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

9616 Micron Ave. Suite 960
Sacramento, CA. 95827
March 26, 2024

Agency	Representative
AlphaOne Ambulance	Matt Burruel Nathan Beckerman
AMR	Jack Wood Arlen Soghomonians
Cosumnes Fire Department	Tressa Naik Julie Carington
Folsom Fire Department	Bryan Sloane
Kaiser Hospital North	Allen Chang
Medic Ambulance	Lisa Curlee
Mercy San Juan	Amelia Hart
Methodist	Krystyna Ongjoro
NorCal Ambulance	Nic Scher Alastair Lavin
REACH	Corey Collier
Sacramento City Fire Department	Matt Barnick
Sacramento Metro Fire Department	Alex Schmalz Adam Blitz
Sutter Hospital Sacramento	Karen Scarpa Jen Denno
Sutter Hospital Roseville	Debbie Madding Rose Colangelo
UC Davis Medical Center	Jeremy Veldstra Sam Brown
VersaCare EMS	David Buettner

ITEM	ACTION	DETAILS
Welcome and Introductions	**None**	**None**
Public Comment	PediPart Presentation by Dr. Nishijima and team	**None**
Minutes Review	December 14, 2023	**Approved:** Dr. Naik and Dr. Sloane
APOT Update	Currently trending at approximately 61 (sixty-one) minutes. An improvement from approximately 67 (sixty-seven) minutes from December. Conversation was had about the new medical director for the jail, and a new subcommittee that is being formed to help with the inflex of people coming from the jail.	**None**

PD# 2524 – Extended Ambulance Patient Offload Time	**Not Approved will be brought back in June:** ~~2. After twenty (20) minutes of APOT, and every twenty (20) minutes thereafter:~~ ~~a. Check in with receiving facility personnel on status of off-load time.~~ 3. If an offload delay of greater than 20 minutes is expected, check to see if a patient meets waiting room criteria outlined per PD# 5050. a. If patient does not meet waiting room criteria and after sixty (60) minutes of APOT:	Public comments suggested changes to be made to the policy to align with AB40 law. However, a decision was made that adding this language would ultimately enlarge the policy and add more verbiage that is already in AB40 and can be found there, instead of in SCEMSA policy. Additional public comments were made about adding an additional check-in time prior to 60 minutes. There was an agreement that this is more of an operational policy rather than a county policy and does not need to be added. Public comments also suggested removing Section A, subsections 3,4, and 5, however SCEMSA believes that keeping this allows for patient movement and management that needs to be maintained. Subsections will not be removed. More conversation was had about confusion over consolidation and what paramedics can and cannot do while on the wall – policy will be brought back in June to paramedic protocols while on the wall.
Old Business:		
PD# 8069 – Buprenorphine	**Approved**	Will be brought back to EMSA for clarification of changes – age criteria from 18 being moved to 16, removing pregnancy as a contraindication, and removing the need for a base medical direction – do not have to call and get a physician order, but can make base hospital contact if needed for clarification. Additionally, adding administration of Zofran, and the need for two objective findings of withdrawal. Conversation was had about the consenting age of 16 to receive Buprenorphine. A COWS score will be required in the documentation.

PD# 5057 – MIH Buprenorphine	**Approved**	Dr. Kann stated that the MIH policy largely mirrors what we are doing with the general county policy, just more tailored with more online medical control.
PD# 8065 – Hemorrhage	**Not approved, will be brought back in June.** Under **Note**: Consider base hospital ~~physician~~ consult for TXA use in the control of head and neck bleeding. Language removed under TXA Inclusion Criteria for Traumatic Hemorrhage: ~~Does patient meet the following inclusion criteria?~~ ~~Head injury with GCS 9-15 AND reactive pupils AND Signs or symptoms of significant TBI or has altered metal status associated with blast injury or blunt trauma with inability to follow commands.~~ Language removed under TXA Exclusion Criteria for Traumatic Hemorrhage: Isolated ~~head~~, neck or extremity trauma Language added and removed under TXA IV/IO **Tranexamic Acid (TXA) IV/IO** ~~Mix 2 gm TXA in 100mL D5W or NS and infuse over 10 minutes~~ Administer 2gm TXA slow IV/IO push over 1 minute	A request was made by a paramedic in the previous Trauma meeting to list considerations for when to use TXA. Conversation was had over the difference between "a bump on the head with a scratch compared to an actual TBI" the term "head injury" could mean the same thing. Dr. Mackey suggested that GCS should be 9-13 with head injury and reactive pupils with history or signs of significant TBI. In order to clarify head injury more, a new policy will be created.
New Business:		
PD# 2105 – Patient Elopement	**New Policy - Approved**	A new policy was added to ensure that EMS crews, at no time, have the responsibility to prevent a patient from leaving hospital grounds. Conversation was had on the wording and verbiage of AMA – a group consensus was made to remove "AMA" throughout the policy to eliminate confusion as AMA can have different meaning

		from hospital vs prehospital personnel.
PD# 5050 – Destination	**Not Approved, will be brought back in June.** ~~(i.e., Labor & Delivery, Ventricular Assist Devices, Cardiopulmonary Arrest with Return of Spontaneous Circulation~~). Refer to PD # 2060 – Hospital Services.	Conversation was had over removing syncope from the list of contraindications for those patients going into the waiting room. Sydney Freer suggested leaving it in due to stroke data stating that many stokes that have been missed in the field, the patient had syncope or near syncope – more discussion will need to be had to potentially add a more defined guideline for these patients to go into the waiting room. There was much conversation about specialized services that each individual hospital offered, however there was a strong consensus that this topic did not belong in 5050 and will be looked at further when policy 2060 – Hospital Services comes up for review.
PD #8062 – Behavioral Crisis/Restraint	**Approved – will be brought back in June to match PD # 9021 – Pediatric Behavior Crisis/Restraint.** Due to extensive changes, check website or archives to see changes.	Sacramento County Fire Based EMS agencies brought this policy forward due to recent deaths that have occurred in the field from sedation or medication mismanagement. Public comments also suggested removing repetitive language in the assessment section.
Scheduled Updates		
PD# 2033 – Determination of Death	**Approved**	
PD# 2527 – STEMI System Data Elements	**Approved with edits:** ~~Sacramento County EMS Agency~~ SCEMSA SCEMSA will extract the EMS elements from the ~~ICEMA~~ CEMSIS database, and hospitals shall submit their data elements at least quarterly. Hospital data shall be submitted to ImageTrend Patient Registry no later than 90 days following the end of the quarter.	Approved by STEMI Committee as well. Will be live as of May 1st, 2024.

	Non-compliance with the data requirements can lead to program suspension.	
PD# 2528 – Stroke System Data Elements	**Approved with edits:** ~~Data collection for both prehospital and hospital Stroke patients is determined by SCEMSA.~~ Hospital Stroke patient care data elements ~~selected~~ required by SCEMSA are compliant with the GWTG-Stroke Registry. SCEMSA will extract the EMS elements from the ~~ICEMA~~ CEMSIS database, and hospitals shall submit their data elements at least quarterly. Hospital data shall be submitted to ImageTrend Patient Registry no later than 90 days following the end of the quarter. ~~The patient care data elements shall be collected and submitted to SCEMSA on a predetermined monthly schedule. Data elements to be included for monthly submission to the SCEMSA include (but are not limited to) the following:~~ Non-compliance with the data requirements can lead to program suspension. ~~**Data Management:**~~ ~~A. Pre-hospital (EMS):~~ ~~1. Agency~~ ~~2. Response unit~~ ~~3. ePCR number~~ ~~4. Name: Last,~~ ~~5. Name: First~~ ~~6. Date of Birth~~ ~~7. Patient Gender~~ ~~8. Dispatch Date~~ ~~9. Dispatch Time~~ ~~10. Arrive on scene time~~ ~~11. Time at patient side~~ ~~12. Depart scene time~~	Approved by Stroke Committee as well. Will be live as of May 1st, 2024.

	~~13. Arrival time at hospital (from prehospital documentation)~~ ~~14. Time Last Known Well (TLKW) (eSituation.18)~~ ~~15. Blood Glucose (eVitals.18)~~ ~~16. Stroke Scale result (eVitals.29)~~ ~~17. Destination Stroke Team Pre-arrival Activation (eDisposition.24) [Yes/No]~~ ~~18. Destination Stroke Team Activation Date Time (eDisposition.25) [mm/dd/yyyy hh:mm]~~ ~~19. Arrival time at Hospital (from hospital documentation)~~ ~~20. Hospital code~~ ~~B. Stroke Centers:~~ ~~1. Name: Last,~~ ~~2. Name: First~~ ~~3. Date of Birth~~ ~~4. Patient Age~~ ~~5. Patient Gender~~ ~~6. Patient Race~~ ~~7. Mode of Arrival (EMS ground, EMS air, PVT, Law)~~ ~~8. If arrival by EMS, was there a Pre-hospital stroke alert notification?~~ ~~9. Time of Pre-hospital Stroke Alert Notification~~ ~~10. Date Patient Last Known Well per EMS~~ ~~11. Time Patient Last Known Well per EMS~~ ~~12. Pre-hospital Stroke Screen Findings per EMS~~ ~~13. Hospital Arrival Date~~ ~~14. Hospital Arrival Time~~ ~~15. NIHSS Score on Hospital Arrival~~ ~~16. Diagnosis~~ ~~17. Thrombolytic Y/N~~ ~~18. Time of Thrombolytic Administration~~ ~~19. LVO Stroke Y/N~~ ~~20. Endovascular Stroke Care Y/N~~ ~~21. Skin / Groin Puncture Time~~	

	~~22. Discharge disposition (home, SNF, higher level of care, etc)~~ ~~**Additional Data Elements for patients who were INTER-FACILITY Transfers:**~~ ~~23. Was this patient transferred to your facility from another acute care hospital? Y/N~~ ~~24. Sending Facility Name~~ ~~25. Sending Facility Departure Time~~	
PD# 5010 – Transfer of Care: Non-Transporting Paramedic to Transporting EMT/Paramedic	**Approved with edits:** EMT or Paramedic was added throughout the policy. It is the responsibility of both providers ~~Paramedics~~ that patient care not be compromised because of transfer of care. A transporting provider may refuse to assume care for a patient they feel has not been adequately treated or stabilized for the given circumstances. Transfer of care shall only be to an EMT when the non-transporting Paramedic has determined that BLS care is adequate for the patient. All transports where the transfer of care is to an EMT must be reviewed through the Quality Improvement Process at the ambulance provider level.	Dr. Kann discussed these policy changes to the group – suggesting SCEMSA adds EMT to the policy to help incorporate the two – tiered BLS system into policy.
PD# 5052 – Trauma Destination	**Approved**	An unknown speaker suggested that direct medical oversight should be the closest trauma center. Dr. Schmalz opposed the geographical recommendation due to the unique relationship his agency has with UC Davis that allows them to do a video-based consultation. All agreed that this would not be changed.
PD# 5053 – Trauma Triage Criteria	**Approved with edits:** ~~Sustained heart rate > 120 beats per minute~~	A public comment was made that the most recent trauma triage criteria recommendations did not include a sustained heart rate greater than 120. There was a strong consensus within the group

	Adults :ALL > 10 feet (one story is equal to 10 feet) Children: > 10 feet	that this is not utilized in the field, and it should be pulled from the policy. Conversation was also had about removing the repetitive language of children and adults – the consensus was the remove the repetitive language.
PD# 6000 – Trauma Care System	**Approved**	
PD# 2530 – Trauma Center Designation	**Approved with edits:** Prior to designation of any new Trauma Center, SCEMSA will conduct a population needs assessment.	Public comment was sent about Level I and Level II wording, where this could open the door for a hospital to open up a Level III center – however SCEMSA will have to do a community needs assessment in order to add another Trauma center, therefore there are other statutory and regulatory safeguards that would prevent this from happening.
PD# 8007 – Abdominal Pain	**Approved**	
PD # 8015 – Trauma	**Approved with edits:** ~~Head Trauma: Closed head injury:~~ ~~a. TXA administration per PD# 8065 - Hemorrhage~~ If possible, obtain patients name and date of birth.	Jeremy Veldstra commented asking if it is feasible for EMS providers to obtain patients name and DOB. Providers agreed that in some scenarios, it is possible to obtain the patient's name and DOB – this will be added to policy.
PD# 8029 – Hazardous Materials	**Approved**	
PD# 8031 – Non – Traumatic Cardiac Arrest	**Not approved will be brought back to June MAC**	Dr. Mackey from Sac City Fire recommended capping the amount of epinephrine during resuscitation to 3 mg. Dr. Kann stated that he was in agreement with this, stating that capping the medication early would be beneficial for crews and the patient. Conversation was had amongst the group about the effectiveness of epinephrine in cardiac arrest. Public comments were made about strengthening language regarding staying on scene, considerations for a 5-minute pause after ROSC before moving a patient,

		encouraging repeating EKG and delaying of EKG until 5 minutes after ROSC – until we get CAL-ROC data, the time of staying on scene is hard to define – SCEMSA will bring this policy back in June after there is more data.
PD# 9001 – Pediatric Airway Obstruction by Foreign Body and Respiratory Arrest	**Approved**	
Chairman's Report		
Roundtable		
Adjournment	**Next MAC/OAC June 13, 2024, at Micron Ave**	