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

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

Agency	Representative
AlphaOne Ambulance	Matt Burruel
AMR	Jack Wood
Bay Medic	Mike Baker
Cosumnes Fire Department	Tressa Naik Julie Carington
Kaiser Hospital North	Richard Meidinger
Kaiser Hospital South	Amy Richards
Medic Ambulance	Brian Meader Lisa Curlee
Mercy San Juan	Amelia Hart Nathan Beckerman
Methodist	Krystyna Ongjoro
Sacramento City Fire Department	Kevin Mackey Brian Morr Matt Barnick
Sacramento Metro Fire Department	Adam Blitz Jon Rudnicki
Sutter Hospital Sacramento	Karen Scarpa Jen Denno Zac Rucker-Christopher
Sutter Hospital Roseville	Debbie Madding
UC Davis Medical Center	Jeremy Veldstra

ITEM	DETAILS	ACTION
Welcome and Introductions	NONE	**NONE**
Public Comment	Brian Meader: Policy 5100 – ALS calls only being ran by ALS, not CCT, and two (2)EMTs having to be on CCT calls as well. Also in policy 5100, home ventilators and level of service provided.	Will discuss later in meeting.
Minutes Review	September 14, 2023	**Approved:** Dr. Naik and Dr.Mackey
SCEMA Updates	David Magnino: CEMSIS Update – Thank you the providers who have started submitting data to NEMSIS 3.5. SCEMSA office will be closed December 26th-29th due to the SCEMSA office being moved to suite 940. Expect some delays due to staff not having full access to computers.	**None**

Old Business:		
PD# 8065 – Hemorrhage	**Approved with Edits:** Language added: Notes: F - epistaxis, and oral bleeding. Note: Consider base hospital physician consult for TXA use in the control of head and neck bleeding. Soak 500 mg of TXA on a cotton pledget and insert into the bleeding nostril. Make base hospital contact for TXA orders for management or epistaxis or oral bleeding.	Conversation was had over MICN giving the order for TXA vs having to get a physician consult for TXA. Due to the broad application of TXA – EMS stakeholders agreed that it is better to have a physician consult.
New Business:		
PD#2224– AEMT Scope of Practice **PD# 2225 –** AEMT Scope of Practice Utilization **PD# 4151 –** AEMT Initial Certification **PD# 5154 –** AEMT Certification Renewal	**Put on hold until board approval:** SCEMSA will be going to the board for approval of AEMT late February. There was some discussion at the last MDAC meeting for broader capabilities for AEMTs and it was met with pushback and that this might require regulation change and a trial study in order to add different scope of practice into the EMT scope. More pointed questions will need to be asked to EMSA. Expanded scope of practice was not discussed at this meeting due to confusion with the state.	Dr. Rose Asked about the anticipation of numbers of the utilization of AEMTs in this county. Dr. Kann stated that initially the request came to incorporate them into the IFT system. Matt Burrell spoke about AlphaOne Ambulance incorporating AEMTs into the 911 system with a three (3) tier response. As well as using them for IFT. An unknown speaker asked if providers were thinking about supplanting medics with AEMTs and calling that unit LALS. David Magnino replied saying that this is not a requirement – it is an optional tool that providers can use to help EMTs who are concerned with making the jump to a paramedic – this step can help EMTs feel more comfortable becoming AEMTs then potentially make the jump to become paramedics. This will help with operation as well as retention. It was stressed that AEMTs are being introduced into Sacramento County – not to replace paramedics but to help with the paramedic shortage in order to help our community.

		Two schools have stepped up to potentially take on AEMT programs – CSU Sacramento and American River College. Dr. Schmalz asked what the general vision is for AEMts – right now would they remain in IFTs then later in the whole system or opening this program up to see what the options are. Dr. Kann responded stating that the current communication with the state has been this would reside in the IFT system – but if it ever got to the point where there was not enough medics to fill the roaster, Sacramento County will have a plan in place.
PD# 5100– Interfacility Transfers ALS-CCT Program Requirements	**Approved with edits:** Language added and removed under protocol: 2. Staff all ALS non-Registered Nurse (RN) transfers with at least one (1) paramedic or one (1) RN. 3. Staff all Critical Care Transfer (CCT) transfers with at least two (2) one (1) EMT and one (1) CCT RN, RN, RN ride-along or Physician ride-along for stable transport. For patients deemed to be unstable, transports must have at least two (2) EMTs and one (1) CCT RN, RN or Physician ride-along. Language added and removed under notes: A. At no time can an Only approved Advanced Life Support (ALS) providers may unit transport a patient on a home ventilator without a RN, LVN, or Caretaker personnel that is qualified and trained on the patient's specific ventilation operating system. The trained and qualified person is required to be at the patient's side during the duration of the transport. B. If the patient is not in an emergent situation and no qualified RN, LVN, or Caretaker is available, the patient must be transported by Critical Care	Dr. Kann stated that there was some interest in allowing CCT nurse units to be able to do an ALS transfer due to limited availability of ALS units to do IFTs. Dr. Kann stated that he thinks it would add some flexibility into the system to allow for that language. This will need to be brought to the state to have a more in-depth conversation. More conversation was had about training for RNs to be able to do these types of transfers. A public comment was made to try to change or consider moving from the usual EMT to CCT RN ratio. Comments were made that they would like to change the wording to say staff all critical care CCT transfers with at least one EMT and one CCT RN or RN ride along for stable patients. For unstable patients have two EMTs and one CCT RN. Dr. Kann asked how we define that. An unknown speaker answered: critically ill or injured. If a defined patient is critically illy or injured on multiple drips or a vent then give them two (2) EMTs. Around the table this was approved.

	Transport (CCT) or approved ALS provider.	Brian Meader from Medic Ambulance asked about the note section under Home Ventilators. Asking why if a caretaker is going to be managing the vent why does there need to be a paramedic – why can't this be a BLS call? An unknown speaker asked what would happen if something happened to the vent during transport – what would the EMT do? Brian Meader responded – bag them or drop an iGel if the tube is displaced. There was agreement around the table and this change was approved.
PD# 8031: Non – Traumatic Cardiac Arrest	**Approved with Edits:** Language removed under **Drug Therapy** • Sodium Bicarbonate IV/IO 50mEq for renal failure or suspected hyperkalemia only	Conversation was had about the effectiveness of Sodium Bicarbonate for patients that were in renal failure or suspected hyperkalemia. Dr. Rose stated that Calcium Chloride would be the treatment for theses patients, but it was noted that we do not carry Calcium Chloride in this county therefore SCEMSA would need to add it to the inventory list as well as all policies and procedures.
PD# 8837: Buprenorphine	**Not Approved – will be brought back in March**	A LOSOP from SCEMSA has been approved by the state. There is some controversy surrounding the COW (Clinical Opiate Withdrawal) Score = flow sheet for measuring symptoms for opiate withdrawals over a period of time – the controversy lies with patients that are having mild withdrawal symptoms and giving those patients Buprenorphine might precipitate withdrawal. This might require some significate ED resources and care. Currently the protocol requires physician base consult – but there is conversation at MDAC that we may be starting to move away from this – but it will stay in protocol for now.

		Amelia Hart asked for a ballpark number of how often this will be used. Dr. Kann responded with about 100 – based on Contra Costa's first year adjusting to our ratio on population. Kristin Bianco asked if non-transporting units will be required to carry this medication. Dr. Kann responded stating that there is an expected transport here because the second leg of this treatment is getting these patients connected to resources in emergency departments. Julie Carrington asked if there would be a primary field impression to initiate this because there is not a specific withdrawal impression – it can be generalized weakness or anxiety, etc. Dorthy Rodrigez stated that we should leave it as is and then see what arises, and if we need to narrow it down then we can. But this way we can see what is being brought in from the field – what their impressions are. Dr. Kann added that that certainly tracking this under medication administration. Dorthy Rodrigez stated that she will release the Rxnorm code to everyone and put it on the website. Kristin Bianco stated that 4/5 Sacramento hospitals are involved in the Bridge Program to help patients get more resources. Methodist Hospitals are not in the Bridge Program. Jeremy Veldstra asked for clarification in regard to contacting medical control – is it going to be any base hospital or UC Davis? Dr. Kann stated that it will be UC Davis to start. That will probably sunset in six-eight months to hopefully not requiring base hospital contact. Amelia Hart asked for clarification in who is in the bridge program.

		Kristin Bianco responded stating that Methodist Hospitals are not, Kaiser, UC Davis and Mercy San Juan, etc. are. Amelia Hart stated that if we are giving this to our patients it would make sense for our crews to transport these patients to a Bridge Hospital so they can get a navigator to follow up with these patients. An unknown speaker asked how the referral to a hospital navigator happens if it is a non-transport? Dr. Kann stated that these conversations are still happening at a county level and that there is some information in the leave behind kits. But this conversation is still missing a piece that we are looking for. Conversation was had about what a navigator is – Dr. Kann stated that these are typically social workers that work with the patient to make sure they are given appropriate care. An unknown speaker suggested that the box stating "inform the patient that the nurse navigator will initiate contact within 72 hours." Sydney Freer stated that there does need to be some education to our field providers about this program and what the hospital plan looks like. An unknown speaker suggested that the wording be changed to "inform the patient of resources available at the hospital." John Rudnicki asked where the COW score is located. Sydney Freer stated we could add a second page with this information on it. An unknown speaker stated that there are still bugs to work out of this protocol and suggested we continue this discussion at a later time. Dr. Kann agreed but we would still like to get this live by May 1, 2024.

PD# XXXX: MIH Buprenorphine	**Not Approved – will be brought back in March**	Dr. Schmalz has requested a slight dosing difference of 8mg given serially. An unknown speaker asked for clarification about the prescription section of this policy. Dr. Schmaltz explained that MIH can write prescriptions. It will be an electronic script.
PD# 4510: EMT Training Program	**Approved**	
PD#4511: AEMT Training Program	**Approved**	
PD# 4520: Paramedic Training Program	**Approved**	
PD# 7601: Quality Improvement Program – Technical Advisory Group (TAG)	**Approved**	Julie Carrington made a public comment supporting the re-establishment of the data group. Dr. Kann agreed that the data groups need to be kept in play.
PD# 7602: Quality Assurance Program	**Approved**	
PD#8063: Nausea-Vomiting	**Approved**	
PD# 9013: Pediatric Shock	**Approved**	
PD# 9014: Pediatric Cardiac Dysrhythmias	**Approved**	
PD# 9017: Pediatric Trauma	**Approved with changes**	A public comment was made with removing opiate pain medicines because we now have IV medicine. SCEMSA made these changes. There was some redundancies with ALS and BLS interventions, these changes were made as well.
Chairman's Report		
MIH/Tele911 Update:	**A presentation by Metro Fire was given about their MIH program.**	
APOT		Dr. Kann stated that recently there were zero (0) medics in the county for approximately 40 minutes. He stated that this is clearly a threat to public safety. He addressed this with the Board of Supervisors on 11/7/2023. Due to the transition of NEMSIS 3.4 to NEMSIS 3.5 we do not have the numbers for Novembers APOT.

		Dr. Kann stated that with the rollout of AB40 our unload time must be 30 minutes.
Roundtable		
	Kristin Bianco: Pediatric Policies will be in flowchart format on May 1, 2024. Tressa Naik: Tella911 will becoming to the department shortly. Currently working with Elk Grove Crisis Unit to start an MIH Program. Jeremy Veldstra: MICN working at the top of their scope at UC Davis came in early spring 2023. Expedited EMS arrival – if two or more EMS providers are there with patients on gurneys, a second nurse will be called to look over these patients and determine if they can go to the waiting room. Amelia Hart: there is a similar program to the Expedited EMS arrival at Mercy San Juan.	
Adjournment		