December MAC 2025 Public Comments

Policy	Agency	Public Comment	Action
2030 – Advanced Life Support Inventories	Dylan Hurley	Add Buprenorphine to medications required. *Optional for ALS Non-Transporting Units	Discuss at meeting. EMS Bup is a priority for the County and needs to be broadly adopted.
2524 – Extended Ambulance Patient Off-Load Time (APOT)	Dylan Hurley	Clarification on whether narcs can be given on the wall for pain management. Guidance on neb treatments when asked to stop by hospital staff	No. EMS treatments need to stop while on wall time. IVF that have been initiated in the field can continue. Nebs should be stopped if hospital staff ask – this is an infection control practice that is reasonable.
8060 – Stroke	Brian Morr	The draft policy does not include Sutter Roseville. Sutter Roseville states that they are a Comprehensive Center. Is it an allowable destination? Is it the closest allowable destination?	Sutter Roseville was added.
8063 – Nausea/Vomiting	Dylan Hurley	Proposed edits: 4. For persistent vomiting, may repeat x one (1) for max dose of eight (8) mg after 15 minutes. 5. Withhold from first trimester (< 12 weeks) pregnant patients not already using Ondansetron. 6. EMS personnel may consider administering Zofran (Ondansetron) prophylactically, prior to or immediately after opioid administration, for a patient with a history of nausea/vomiting secondary to opioid administration.	I don't see a compelling reason to add the 15-minute timeline. 8 mg of Zofran is given routinely in the ED without issue. Not sure if this needs to be added into this policy. If patient experiences symptoms after narcotic administration patients can be medicated.
8066 – Pain Management	Dylan Hurley	Proposed edits: **NOTE**: Analgesic medications should be considered in ALL patients complaining of pain. Consider co-administration of Acetaminophen with Fentanyl/Morphine for multimodal pain relief in moderate to severe pain. With the exception of Ketamine and Acetaminophen, analgesics should be	Larger group discussion. MAC group has rejected attempts to add teaching or similar 'consider' points in the past. I don't feel that there is a role for Versed in pain management protocol. Narcotic + benzo can be considered sedation

		avoided if the patient's systolic blood pressure (SBP) is <90 mmHg, respiratory rate (RR) is ≤ 10 breaths per minute, and/or decreased sensorium or suspicion of traumatic brain injury. f. Midazolam (For patients with anxiety from severe pain after Fentanyl/Morphine) • 1mg slow IV/IO or IM/IN • May repeat once after 5 minutes (Max: 2mg) • Wait 5 mins after Fentanyl administration before administering Midazolam • Monitor for signs of respiratory depression. 5. Fentanyl/Morphine should be avoided in the following patients: • Systolic blood pressure (SBP) is <90 mmHg. • Respiratory rate (RR) is ≤ 10 breaths per minute. • Decreased sensorium or suspicion of traumatic brain injury. 6. Acetaminophen should be avoided in the following patients: • Active liver disease (such as cirrhosis or severe alcoholic hepatitis). 7. Midazolam should be avoided in the following patients: • Systolic blood pressure (SBP) is <90 mmHg. • Respiratory rate (RR) is ≤ 10 breaths per minute. • SpO2 <94% • Decreased sensorium	
8066 – Pain Management	Sam Brown	Request by UCD EM pharmacists to Consider lowering dose of Ketamine to 0.2mg/kg or just single dose of 0.3mg/kg. Have had multiple cases of patients getting into the subdissociative stage from Ketamine and causing some issues with agitation	Dosing is consistent across the state.

9013 – Pediatric Shock	CFD	Suggest adding push-dose epi after or concurrent with fluid challenge.	Stepwise approach – fluids then epi.
9018 – Pediatric Pain Management	Dylan Hurley	Proposed edits: **NOTE:** Analgesic medications should be considered in ALL patients complaining of pain. Consider co-administration of Acetaminophen & Fentanyl/Morphine for longer lasting pain relief in moderate to severe pain. With the exception of Ketamine and Acetaminophen, analgesics should be avoided if the patient's systolic blood pressure (SBP) is <90 mmHg, respiratory rate (RR) is ≤ 10 breaths per minute, and/or decreased sensorium or suspicion of traumatic brain injury. 3. Fentanyl/Morphine should be avoided in the following patients: • Systolic blood pressure less than 70 + (2 x Age) • Respiratory rate (RR) is ≤ 10 breaths per minute. • Decreased sensorium or suspicion of traumatic brain injury. 4. Acetaminophen should be avoided in the following patients: • Active liver disease (such as cirrhosis or severe alcoholic hepatitis). 5. Midazolam should be avoided in the following patients: • Systolic blood pressure less than 70 + (2 x Age) • Respiratory rate (RR) is ≤ 10 breaths per minute • SpO2 <94% • Decreased sensorium Clarification on contraindications for Toradol. Indication says >4 years old or >10kg. 10kg is generally considered a 1 year old so that's a difference between 1 to 4 years old. Listed contraindications also mention (<4 or >65 years old) and	MAC group has been resistant to 'consider' type statements previously.

		does not mention weight consideration compared to above. Can remove >65 years old as contraindication as this is the pediatric protocol.	
TBD – Declared APOT Emergency	Brian Meader	C. Release Priority 1. Release two ALS crews who are actively operating in the 911 system. The clause should be removed because all ambulances, whether dispatched through 911 or a seven-digit call, are integral components of the county's emergency medical system. Release priority should be determined by objective factors such as order of hospital arrival, not by dispatch origin, to ensure fairness and operational efficiency. Creating artificial distinctions between emergency providers undermines the system and can negatively impact patient care.	DAE discussion are continuing at the county level. This discussion will be tabled at the MAC until meetings have occurred. Anticipate bringing this back in March.
TBD – Declared APOT Emergency	Jeremy Veldstra	Currently, hospitals have no access to what EMS resources are available in the county. The only opportunity for hospitals to have insight into EMS resources county-wide is when they hit a specific drawdown level, and SCEMSA sends an alert via EMResource that they are extremely low. Since APOT is a community problem, it would be reasonable to utilize EMResource to provide real-time EMS resource availability for all hospitals to view. Having this real-time view as resources are drawn down would give hospitals the ability to make potential adjustments before reaching critical drawdown.	DAE discussion are continuing at the county level. This discussion will be tabled at the MAC until meetings have occurred. Anticipate bringing this back in March.
TBD – Declared APOT Emergency	Matt Burrel	I would like to thank Sacramento County EMS Agency for taking on the development of this Declared APOT Emergency (DAE) policy. The challenges of balancing 911 system readiness with the realities	DAE discussion are continuing at the county level. This discussion will be tabled at the MAC until meetings have occurred.

		of prolonged APOT have placed a tremendous strain on all providers, and it is commendable that SCEMSA is proactively addressing this critical issue on behalf of both the community and EMS stakeholders. I am grateful for the consideration given to the suggested changes in Section "C" under Release Priority. Updating this language will include private/non-911 units alongside 911 units in the release sequence. This will reflect a fair and practical solution. This thoughtful adjustment prevents unintended disparities between provider types, while reinforcing the principle that all units (regardless of designation) contribute to the safety net of Sacramento County's EMS system. To preserve system balance and community protection, this process requires that one private/non-911 unit be released from the wall with the same urgency as a 911 unit whenever a DAE is declared. This ensures that both 911 and non-911 resources remain available to meet community needs across the county. If, during a DAE, no private/non-911 units are on the wall, then two 911 units will be released instead. Failing to equally prioritize the release of non-911 and 911 units will ultimately drive a disproportionate increase in call volume for the 911 system. This imbalance will create unforeseen consequences for providers, degrade response reliability, and negatively impact patient outcomes. The community as a whole will suffer if unit release is not applied equitably across both non-911 and 911 resources. Purpose: A. To establish an emergency protocol for releasing Advanced Life Support (ALS) units back into the 911 system during times of	Anticipate bringing this back in March.

		extreme ambulance shortage caused by prolonged Ambulance Patient Offload Times (APOT). Authority: A. California Health and Safety Code, Division 2.5 B. California Code of Regulations, Title 22, Division 9 Protocol: A. Activation Criteria 1. A Declared APOT Emergency (DAE) shall be initiated when systemwide ALS ambulance availability decreases to 15 or fewer units. 2. The SCEMSA Duty Officer shall be advised of critical EMS status. 3. Under the direction of the SCEMSA Medical Director, the Duty Officer shall issue a DAE alert through EMResource to all Sacramento County hospitals. B. Hospital Response 1. Upon receipt of a DAE alert, each hospital is required to release two (2) ambulances back into the 911 system within 20 minutes of the declaration. (Suggested edits section) C. Release Priority 1. One private/non-911 ALS unit shall be released with equal urgency as a 911 ALS unit whenever possible. 2. If one or more private/non-911 ALS units are present on the wall, at least one shall be released first, with an additional 911 ALS unit released to meet the requirement of two total units. 3. If no private/non-911 ALS units are present on the wall, then two 911 ALS units shall be released. 4. If no 911 ALS units are present on the wall, then two private/non-911 ALS units shall be released. (This process ensures equitable release between 911 and non-911 resources, preventing disproportionate strain on the EMS system.) D. Patient Reassessment 1. All ambulance patients shall be	

		reassessed for potential waiting room placement using SCEMSA Policy #5050 (Destination/Patient Stability Criteria). E. Documentation 1. The release of units shall be documented using the DAE Form available in EMResource	