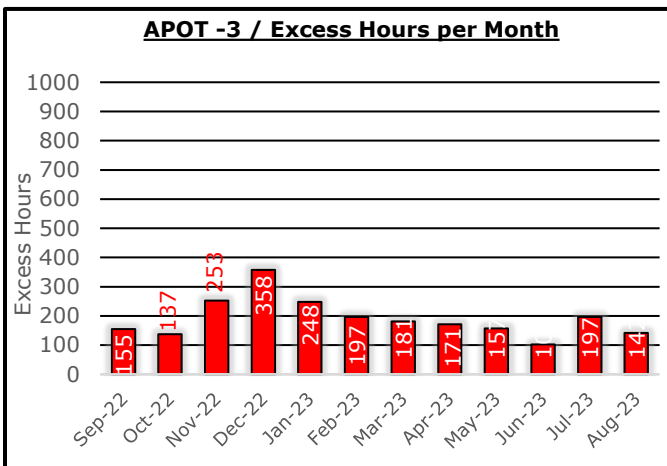
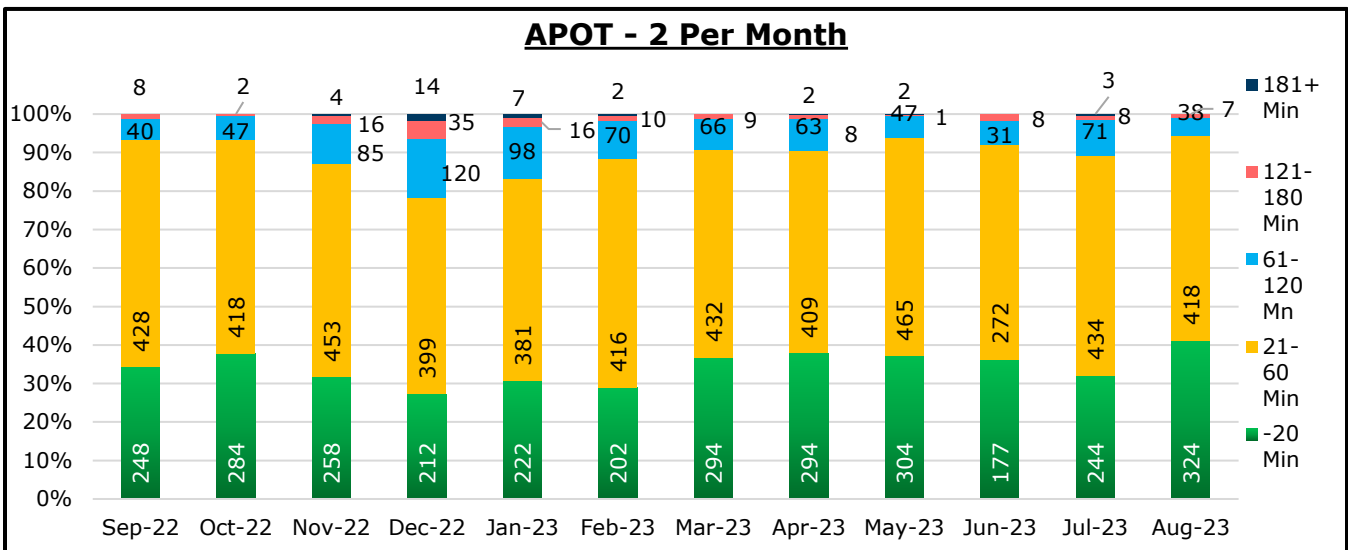
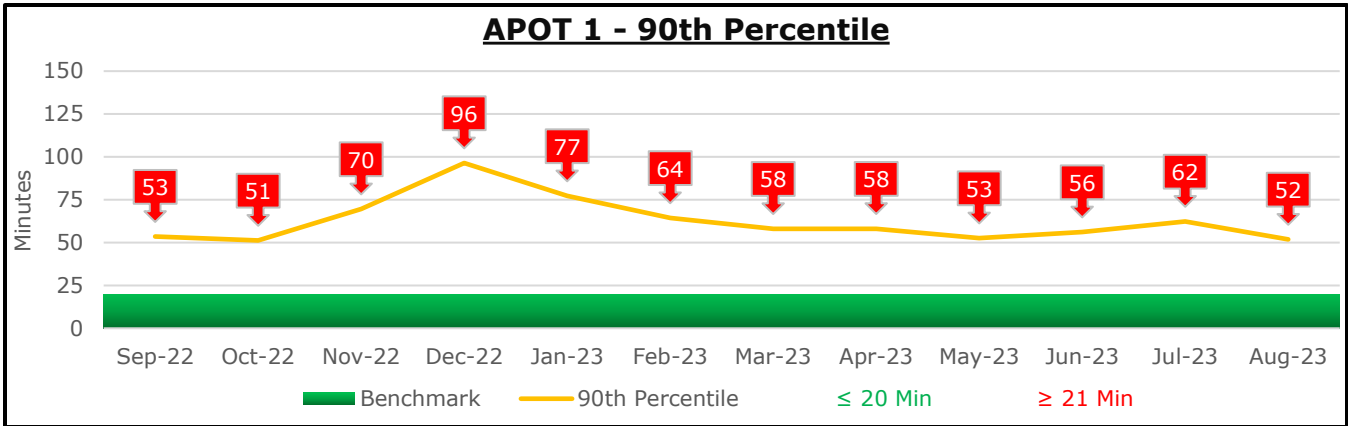
APOT 1, 2 & 3 - ROLLING 12 MONTHS / MERCY OF FOLSOM (MHF)

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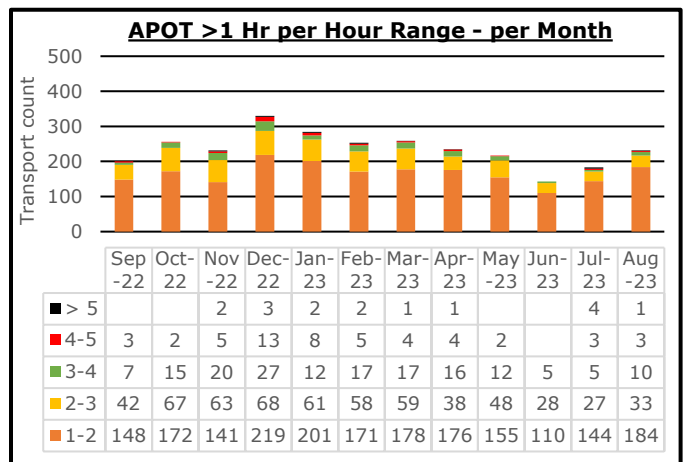
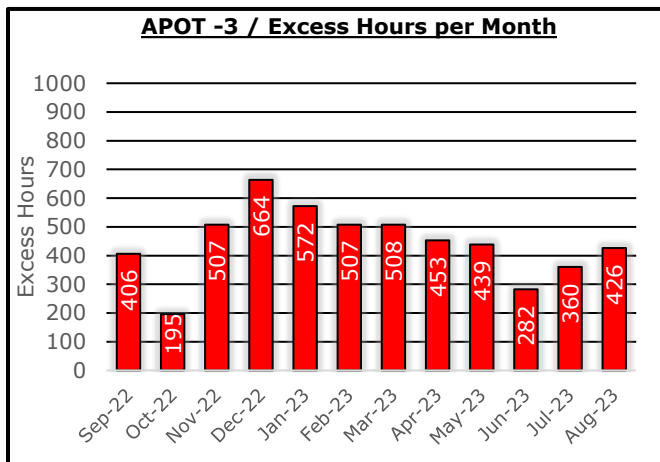
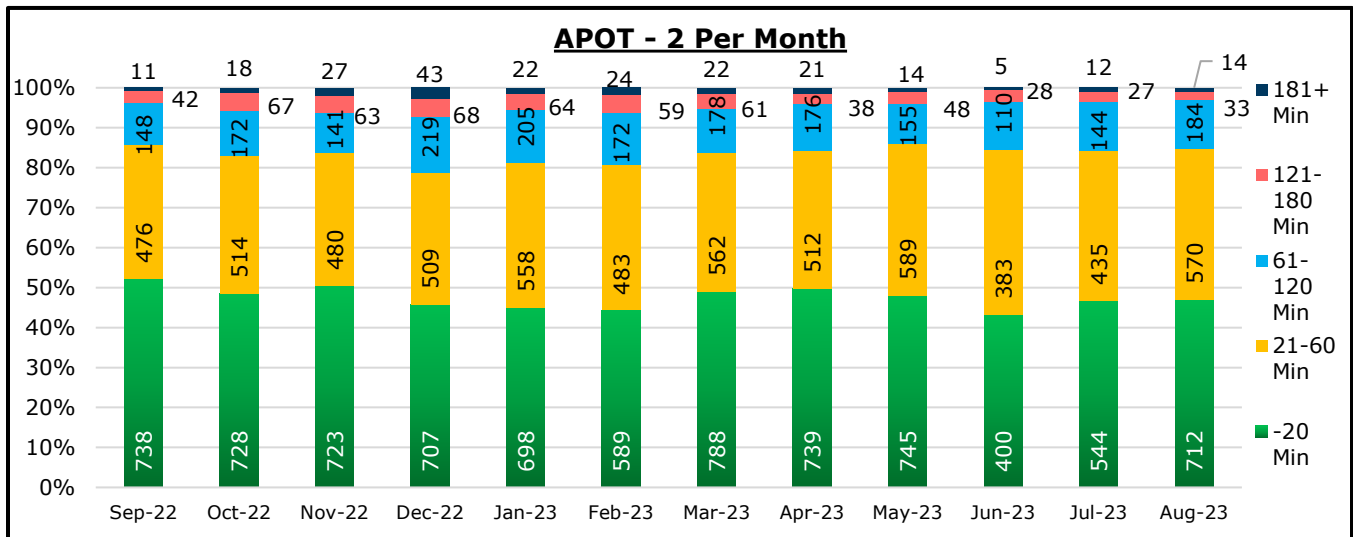
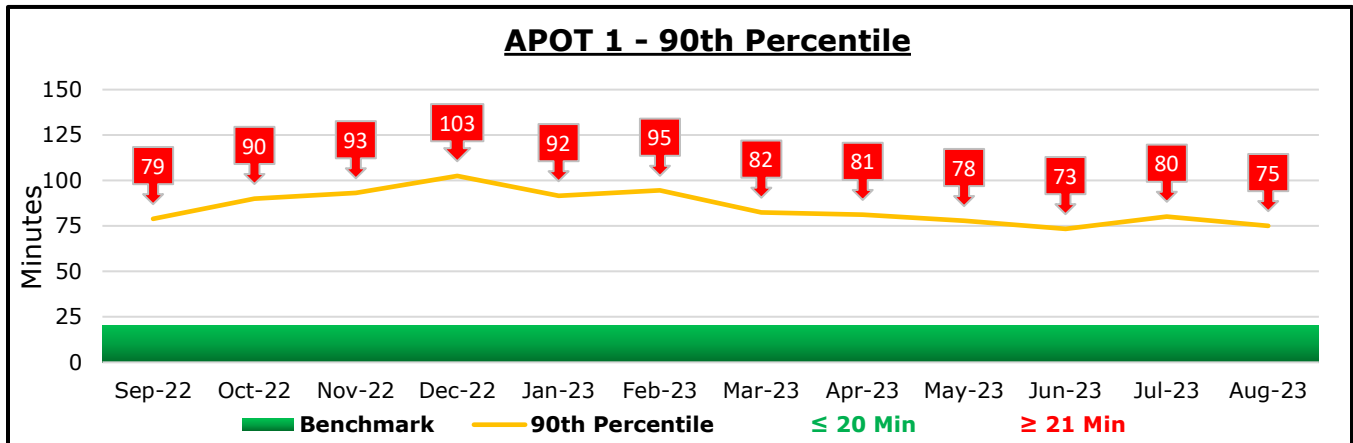
APOT 3 - ROLLING 12 MONTHS /METHODIST HOSPITAL SOUTH (MHS)

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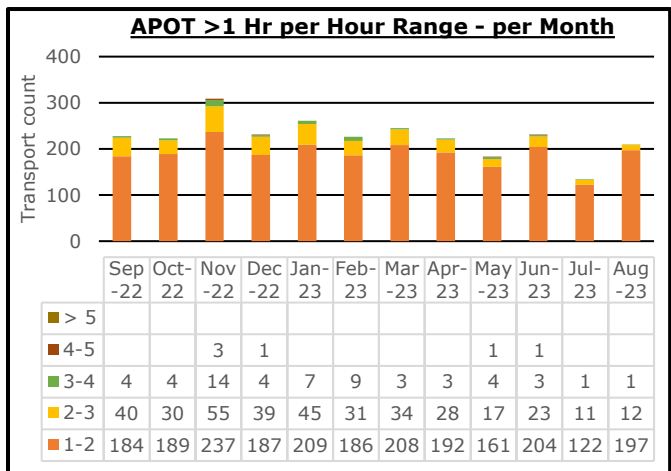
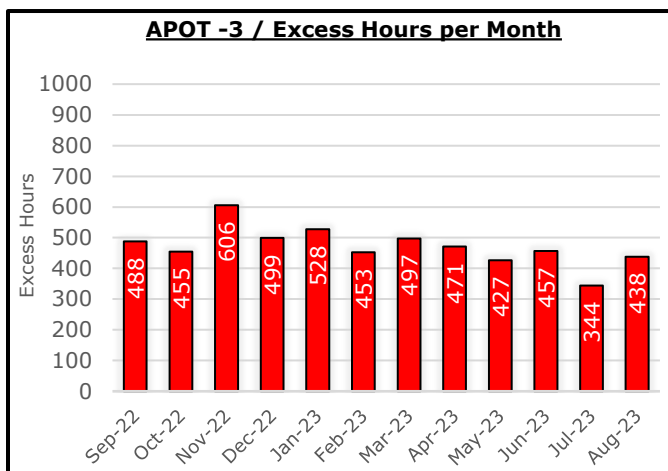
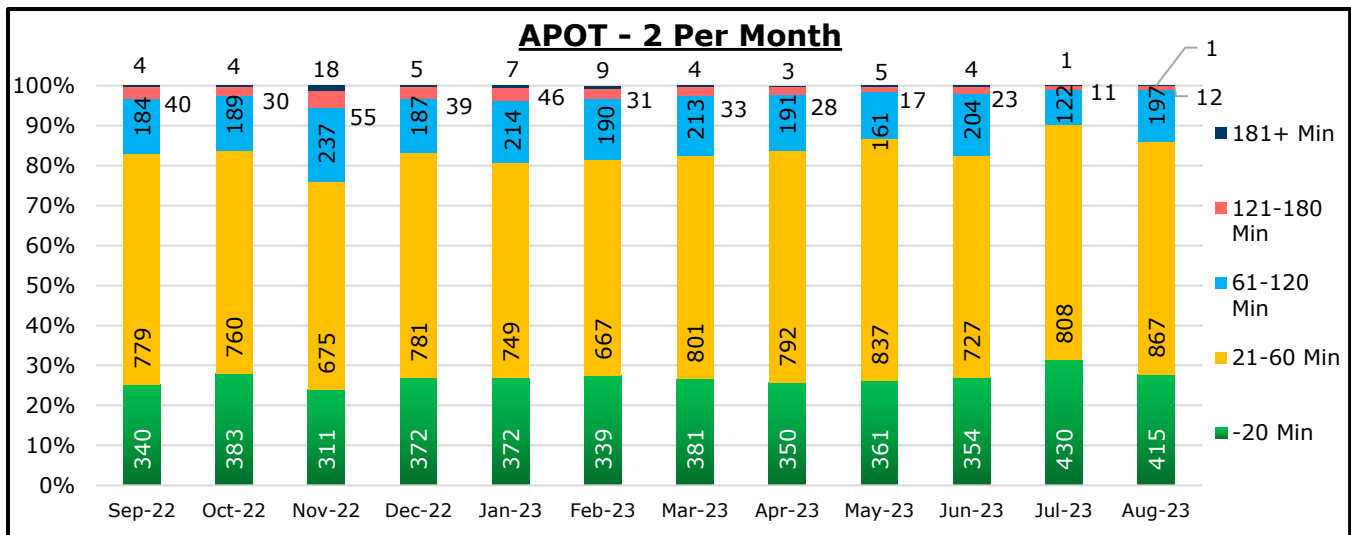
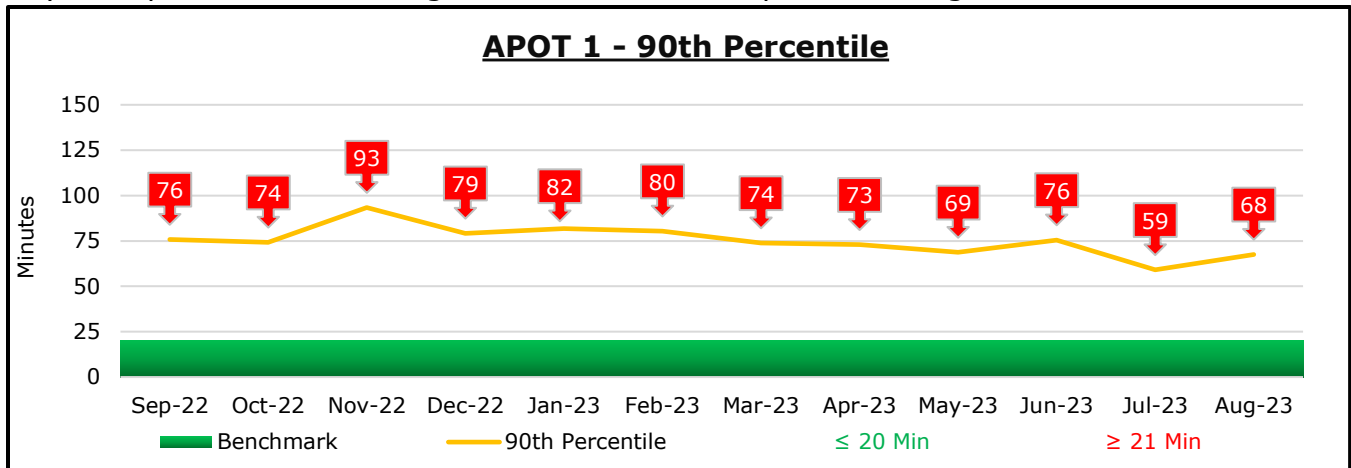
APOT 1, 2 & 3 - ROLLING 12 MONTHS / MERCY SAN JUAN (MSJ)

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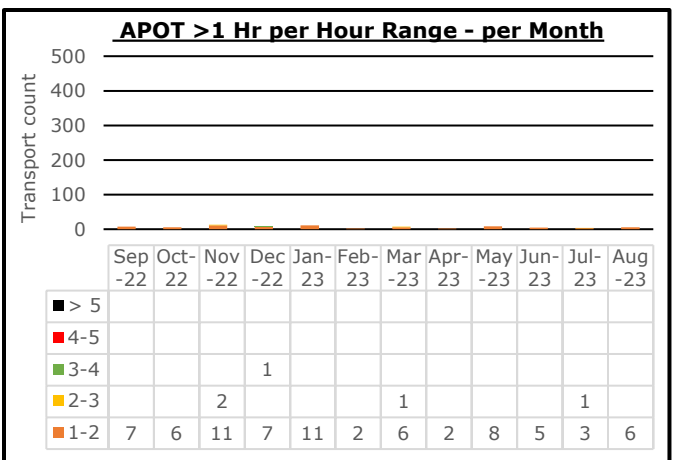
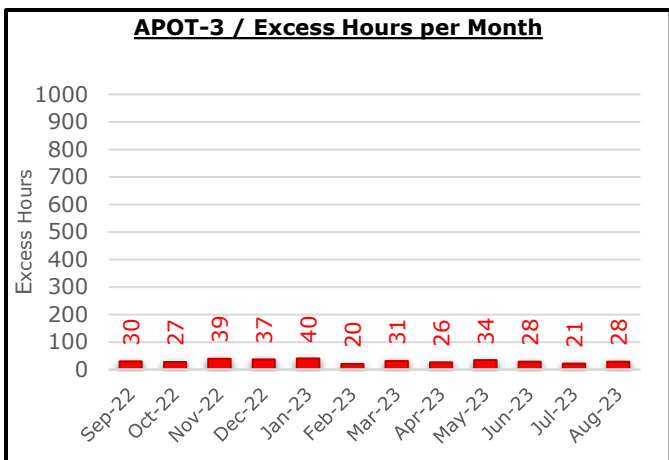
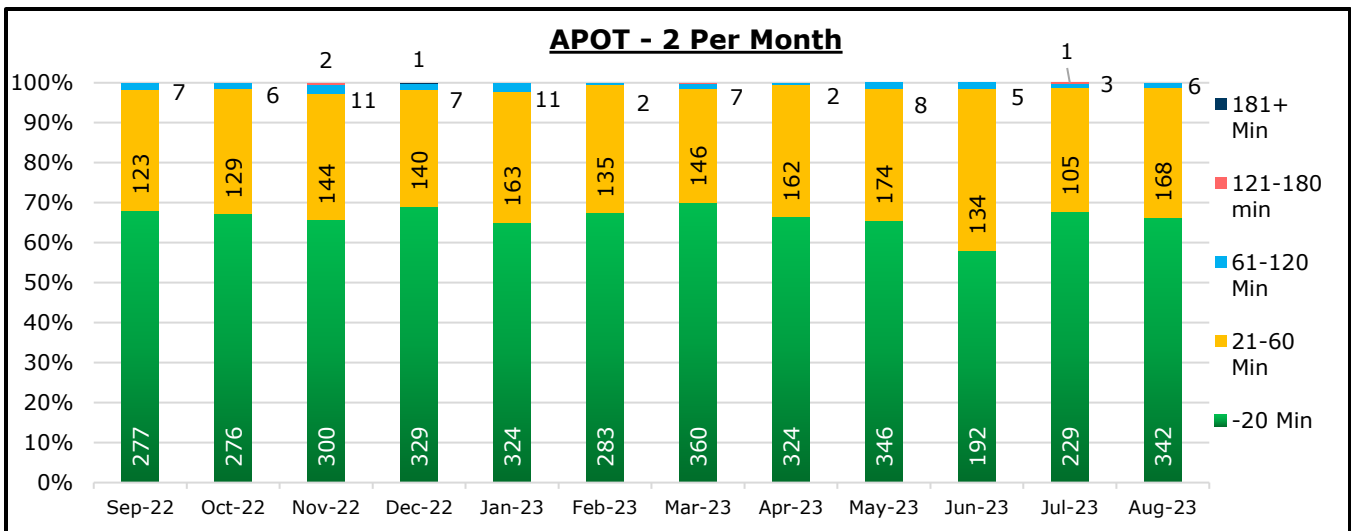
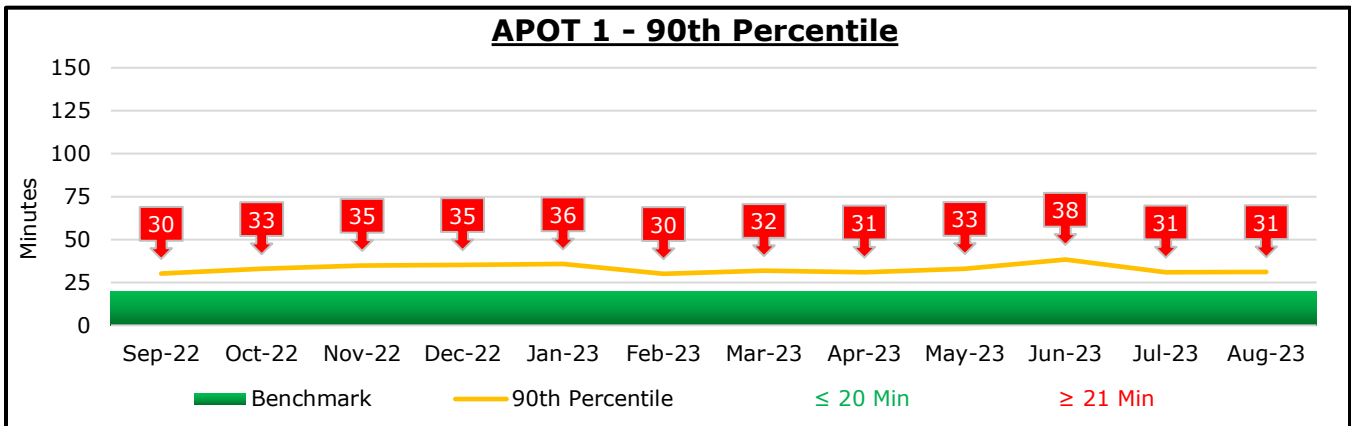
APOT 1, 2 & 3 - ROLLING 12 MONTHS / SUTTER SACRAMENTO (SMCS)

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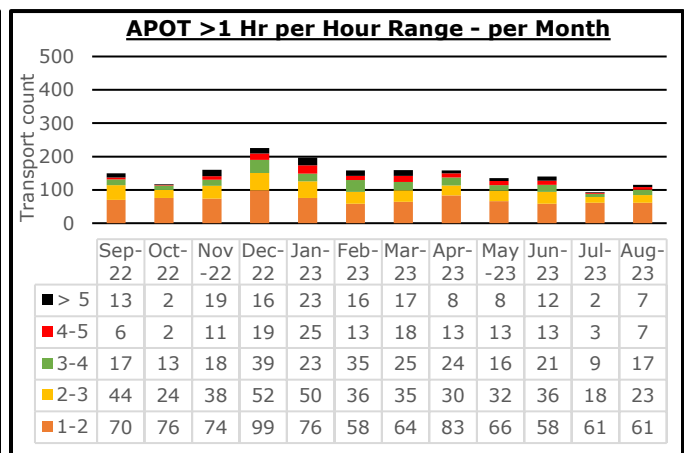
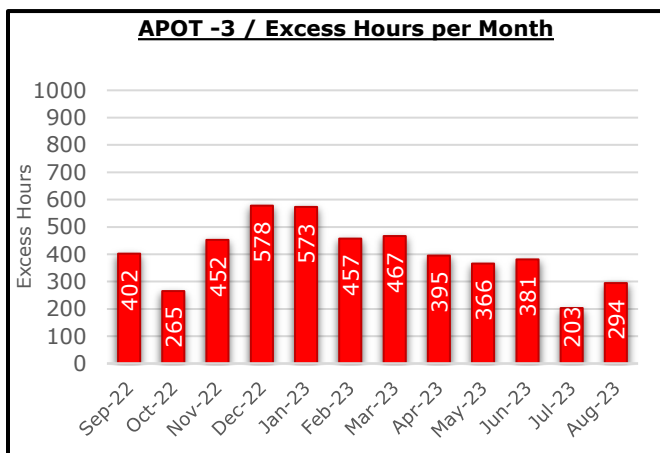
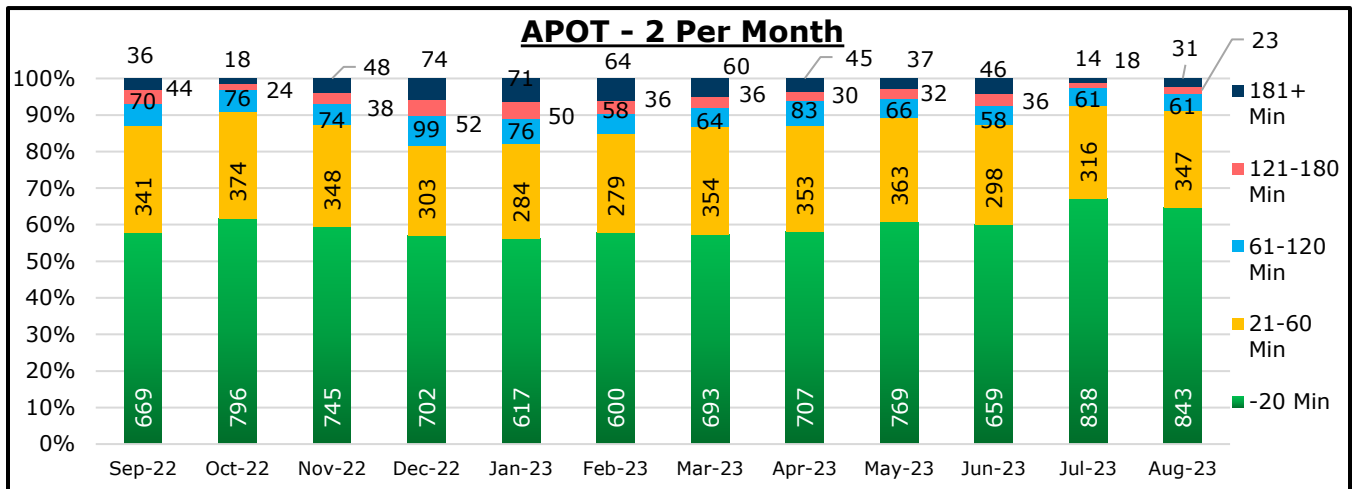
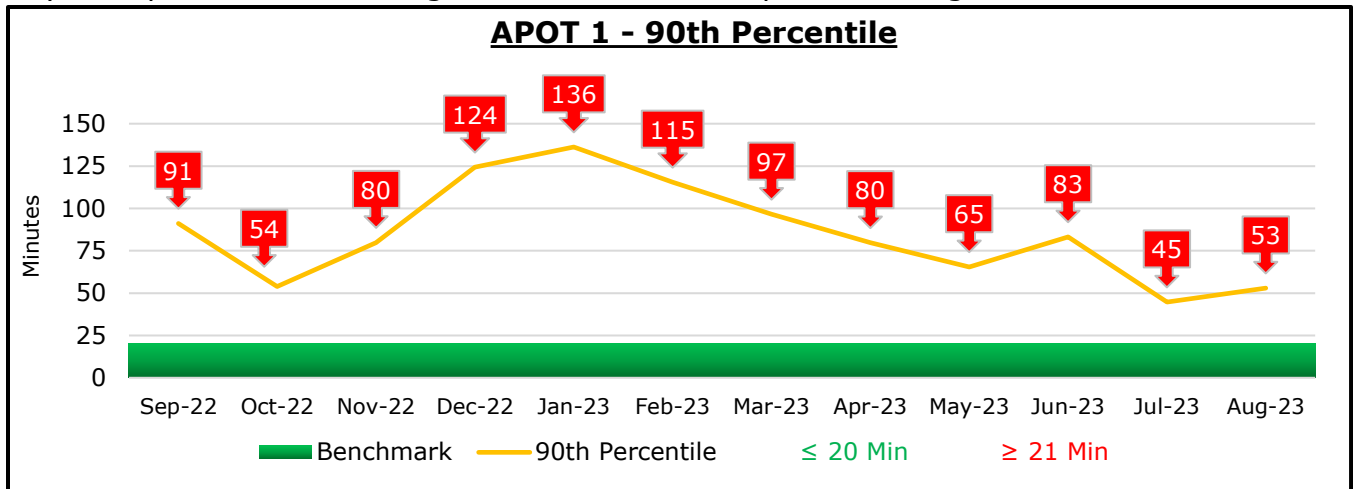
APOT 1, 2 & 3 - ROLLING 12 MONTHS / SUTTER ROSEVILLE (SRMC)

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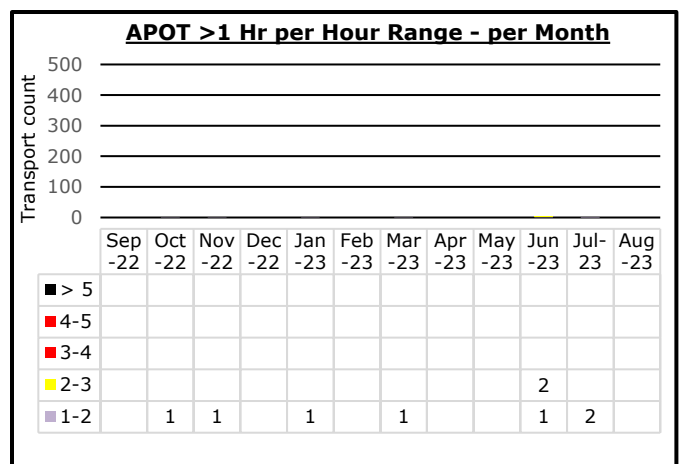
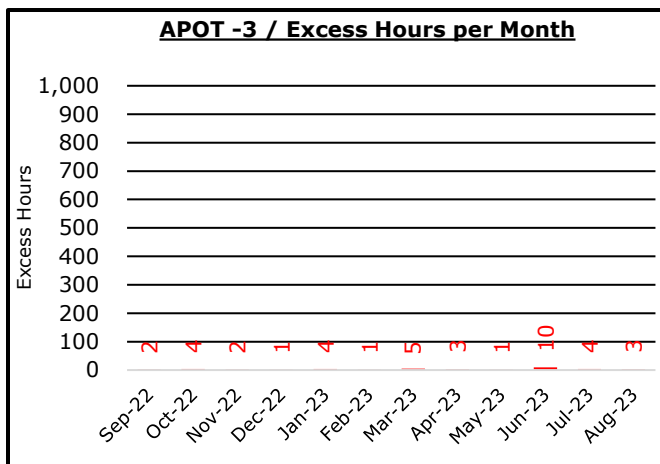
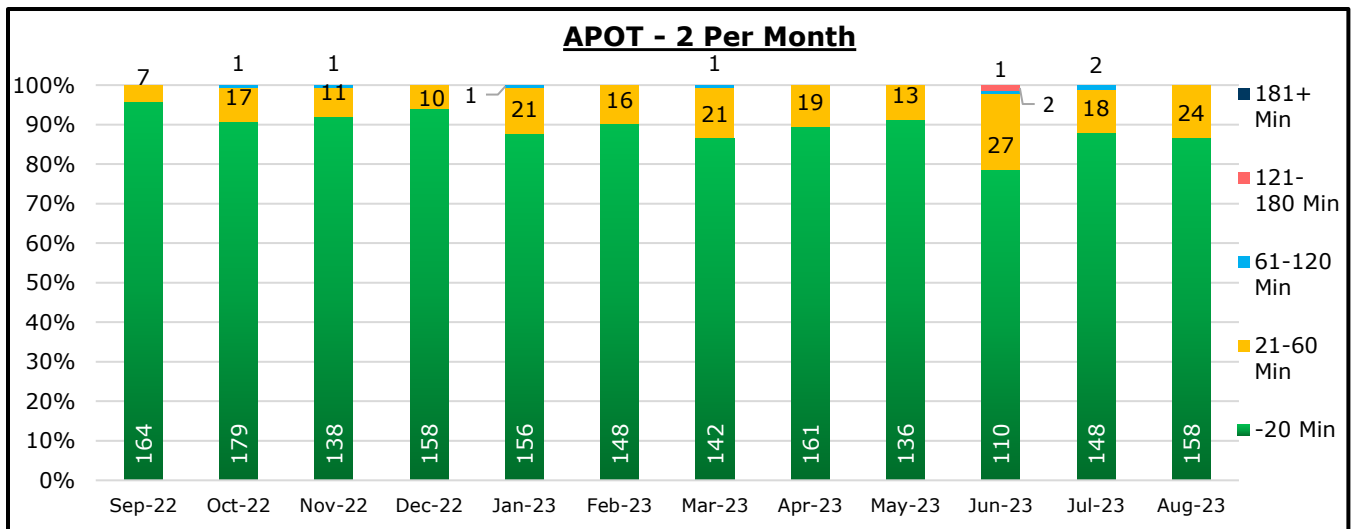
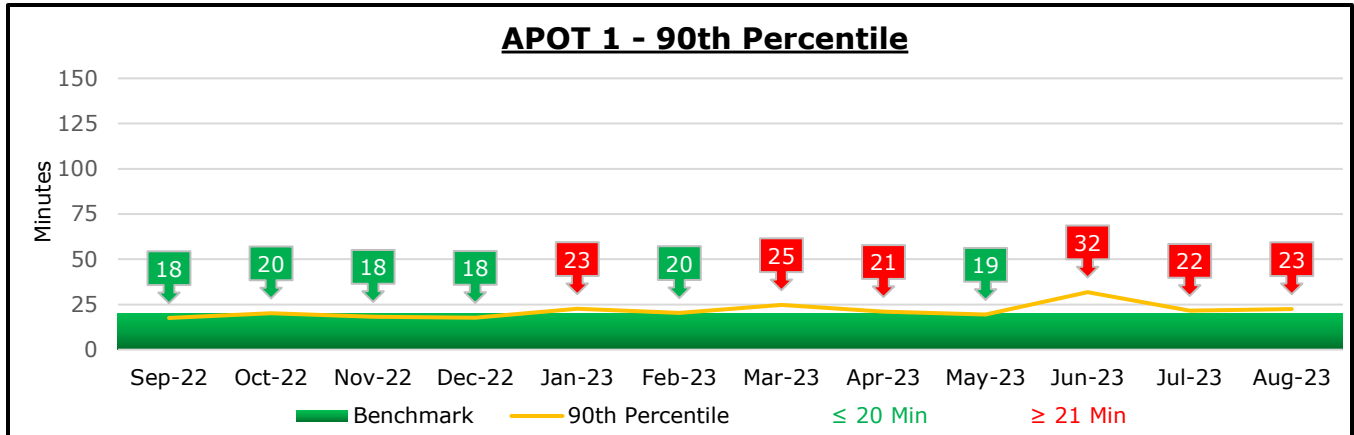
APOT 1, 2 & 3 - ROLLING 12 MONTHS / UC DAVIS (UCDMC)

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

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August 2023 Average Psych/ Medical / Census

■ Average of Psych Hold
 ■ Average of Med Hold
 ■ Average of ED Census
 — APOT HH:MM:SS

