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

9616 Micron Ave. Suite 960
Sacramento, CA. 95827
June 13, 2024

Agency	Representative
AlphaOne Ambulance	Matt Burruel Nathan Beckerman
AMR	Jack Wood Paul Harper
Cosumnes Fire Department	Tressa Naik
Folsom Fire Department	Bryan Sloane
Kaiser Hospital South	Amy Richards Greg Smith
Medic Ambulance	Lisa Curlee Brian Meader
Mercy San Juan	Amelia Hart
Methodist	Krystyna Ongjoro
NorCal Ambulance	Nic Scher Alastair Lavin
ProTransport	Brendon Miramontes
Sacramento City Fire Department	Kevin Mackey Daniel Kolb
Sacramento Metro Fire Department	Jon Rudnicki Adam Blitz
Sutter Hospital Sacramento	Zac Rucker-Christopher Karen Scarpa
Sutter Hospital Roseville	Debbie Madding Rose Colangelo
UC Davis Medical Center	Jeremy Veldstra Sam Brown
VersaCare EMS	David Buettner
Zoll	KimTanner

ITEM	ACTION	DETAILS
Welcome and Introductions	**None**	**None**
Public Comment	SALT/START triage presentation by Dr. Kevin Mackey	**None**
Minutes Review	March 26, 2024	**Approved:** Dr. Naik and Dr. Sloane
Old Business:		
PD# 5050 – Destination	**Approved** 1. Has complaint of multiple syncopal events. • **NOTE:** If a singular syncopal event has resolved and patient now meets waiting room criteria outlined	-Everyone agreed with "highly encourage" patients to be transported back to initial hospital they were seen at.

	in subsection B above – patient can be moved to the waiting room. 2. Patients with a known communicable disease such as C. Diff, TB, or other need for isolation. • Patients with a suspected viral illness can be placed in the waiting room - masking is encouraged. **Patients intend to elope on hospital grounds – reference PD# 2105** [1]If it is determined, by hospital identification armband or from patient verbalization, they were transported, treated, released, refused care, or departed against medical advice from the identified Hospital within the past twelve (12) hours, and there exists no medical condition that the prehospital personnel believes is unstable, and no Special Triage Policy applies, the patient is highly encouraged to ~~can~~ be transported back to the identified Hospital.	-Making the distinction of one singular, syncopal episode vs multiple syncopal events -One resolved syncopal episode and two rounds of stable vital sounds now meets waiting room criteria -Complaint of MULTIPLE syncopal events does not meet waiting room criteria. -Is age a factor? ≥65? -consensus of the group was not to put age parameters on syncopal episode complaints -Orthostatic vital signs? -Dr. Kann: outside of paramedic scope. If concerned for GI bleed or hypovolemia, they should be offloaded and put in a bed. We're not having EMS initiate interventions while in the ER. -Who's protocol is used when EMS and hospital staff differ on whether the patient is waiting room appropriate? -Dr Kann: if patient is still on EMS gurney, the decision can be made by EMS. If the hospital is concerned about the patient being unstable, they should already be trying to find a bed for that patient. -Communication and feedback between hospital staff and EMS. Metro uses the form: Name Unit # Hospital Incident Number Staff Name Room Number Patient was Transferred to Date Time Did you contact EMS 24? Did you notify your Captain? Do you want EMS to follow up with you?

		Narrative Concerns or comments?
PD# 8024 – Cardiac Dysrhythmia	**Approved**	-No comments or changes.
PD# 8031 – Non-Traumatic Cardiac Arrest	**Not Approved** A. Any patient with ~~an initial~~ shockable rhythm (VT or VF 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-resuscitation bradycardia, hypotension, shock and pulmonary edema.~~ 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 an ECG approximately 7 minutes post-ROSC. e. Recommendation to remain on scene for 10 minutes for post-ROSC care to optimize parameters listed in a-d.	-Sac City Fire: more aggressive post ROSC approach to maintaining systolic blood pressure of at least 90 by SIMULTANEOUSLY giving fluid boluses and push dose pressors. -Dr. Kann: target blood pressure may be increased from 90 systolic to 110-120 in the future. -Group conversation on how to use proper and concise verbiage of giving fluids and push dose pressors concurrently to maintain a blood pressure of at least 90 systolic. -Dr Kann: recommending crews to stay on scene at least 10 minutes post ROSC to treat reversable causes. -Dr Kann: one ECG at or around 7 minute mark post ROSC (sweet spot) -Multiple MD's agreed about the importance of a delayed ECG post ROSC -Group discussion on Refractory v-fib/v-tach. Use of a second agent and at what point? -Dr. Kann- need to look at the science/data and bring this idea back.

	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~~ Drug therapy: Epi IV/IO dose: 1mg every 3-5 minutes up to a total of 3mg	
PD# 8062 – Behavioral Crisis/Restraint	**Approved** Due to extensive changes, check website or archives to see changes.	-General discussion about the importance of frequent monitoring/re-assessments and managing the airway.
PD# 9021 – Pediatric Behavioral Crisis/Restraint	**Approved** Due to extensive changes, check website or archives to see changes.	-No changes or comments.
PD# 8065 – Hemorrhage	**Approved** Under **Note**: Consider base hospital ~~physician~~ consult for TXA use in the control of head and neck bleeding.	-Discussion about the novel uses of TXA for epistaxis and oral bleeding. Should a list be created for crew use? How can we train our crews? -Dr Kann: lets not be overly prescriptive on use and suggest a base consult if crews want/need to use TXA in these novel cases. We

	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 added and removed under TXA Exclusion Criteria for Traumatic Hemorrhage: Isolated ~~head~~, neck or extremity trauma Head injury with GCS <9 OR unreactive pupils 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	can put TXA uses in a formulary document (drug reference guide) that outlines different uses like nebulization, oral bleeding and epistaxis. That would satisfy the training requirement. Writing a policy that would cover every possible novel use of TXA would be near impossible. -Crews have already been making base contact for TXA use for "outside of the box" ideas (post partum bleeding and non-traumatic, wound bleeding)
ALOC POLICY	**Not a current policy-**plan is to add ALOC to PD#8068 General Medical Complaint which will be reviewed in the September MAC meeting	-Sam Brown: multiple medics are wanting an altered mental status protocol back. Crews feel like they don't have a protocol to fall back on for cases live severe alcohol intoxication. They don't feel protected or have guidance. -Dr. Kann: a lot of the ALOC policy has teaching in it. There has been a general want for policies to not have teaching language in them -The issue of not having a protocol that fits into the primary impression to justify glucose sticks and Narcan use -Dr. Kann: we will put the ALOC policy back in, but I will save this recording (crowd laughs) -This policy for the truly altered patient when we don't know why they are altered, it's not initially clear

		-Sydney Freer: we are coming up with flow charts soon which should alleviate this issue -Does ALOC fall under the general medical complaint? Maybe we just add some verbiage to include ALOC. -Dr. Kann: Do we add to this to the general medical complaint or make a separate ALOC protocol? -general consensus to add ALOC under the general medical complaint
New Business:		
PD#8064 – Traumatic Brain Injury Management	**Not Approved**	-Dr Kann: it's a hole in our policy deck. We don't currently have a policy to treat these patients. Current studies are compelling for the use of TXA in TBIs. There has been a lot of recent push back in the trauma meeting and other concerned voices about the use of TXA in TBIs. I have decided to remove the use of TXA in the TBI protocol for now. UC Davis wants to study this. Us putting a TXA protocol for head injuries into the county might torpedo their research. We will continue to look at the data and will have another conversation about this soon. -The use of push dose epinephrine in isolated head injuries to maintain blood pressure. Can medics decipher what is an isolated head injury? A baseball bat to the head is obvious, but in most other cases it is not. -Dr. Kann: so should the push does epi be put into the trauma policy? We will look into this and move forward.

Scheduled Updates		
PD# 2103 – Off-Duty Provision of ALS by Sacramento County Accredited Paramedics	**Remove Policy**	-This policy has not been properly used in over 23 years. General agreement from everyone that this policy is not relevant and not needed anymore.
PD# 2210 – EMR Scope of Practice	**Approved** ~~A. California Code of Regulations, Title 22, Division 9~~	-Sac City Fire: can an EMR administer oral glucose? -Dr. Kann: a public safety officer can administer oral glucose, therefore an EMR should be able to as well. There is no downside to this. We will maintain the current language that allows an EMR to administer oral glucose.
PD# 2501 – Emergency Medical Dispatch	**Approved** 1. A licensed Physician with an unrestricted license in the state of California.	-Change in verbiage to "a licensed physician with an unrestricted license in the state of California".
PD# 5001 – Equipment and Supply shortages	**Approved**	-No comments or changes.
PD# 5100 – Interfacility Transfers – ALS/CCT Program Requirements	**Needs changes – not approved** **AEMT pilot policy will be outside of policy 5100 during the 18-month duration of the pilot program**	-Brian Meader: Section A3- One EMT on CCTs and can home vents be transported by BLS? -Dr. Kann: I will follow up with Kristin Bianco.
PD# 5102 – Interfacility Transfers	**Needs changes – not approved** ~~**Definitions:**~~ ~~A. **Sending Facility**: The facility FROM which the patient is being transferred.~~ ~~B. **Receiving Facility**: The facility TO which the patient is being transferred.~~ ~~C. **Online Medical Direction (OLMD):** Also known as "Direct" Medical Oversight. Medical direction is provided by a SCEMSA-approved base hospital physician or Mobile Intensive Care Nurse (MICN). This direct medical oversight is concurrent with patient transport.~~ ~~D. **Indirect Medical Oversight**: Medical direction provided~~	-Brian Meader: again, vent is listed under ALS -Dr. Kann: I will follow up with Kristin Bianco.

	~~prospectively as with protocol and policy implementation and retrospectively as with quality improvement and case reviews.~~ ~~E. **Base Hospital:** A SCEMSA-approved hospital with trained physicians and nurses that are available for online medical control when requested by field personnel.~~ ~~**IFT:** Interfacility Transfer~~ **NOTE: A-EMT pilot policy will be outside of policy 5102 during the 18-month duration of the pilot program.**	
PD# 5550 – Bio-Medical Maintenance	**Approved**	-No comments or changes.
PD # 8001 – Allergic Reaction/Anaphylaxis	**Approved** **NOTE:** EMTs who have received Epi autoinjector training pursuant to SCEMSA PD# 2220 – EMT Scope of Practice, or possesses a CAEMSA Epinephrine Certification may administer an autoinjector that is not specifically prescribed to the patient. 1. Epinephrine: 1:1,000 a. 0.3 mg IM ~~(Max dose 0.9 mg).~~ b. May repeat in 15 minutes up to three (3) doses (Max dose 0.9 mg) if symptoms persist.	-Sac City Fire: recommendation to change the wording in the IM dose to Max Dose of 0.9mg. -Dr. Klann: new wording provides more clarity.
PD# 8017 – Dystonic Reaction	**Approved** ~~ABC's~~ C-A-B's	-No changes or comments.
PD# 8018 – Overdose and/or Poison Ingestion	**Approved**	-No changes or comments.
PD# 8038 – Shock	**Approved** ~~1. Insulin Shock~~ ~~In patients with severe hypotension refractory to fluid bolus Consider Push Dose Epi 1 ml (10 mcg) IV/IO every 3 min Titrate to SBP > 90~~	-General comments to remove push dose pressures in the shock protocol due to it not being used in hemorrhagic or neurogenic shock. It can be found in other more appropriate policies. Clears confusion by removing it from the shock policy. -Remove insulin shock as it is "old terminology"

<table>
<tr><td>PD#8044 – Spinal Motion Restriction</td><td>Needs Changes - Approved</td><td>-Should the backboard only be used an extrication tool? Not a restriction tool?
-Dr. Kann: I'm happy to incorporate that if nobody objects?
-no objections</td></tr>
<tr><td>PD# 8808 – Vascular Access</td><td>Approved

Insertion Sites in Order of Preference
<table><tr><th>Pediatrics</th></tr><tr><td>Proximal Tibia
~~Proximal Humerus~~
Distal Tibia
Distal Femur</td></tr></table></td><td>-IO sites-Recommendation to remove proximal humerus with the addition of distal femur. Then re-order the IO sites to be proximal tibia, distal tibia, distal femur.</td></tr>
<tr><td>PD# 8827 – 12-Lead ECG</td><td>A. Repeat ECGs ~~can~~ should be performed if there is a change in the patient's status or clinical presentation.~~, but otherwise,~~ Prehospital serial ECGs are not indicated due to the high instance of false alerts.
1. In the setting of ROSC: Repeat ECGs are most accurate seven (7) minutes after obtaining ROSC, as the initial ECG can reveal STEMI, but subsequent ECGs may normalize.</td><td>-Dr. Kann: This topic has already been talked about approved.</td></tr>
<tr><td>PD# 9016 – Pediatric Parameters</td><td>Approved</td><td>-Sac City: wants base consults for every child 12 months or younger.
-Dr. Kann: we want our medics to be critically thinking and I don't think a required base consult for this age group falls in line with that.</td></tr>
<tr><td>Chairman's Report</td><td>APOT – Growth Factory Presentation</td><td></td></tr>
<tr><td>Roundtable</td><td></td><td></td></tr>
<tr><td>Adjournment</td><td>Next MAC/OAC September 12, 2024, at Micron Ave</td><td></td></tr>
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