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

9616 Micron Ave. Suite 940
Sacramento, CA. 95827
June 12, 2025

Agency	Representative
AlphaOne Ambulance	Nick Coibian
AMR	John Perino
Bay Medic	Doug Ogneff
Cosumnes Fire Department	Tressa Naik
EDC JPA	Cristy Jorgensen
HFPD	Glory Barthel
Kaiser	Rich Meidinger Allen Chang
Medic Ambulance	Lisa Curlee Brian Meader
Mercy General	Najwa Green
Mercy San Juan	Terry Hiddell Nathan Beckerman
Methodist	Krystyna Ongjoro
NorCal Ambulance	Alastair Lavin Nic Scher Carrie Hansen
Pro Transport	Sarah Spanglo
Sacramento City Fire Department	Matt Barnick
Sacramento Metro Fire Department	Alex Schmalz Adam Blitz Dylan Hurley Scott Perryman
Sutter Hospital Sacramento	Jen Denno Karen Scarpa
Sutter Hospital Roseville	Debbie Madding
UC Davis Medical Center	Jeremy Veldstra Sam Brown John Rose
Zoll	Kim Tanner

ITEM	ACTION	DETAILS
Welcome and Introductions	**None**	**None**
Minutes Review	March 13, 2025	**Approved:** Adam Blitz & John Rose
Old Business: **PD# 4302** – Continuing Education Provider	**Approved** 1. SCEMSA shall approve or ~~disapprove~~ deny the request for a CE course within sixty	• Discussion: Current policy requires CE providers to submit pre-instruction summaries • Concerns raised about administrative burden

	(60) calendar days of receipt of the completed request. ~~a. Submit a Continuing Education Course Summary FORM for each CE course being offered prior to teaching.~~	• Decision: Remove pre-instruction summary requirement • Rationale: Streamline provider process while maintaining post-instruction documentation
PD# 9004 – Pediatric Burns	**Approved** 1. Remove the patient from the source of the burn, then remove burning or smoldering clothing and remove jewelry 2. Perform ABCs 3. Assess for inhalation injury (singed nasal hairs, hoarse voice or stridor, oral or facial burns) and administer supplemental O_2 as necessary to maintain SpO2 ≥ 94%. Be prepared to support ventilation with appropriate airway adjuncts. 4. Estimate the size of the burn (see below) 5. 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. 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,	Identified outdated language restricting monitoring and pain medication protocols

cooling should continue en route whenever feasible.

6. After cooling the burn, apply a covering to the burn (dry non-stick gauze, loose plastic wrap, etc.).
7. 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.
8. 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.
9. Electrical Burns: Check for, and dress all entrance and exit wounds.
10. ~~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.~~
11. ~~After cooling the burn, apply a covering to the burn (dry non-stick gauze, loose plastic wrap, etc.).~~

NOTE: Check for associated injuries. Treat shock, if present.

Do not apply ice or creams to the burned area.

Fire in enclosed space suggests smoke inhalation or carbon monoxide poisoning.

ALS

1. Initiate vascular access in patients with major burns (> 9%). For BSA > 9% or hypotension. Administer 20ml/kg NS fluid bolus.
    - When possible the preferred vascular access site is an unburned area.
2. Albuterol (if wheezes present)
    - 5 mg via HHN, mask or BVM.
3. Cardiac monitor with SpO_2.

	~~If partial thickness burn with severe pain and without evidence of or mechanism of internal head, chest or abdominal injury:~~ 4. Consider administration of pain medication as per PD# 9018-Pediatric Pain Management.	
New Business: **PD#8003** – Seizures	**Approved** 7. If known or suspected pregnancy (greater than 20 weeks) OR if possible pregnancy within the last 6 weeks, administer magnesium sulfate even if seizure has resolved. • Magnesium Sulfate: -10g IM (5 g in each buttock) OR 6g IV/IO in 250 NS, infusion over 10 minutes. * No repeat magnesium dosing without base hospital consultation.	Added magnesium administration for pregnancy > 20 weeks Dosage: 10 grams IM (5g in each buttock) 6 grams IV/IO No repeat dosing without base hospital consultation Supported by regional best practices
PD# 8026 – Respiratory Distress	**Approved** **Albuterol/Atrovent:** Mix 2.5mg Albuterol & 0.5mg Atrovent via HHN, mask or inline nebulizer. May repeat up to 3 doses of this mixture. Magnesium Sulfate 2 g IV/IO over 1-2 minutes No repeat magnesium dosing unless base hospital consultation.	Added magnesium administration for moderate to severe respiratory distress Discussion on increasing atrovent to 3 doses. Group agreed to 3 doses of albuterol/atrovent
PD# 8031 – Non-Traumatic Cardiac Arrest	**Approved** Magnesium Sulfate If at any time a patient presents with suspected polymorphic ventricular tachycardia (Torsades de Pointes), magnesium sulfate 2g IV/IO over 1-2 minutes may be given at any time after the first epinephrine dose.	Added magnesium for torsades de pointes 2 grams IV over 2 minutes Administration after first epinephrine dose
PD# 9003 – Pediatric Respiratory Distress	**Approved** **Asthma/Bronchospasm - Condition is severe**: **BLS**	Implemented weight-based magnesium dosing 50mg/kg Maximum 2 grams in 250 saline bag over 10 minutes

	ALS 1. Airway management as per PD# 8837- Pediatric Airway Management. 2. Pulse Oximetry, when available, may be used to titrate oxygen saturation to a $SpO_2 \geq 94\%$. 3. Mix 2.5 mg Albuterol & 0.5 mg Atrovent via HHN, mask or inline nebulizer. May repeat up to three doses of this mixture. 4. **Epinephrine:** 0.01 mg/kg of 1:1,000 (1 mg/ml) solution Intramuscular (IM) up to a maximum dose of 0.3 ml. 5. Initiate vascular access. Titrate to a minimal Systolic Blood Pressure (SBP) for the patient's age. Vascular access shall not take precedence over the administration of Albuterol or Epinephrine. 6. For moderate to severe exacerbations, administer magnesium sulfate 50 mg/kg to a maximum dose of 2g IV/IO in 250 NS, infusion over 10 minutes. 7. A. **Croup/Stridor - Condition is severe:** **BLS** 1. **ALS** 1. Airway management as per PD# 8837 2. Pulse oximetry, when available, will be used to titrate oxygen saturation to SpO2 ≥ 94%. 3. **Epinephrine**: 2.5mg 1:1000 via nebulizer or 0.01 mg/Kg of 1:1,000 (1mg/ml) solution IM up to a maximum dose of 0.3 ml.	Add nebulized epinephrine for severe croup Discussed potential risks and operational considerations

Scheduled Updates **PD# 2080** – EMS Orgon Donor Information	**SUNDOWN (removed)**	Group discussion on best practices for when a patient is an Organ Donor. Group decided to discontinue policy.
PD# 2085 – Do Not Resuscitate Committee	**Approved**	No comments.
PD# 2101 – Patient Initiated Refusal of Service and/or Transport	**Approved** 1. Base hospital consult is NOT for the base hospital to grant or deny a refusal of service.	Group discussion on base hospital responsibility in regard to AMAs. Base hospitals are a "phone a friend" for when help is needed. They do not need to be contacted for every AMA.
PD# 2200 – Medical Oversight	**Approved**	No comments.
PD# 2210 – EMR Scope of Practice	**Approved**	No comments.
PD# 2220 – EMT Scope of Practice	**Approved**	No comments.
PD# 2221 – Paramedic Scope of Practice	**Approved** 1. Magnesium Sulfate	No comments.
PD# 2223 – Paramedic Scope of Practice Utilization	**Approved**	No comments.
PD# 2305 – EMS Patient Care Report: Completion, Distribution, Submission	**Approved**	No comments.
PD# 2511 – Infectious Disease Ambulance Response Team	**Approved**	No comments.
PD# 2529 – Stroke Receiving Center Designation	**Approved**	No comments.
PD# 4006 – Reporting Responsibilities of Relevant Employers	**Approved**	No comments.

PD# 5001 – Equipment and Supply Shortages	**Approved**	No comments.
PD# 6002 – Stroke Critical Care System General Provisions	**Approved**	No comments.
PD# 8002 – Diabetic Emergencies	**Approved** • Dextrose ~~10~~ 12.5 grams IV. If blood sugar remains ≤ 60 mg/dl, give additional Dextrose 12.5-25 grams IV. May repeat for a total of 50 grams.	Group discussion on editing the wording to alleviate confusion.
PD# 8004 – Suspected Narcotic Overdose	**Approved** If patient is revived by Narcan and GCS15, consider Buprenorphine administration.	Group discussion on the benefits of buprenorphine administration and its positive impact on patient outcomes
Chairman's Report	APOT	**Ambulance Patient Offload Times (APOT)** Presented comprehensive data analysis Current 90th percentile offload time: 35 minutes Compared with 6 peer counties Sacramento experiencing slight upward trend while others decline Discussed stakeholder collaboration strategies Hospitals implementing new mitigation efforts **Additional Discussions** Amiodarone Shortage Management Approved lidocaine substitution for amiodarone when needed

		Non-transporting ALS units will not be required to stock amiodarone during the shortage Provides operational flexibility during medication shortage
Roundtable		
Adjournment	**Next MAC/OAC September 11, 2025, at 9616 Micron Ave**	