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

9616 Micron Ave. Suite 960
Sacramento, CA. 95827
September 23, 2024

Agency	Representative
AlphaOne Ambulance	Matt Burruel
AMR	Jack Wood Paul Harper Gabriel Cruz
Bay Medic	Josh Enea Doug Ogneff
Cosumnes Fire Department	Tressa Naik Julie Carrington
Folsom Fire Department	Mark Piacentini Brian Beck
Kaiser Hospital South	Amy Richards
Life Assist	Chelsea Camp
Medic Ambulance	Lisa Curlee Brian Meader
Mercy General	Maryam Gol Jean-Marc Ault-Riche
Mercy San Juan	Amelia Hart Terry Hiddell
Methodist	Krystyna Ongjoro
NorCal Ambulance	Nic Scher
Reach	James Garcia
Sacramento City Fire Department	Kevin Mackey Brian Morr
Sacramento Metro Fire Department	Alex Schmalz Adam Blitz
Sutter Hospital Sacramento	Karen Scarpa
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**
Minutes Review	June 13, 2024	**Approved:** Dr. Schmalz and Dr. Naik
Old Business: **PD# 8031 –** Non-Traumatic Cardiac Arrest	**Approved** Patients in persistent/refractory VF/VT at 15 minutes should be transported to the closest receiving facility.	-Dr. Mackey- (regarding the new language of transporting any patient with a shockable rhythm at <u>any time</u>) - if we use the language of “shockable rhythm at any time”

	1. **NOTE**: consider changing the vector of defibrillation by changing the pad placement from anterolateral to anteroposterior (or vice versa). A. Any patient with ~~an initial~~ a shockable rhythm (VF or VT or shocked by an AED) at any time who has a ROSC during any part of the resuscitation and who is transported shall be transported to a STEMI center B. Post-ROSC Care Bundle 1. ROSC Obtained: a. Manage airway • Early placement of supra-glottic airway or endotracheal tube. b. Manage respiratory parameters – SpO2 92-98%. End tidal CO2 measurement between 35-45 mm Hg. • Initial respiratory rate, 10/minute. c. Manage hypotension/shock with the goal of Systolic Blood Pressure (SBP) ≥ 90 mmHg • Normal Saline 1000 ml bolus **AND** concurrent Push Dose Epinephrine 0.01 mg/ml (10mcg/ml). Dose: 0.5-2 ml every 2-5 minutes (5-20mcg). • Titrate to SBP ≥ 90 mmHg. Reassess vital signs after each bolus. d. Obtain a 12 – Lead ECG approximately 7 minutes post-ROSC. e. Remain on scene for approximately 10 minutes for post-ROSC care to optimize parameters listed in a-d.	we might be bombarding STEMI centers with patients that don't necessarily need to be there. Crews sometimes default to v-fib when they're not 100% sure when in fact it could have been patient or ambulance movement. -Dr. Kann- many studies are showing that the survival rate and discharge with a good neuroglical outcome are significantly higher when the patient is transported to a specialized cardiac center. The literature supports these patients being transported to the STEMI centers and I think it is reasonable that we do that. -Group conversation on whether the post rosc bundle will affect the Cal Rock study and group consensus is that it will not.

	Evaluate and treat for reversible causes for arrest (H's and T's). 2. Bradycardia, refer to PD# 8024 – Cardiac Dysrhythmias. 3. Congestive Heart Failure/Pulmonary Edema refer to PD# 8026 – Respiratory Distress. ~~4. Hypotension/Shock~~ ~~a. Normal Saline 1000 ml bolus, may repeat once to achieve Systolic Blood Pressure (SBP) > 90 mmHg. Reassess vital signs after each bolus~~ ~~b. Push Dose Epinephrine 0.01 mg/ml (10mcg/ml).~~ ~~• Dose: 0.5-2 ml every 2-5 minutes (5-20mcg). Titrate to SBP ≥ 90 mmHg.~~ ~~**NOTE:** Once ROSC is obtained, monitor SBP frequently while administering/titrating.~~	
New Business: **PD# 8068 –** General Medical Complaint	**Approved** 1. If the patient has ALOC, consider possible causes using AEIOU-TIPS: • A – Alcohol, abuse of substances • E – Electrolytes • I – Infection • O – Oxygen (hypoxia), overdose • U – Uremia • T – Trauma, tumor, child maltreatment, toxic substance (or adverse reactions to medications) • I – Insulin (hypoglycemia) • P – Poisoning, Psych • S – Seizures, Sepsis, Stroke, Subarachnoid Hemorrhage	-Dr. Kann-historically the stand-alone ALOC policy was removed because the interventions for these patients are covered in other policies. SCEMSA's concern is that you will lose validity in the data collected on ALOC patients because they will all be reported in the broad ALOC complaint and not recorded into in a more specific complaint (AEIOUTIPS). There also haven't been any questions or concerns from the field so are we implementing a policy that is for the sake of just implementing a policy. Dr. Brown- I have gotten comments from the field that they have concerns about not having a

		ALOC policy. Can we add ALS interventions to the general medical policy that gives the medics protections to do the interventions that their patient needs? -General agreement from all SCEMSA employees is that the paramedic does not need to stick to one exact policy when treating the patient. The paramedic can use multiple polices if needed. If the medic treats the patient and their current symptoms and does what is best for the patient, the paramedic is "covered" -Fire agencies agree that the five medics that brought this concern to Dr. Brown should contact their agency's medical director, and they will follow up with education if need be. -Dr. Kann- the phrase "being covered" means you do what is right for the patient.
Scheduled Updates **PD# 2512** – Designation Requirements for Administration of Naloxone by Law Enforcement First Responders	**Approved** A. Public safety first aid personnel shall demonstrate trained optional skills competency at least every two years, or more frequently as determined by the EMS quality improvement program (EMSQIP).	-Dr. Kann- Title 22 requires a roster of who is trained to administer naloxone and law enforcement is aware and has no complaints.
PD# 5060 – Hospital Status Change	**Approved**	-Dr. Naik-should the hospitals call dispatch to let them know they will be going on diversion? Dispatch does not monitor EMResource 24/7. -Jeremy Veldstra- it is not possible for my MICNs to call nine different dispatchers to let them know of hospital status. Are we using EMResource to its full capability?

		-Dr. Naik- I will talk to our dispatch supervisor who is the only one who has access to the EMResource on the importance of monitoring it more regularly. Jeremy Veldstra- I will add a phone call to dispatch to let them know of a diversion.
PD# 5070 – Hospital Transfer Agreements	**Approved**	-No changes or comments.
PD# 7500 – Disaster Medical Services Plan	**This policy is being replaced with an MCI Plan**	-SCEMSA-PD#7500 will now state, "please reference the MCI plan" -no other comments
PD# 7501 – MCI Critique	**Remove Policy**	-Julie Carrington- the current form does not seem modernized. Can we submit these online? Kristin Bianco- we receive these in an email and I save them if they are ever needed. We have never had any issues with how your MCIs are run. -Jeremy Veldstra- as a control facility, you can get rid of these forms. They are not needed. We look at every MCI and work directly with that agency with our feedback. -Group agreement to pull the MCI Critique Form.
PD# 7509 – Out of County Response	**Approved**	-No comments or changes.
PD# 8020 – Respiratory Distress: Airway Management	**Approved** Moved ALS to BLS In Interventions: 1. Consider and treat causes of respiratory distress, per PD# 8026 – Respiratory Distress, and	-No comments.

	PD# 8004 – Suspected Narcotic Overdose.	
PD# 8026 – Respiratory Distress	**Approved** Initial nebulized breathing treatment will be 0.5mg of Atrovent mixed with 2.5mg of Albuterol. All subsequent treatments will be albuterol only.	-Dr. Kann- Request made by a Metro MIH paramedic to add Atrovent with Albuterol in nebulized breathing treatments. There is a clear benefit to add the Atrovent to these nebulized treatments. I am in favor of adding Atrovent to the albuterol treatments, but I know its an additional cost for the providers. What is the group census? -All agencies agreed that the benefit of using Atrovent outweighs the cost. Most private ambulances already have Atrovent stocked on their ambulances. Dr. Kann- it would be appropriate to mix one pillow of Atrovent with one pillow of Albuterol on the initial breathing treatment. All subsequent treatments will be albuterol only.
PD# 8027 – Nerve Agent Treatments	**Approved**	-No comments or changes.
PD# 8030 – Discomfort-Pain of Suspected Cardiac Origin	**Approved** • Perform a Pre-Alert notification to the closest designated STEMI center. The alert should include the following information when possible: patient's name, date of birth, and / or medical record number. Special Considerations #3 ~~Hemodynamically unstable patients (SBP < 90 mmHg) with an acute STEMI ECG shall be transported to the time closest facility providing interventional cardiac catheterization services.~~	-Dr. Kann-we had a request in one of our STEMI meetings to treat our stemi alerts like stroke alerts and provide patient information in the paramedic's radio report. This will allow for the patient to be registered faster and allow for the doctors to review their chart and past 12 leads. -Group conversation on the importance of the patient initials being added to the 12 leads that the medics are transmitting to the hospital. -Julie Carrington- our firefighters are already doing this, however

		sometimes the initials just aren't showing up on the transmitted 12 lead. We're looking into this matter. -SCEMSA- the current policy change is that medics should add the patient's information to their radio report when possible. The patient initials added to the 12 lead ECG is not yet in policy but is highly recommended. -Julie Carrington- is the information listed in ALS #5 the same as special considerations #3? Is this redundant? It can add confusion. -Dr. Kann- the information in both areas are saying the same thing, we can pull special considerations #3.
PD# 8067 – Sepsis-Septic Shock	**Approved**	Dr. Kann- there were no public comments made. For our altered patients, if stroke is ruled out, sepsis needs to be highly considered. We want our crews to focus on calling the sepsis alerts. I want to see the crews using the pressure bags on all saline boluses. I can't remember the last time I saw a crew come in with a septic patient with a pressure bag hung. Early fluids help. Paul Harper- should we increase the 500ml of saline to 1000ml? Dr. Kann- 500ml is safe spot so we aren't overloading the critical CHF patient. Julie Carrington- should we add a shock index to our policy? Dr. Kann- there is room for us to look into adding a score of some type to help identify these septic patients that we are missing.

PD# 8805 – Intubation Stomal	**Approved**	-No comments or changes.
PD# 8833 – Ventricular Assist Device (VAD)	**Approved**	-No comments or changes.
PD# 9005 – Pediatric Traumatic Cardiac Arrest	**Approved**	-Dr. Kann- there were no comments here, but I want to reiterate the point that we are transporting all these pediatric patients to the hospital. The literature supports this.
Chairman's Report	APOT & Whole Blood	
Roundtable		
Adjournment	**Next MAC/OAC December 12, 2024, at 9616 Micron Ave**	