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

9616 Micron Ave. Suite 940
Sacramento, CA. 95827
March 13, 2025

Agency	Representative
AlphaOne Ambulance	Matt Burruel
AMR	Jutin Begley Arlen Soghomonians
Bay Medic	Doug Ogneff
Cosumnes Fire Department	Tressa Naik Julie Carrington
EDC JPA	Cristy Jorgensen Hope Youngblood
HFPD	Glory Barthel
Kaiser	Rich Meidinger Amy Richards Allen Chang
Medic Ambulance	Lisa Curlee
Mercy General	Najwa Green
Mercy San Juan	Terry Hiddell Nathan Beckerman
Methodist	Krystyna Ongjoro
NorCal Ambulance	John Brooks Carrie Hansen
Pro Transport	Brendon Miramontes
Reach	James Garcia
Sacramento City Fire Department	Kevin Mackey Brian Morr
Sacramento Metro Fire Department	Alex Schmalz Adam Blitz Kiley Keeley Dylan Hurley Amelia Hayden
Sutter Hospital Sacramento	Jen Denno Zachary Rucker-Christopher
UC Davis Medical Center	Jeremy Veldstra Sam Brown
VersaCare EMS	David Buettner
Wilton Fire	Rodrick Huerta-Moore
Zoll	Kim Tanner

ITEM	ACTION	DETAILS
Welcome and Introductions	**None**	**None**
Minutes Review	December 12, 2024	**Approved:** Jeremy Veldstra & Tressa Naik
New Business: Transporting Service Animals		**Sacramento Fire** brought forth this issue to see where the hospitals and other departments

		stand on transporting service animals. **Sacramento Fire**-Generally, most hospitals follow the federal ADA guidelines however there are some variances from hospital to hospital. Should we have a county policy so that everyone is on the same page? **Dr. Kann**-How could a LEMSA policy provide clarity to a federal law and furthermore, dictate ER room procedure? I'm not sure how we have any jurisdiction here. **Dr. Mackey**- Federal law goes into what a service animal is, (dog and mini-horse) it does not go into how an EMS provider will handle the transportation of a service animal. We are looking for a unified approach here. **Brian Morr-** The law states that a service animal can be denied if it effects the ability to functionally deliver service which is a massive gray area. It then comes down to our crews making a judgment call on whether the patient can control their service animal. **Ben Merin-**Having dabbled in ADA guidelines with my service animal, this federal law is kept gray for a reason. While I understand the want for a county wide policy on this issue, I believe it could get you into more trouble. You're only able to ask two questions, what is your disability and what is your dog trained to do. If a patient is unable to answer both of those questions, you can deny the animal transport. However, what if the patient does answer both questions about their animal and then the dog becomes aggressive at some point because

		the patient became unconscious, then what do you do? You can take the dog because it is being aggressive and will hinder care, however our policy would be stating that you do have to transport the service animal. What do they do? I think more harm than good will come from a formal policy on this issue. **Jeremy Veldstra**-At UC Davis, our policy is to ask the patients those two questions: What is your disability and what service does your animal provide? If they can answer both of those questions appropriately, we do our best to accommodate the service animal. If they cannot answer both of the questions, we clearly state that the animal can not stay and we will contact animal control if other arrangements can't be made for the dog. **Dr. Kann**-Lets see where the commonality is between the different hospitals and what their policy is on this matter. **Dr. Mackey**-The problem is that LEMSA does not have the authority over the hospitals to implement a policy like this. We all talked about this issue, we checked the box, but maybe we just move on from this. **Dr. Kann**-I am happy to pose this question to the County Council to see if they have any guidance to put forward, but I imagine they will fall back to what the federal law says. **Group discussion** on the possibility of each provider sharing their procedure/process for how they handle the transportation of service animals and everyone

		learning from one another to find the best practice.
Behavioral Crisis Memo	**Approved** **Behavioral Crisis Memo**	**Dr. Kann**- This memo is hot off the press and I think it will spark a lot of conversation. Recently, the Sac County Sheriff came out in a very public press conference and said “we will not be responding to behavioral health calls”. They have taken a very different approach to this issue than other local agencies. I know that Sac City PD has also had some non-response to some of these behavioral crisis calls as well. This issue has been brewing for quite some time now. A year ago last March is when we made changes to 8062 to prioritize scene safety for our crews. Basically, stating that if a scene is unsafe for the crew, they may stay away or exit the scene and with the goal of keeping a visual line of sight on the patient. Then with appropriate leadership on scene, try and de-escalate the issue. The problem with those policy changes, is it left things very open ended. What happens when the crew is never able to make access to the patient because the patient has a weapon or is aggressive making the scene unsafe? What is the crew going to do? They can’t make an assessment, are they just going to sit there forever? That is obviously not a situation we want our crews stuck in and furthermore, it takes an ambulance out of service. There have been several high-level discussions with county leadership up to the executive level on how we approach this issue. We are still trying to engage with our law enforcement partners. In the short term, this memo will provide guidance on how a crew should manage that instance where the scene remains unsafe and there is

		not an ability to go in and do an assessment on the patient. I want to go into the why this is being done as a memo. This is a policy memorandum that is meant to stay in place as long as law enforcement is not responding to these cases. County Council asked us to go a memorandum route because they felt that if we did an actual change to the county policy, that would be providing implicit acceptance and agreement with law enforcement's current practice and we do not agree with this. In essence, this memorandum will stay in effect for as long as law enforcement does not respond to these types of situations. Were asking that the crews continue to follow 8062 but if that scene is unsafe, you don't enter the scene and remain at a safe distance with the goal of keeping a visual line of sight on the patient. Letter B was added to this memo stating that: "If (per Dispatch or other information source) a patient has an identified or suspected weapon, an EMS unit, in consultation with a supervisor, may not engage with the patient if determined to be unsafe. If possible, the EMS Supervisor shall conduct and document a Behavioral Activity Rating Scale (BARS) assessment consistent with all listed steps below." We have put together a pathway here from letter C on down to handle these calls. The city council made a request that an EMS supervisor should respond to this scene to help work with law enforcement to ensure scene safety and mitigation measures. The EMS supervisor should document in the PCR the law enforcement officer who was contacted and the outcome of that

		discussion. We ask that there be an objective way of assessing these patients and that's why we have the BARS assessment listed here. **Group discussion** on how the BARS assessment works. **Dr. Kann**: This memo really focuses on the patients with a BARS of 6 or 7. If there is a continued non-response from law enforcement, EMS providers with supervisor consultation may elect to not engage with the patient due to scene safety. If all the measures above have been completed and no response from law enforcement for 30 minutes, the EMS supervisor may authorize the unit to clear the scene and go back into the 911 system. Were asking that the disposition for this call be recorded as "released following protocol guidelines". San Francisco does this by using an AMA, but we do not agree with that because this is not an AMA. This is a per protocol driven release. **Group discussion** on possible scenarios that could arise. **Dr. Mackey**-I applaud you work on this. This memo will no way address every possible scenario that could arise out there, but I think this is a massive step forward compared to what we have right now. Thank you! **Dr. Kann-**I have been doing medical direction for 6 years now and I say this all the time, "you can't make a glove that is going to fit every hand and that is how I feel about policies as well." There is a framework here that will help guide most situations. Obviously,

		there is legal risk here and that is why we have a step wise approach to this with the crews checking each box. We will be doing a 100% QI with these calls making sure the narrative is intact, and that all pertinent information is there. If we find that there are elements missing from the PCRs, we will reach out and have the crews make amendments. **Group discussion** on the crews using a universal statement when requesting law enforcement. Example: Send me law enforcement for a 5150 evaluation. Send me law enforcement for a person breaking 'this law'. This sets the officer up to respond under dereliction of duty. **Dr. Kann-** I don't think this is the place for us to decide on certain language a crew must use. I think the education should come at the provider level.
PD#4302 – Continuing Education Provider	**Not Approved**	**Dr. Mackey-**Can I request to table this policy to our next meeting? I want to have a discussion with you and now is not the time to have that discussion. I prefer not to go into the details right now. I can lay out all my thoughts at the next meeting. **Dr. Kann**- We can table this until the next meeting.
PD#4510 – EMT Training Program	**Approved** -minor changes made to reflect recent updates to Title 22.	-No comments
PD#4520 – Paramedic Training Program	**Approved** -minor changes made to reflect recent updates to Title 22.	-No comments
PD#7500 – Multi-Casualty Incidents & MCI Plan	**Approved**	**Dr. Kann**-This plan is a significant change to our approach to MCI's specifically changing from START triage to SALT. We also updated

		the capabilities of our local hospitals and how many patients they can receive from these scenes. When you look statewide at other counties MCI plan, these are bloated documents that are 100-150-200 pages long. I don't think that is where we need to be. This plan is a framework to respond to MCIs. SALT triage is important. How patient destination to each hospital is decided at the scene and not decided by the control facility. **Question on Hazmat MCI response**: **Dr. Kann**-I don't think we need to bloat out our MCI plan with how we are going to respond to each possible MCI when we have policies in our deck that that already over those instances. How do we handle intentional MCIs? That gets more into crime scene discussion and I think the guidance here comes down to who is the scene commander for that incident. Whoever has investigative authority for an incident will be the on scene commander for that incident. **Brian Morr-** We were surprised to see that were not classifications for the different types of MCIs in the new MCI plan when they were in the old policy. **Ben Merin-** Great point. However, this is an operational issue on how to respond to a MCI and we will work with the control facility and there will be a designation of medical vs trauma vs hazmat MCI. **Jeremy Veldstra-** From a control facility standpoint, the most important thing for us is the communication piece from the field

		with the field crew being very explicit with what they are seeing on scene. The scene needs to be described in complete detail. That's the most important piece. I don't think this needs to be dictated in the plan/policy like it was previously. It more of a training piece for each agency. **Ben Merin-** This all has been developed over time by the MCI workgroup which includes members in this room. We are not done with plan. We are going to continue to meet and make changes when needed. **Jeremy Veldstra-** My goal when making this plan was to make this as operationally as easy as possible. We know there are going to be hiccups over the next 18 months plus as we go forward. As we evaluate this plan, we will make the necessary steps/improvements to continually update the plan. As a control facility, I am happy to put forth time and energy in reviewing every MCI as I have for the past 2.5 years. However, as we move forward with these changes, I would appreciate that performance improvement was done on every MCI and I think this should start at the LEMSA level. If not, I will continue to do the reviews from the control facility standpoint. **Ben Merin-** The MCI workgroup would be a great place for all of us to share the workload on reviewing each MCI.
Scheduled Updates **PD#2001** – Document Manage System	**Approved**	**Julie Carrington**-Is there a way to revise the policy schedule so that the policies that we are reviewing relate to each another?

		Dr. Kann-I hear what you're saying and I think that would be a good place to land in the future. It'll take time, but I think trying to get the policies in a more bucketed approach is reasonable.
PD#2027 – Stroke Care Committee	**Approved** All members will sign a confidentiality agreement not to divulge or discuss any ~~personal~~ protected health information (PHI) or clinical care details of cases discussed at meetings. Prior to the guest(s) participating in the meeting, the Chairperson is responsible for explaining, and obtaining, a signed confidentiality agreement from invited guests	-No comments
PD#2028 – STEMI Care Committee	A. All members will sign a confidentiality agreement not to divulge or discuss any ~~personal~~ protected health information (PHI) or clinical care details of cases discussed at meetings. Prior to the guest(s) participating in the meeting, the Chairperson is responsible for explaining and obtaining, a signed confidentiality agreement from invited guests.	-No comments.
PD#2030 – Advanced Life Support Inventories	**Approved** Hemorrhage control supplies and/or Quick Clot	-No comments.
PD#2032 – Controlled Substances	**Approved**	-No comments or changes.
PD#2033 – Determination of Death	**Approved – flowchart to come** A. ~~Where more than one criterion is listed, all (elements) must be present to confirm death in the identified setting. These apply only to the initial assessment and will determine whether or not cardiopulmonary resuscitation efforts will be initiated.~~ In all cases when determination is considered, it is assumed that there is no	**Dr. Kann-** Is there a want for a flowchart for this policy vs the narrative form it is already in? **Dr. Mackey**-I thought the plan was to move all of the policies into flowcharts? **SCEMSA**- Yes, that is the plan but do all policies need to be in flowcharts?

	breathing, no pulse and no response to stimuli. If there is any doubt, initiate cardiopulmonary resuscitation. Assessment for confirming conditions shall take thirty (30) seconds or less.	**Adam Blitz**- I did propose a flow chart for this policy and the idea behind that was that the listed definitions in the current policy used to be listed as a steps to take when determining death. I think the document needs to be cleaned up and I think listing the steps will help that. **Dr. Kann**- I think the point in breaking it out into a BLS vs ALS assessment is fair and we have that formatting in other policies, I'd be fine with doing that. **SCEMSA-** Do we want this as a flowchart? **Group** census is yes on flowchart.
PD#2036 – Medical Scene Authority	**Approved**	-No comments or changes.
PD#2039 – Physician and/or Registered Nurse at the Scene	**Approved**	-No comments or changes.
PD#2055 – On-viewing Medical Emergencies by ALS/BLS Providers	**Approved**	-No comments or changes.
PD#2060 –Hospital Services	**Approved**	-No comments or changes.
PD#2526 –STEMI Receiving Center Designation	**Approved**	-No comments or changes.
PD#4400 – Paramedic Accreditation to Practice	**Approved** **General**: A. In order to maintain Sacramento County Emergency Medical Services Agency (SCEMSA) accreditation, paramedics must keep their certifications ~~current~~ valid and up to date, follow all SCEMSA policies, maintain employment as a paramedic with a Sacramento County Advanced Life Support (ALS) provider, and submit for	-No comments.

	continuous accreditation prior to expiration. B. Upload (front and back) a valid American Heart Association Pediatric Advanced Life Support (PALS) card or ~~equivalent* or~~ Pediatric Education for Prehospital Professionals (PEPP) card, or ~~Advanced Pediatric Life Support (APLS) or~~ Handtevy Pre-Hospital Pediatric Provider card. **NOTE**: Once accredited, the paramedic shall possess valid and up to date certifications at all times while on duty and be able to provide immediate proof (physical cards and/or digital) upon request.	
PD#6001 – STEMI Critical Care System General Provisions	**Approved**	-No comments or changes.
PD#8837 – Pediatric Airway Management	**Approved**	-No comments or changes.
PD#9001 – Pediatric Airway Obstruction	**Approved**	-No comments or changes.
PD#9002 – Pediatric Allergic Reaction/Anaphylaxis	**Approved**	-No comments or changes.
PD#9003 – Pediatric Respiratory Distress	**Approved**	-No comments or changes.
PD#9004 – Pediatric Burns	**Approved** 1. For burns < 30% TBSA AND no inhalation injury, stop the burning process by applying cool running water over the burn. The goal is cumulative (bystander and first responder) application of cool running water for 20 minutes.	**Dr. Kann-** Dr. Mackey had proposed some changes to this policy which I think are reasonable. The whole idea of cool running water is that the 20 minute time period should be done on scene prior to transport (if safely possible). My experience with

	Whenever possible, this should be completed prior to transport. a. It is critical that providers remain on scene to complete a full 20 minutes of continuous cooling with running water before initiating transport unless the scene becomes unsafe or the patient's condition necessitates immediate transport. b. Early cessation of cooling may lead to worsened burn severity and increased tissue damage. If transport is initiated before 20 minutes of cooling is completed, cooling should continue en route whenever feasible. 2. After cooling the burn, apply a covering to the burn (dry non-stick gauze, loose plastic wrap, etc.). 3. Avoid hypothermia by isolating and cooling only the burned area. Keep unaffected body parts warm by covering them as much as possible, and use the heater in the passenger compartment. 4. Caustic and Chemical Burns: Wear protective clothing and gloves and consider the presence of hazardous materials. Remove the patient's clothing. Apply cool running water over the burn for 20 minutes. Do not scrub. 5. Electrical Burns: Check for, and dress all entrance and exit wounds. 6. ~~Avoid hypothermia by isolating and cooling only the burned area. Keep unaffected body parts warm by covering them as much as possible, and use the heater in the passenger compartment.~~ 7. ~~After cooling the burn, apply a covering to the burn (dry non-stick gauze, loose plastic wrap, etc.).~~	burns in the ER department is that it is not always easy to have access to cold running water. It can actually be easier to use the patient's kitchen than to find running water in the ER. **Sam Brown-** Are we going to put in an upper limit TBSA like we do in the adult policy? **Dr. Mackey-** If we are going to stay to the science which this is based on, I think we have to add TBSA limit. My concern is that it wont take much for a child to reach the 30% burn limit. Those patients need to be transported to the hospital quicker for stabilization. **Dr. Kann-** You also run the risk of hypothermia. **Jeremy Veldstara**- You can just copy the first part of the adult policy that mentions "for burns less than 30% TBSA and no inhalation injury". **Dr. Kann-** I am fine that, my biggest concern here is the hypothermia issue. **Dr. Mackey-** To remind everyone on the stats on this, 63% reduced odds of full thickness burns, 46% reduced odds of skin grafts, healing 3 days faster, 36% reduced odds of surgery, 31% reduced odds of hospitalization and this was found with 11,383 patients. This makes a massive difference.
Chairman's Report	APOT	
Roundtable		

Adjournment	**Next MAC/OAC June 12, 2025, at 9616 Micron Ave**	