MAC September 2025 Public Comments

Policy	Agency	Public Comment	Action
2030 – Advanced Life Support Inventories	Edward McThorn	On page 2 Category AIRWAY please remove the word "iGel" under supraglottic allowing other branded items/generic to submit for usage under supraglottic. On page 2 Category IV ACCESS please remove the word or brand name EZ IO and replace with just IO or IO access. Both requests remove brand name items a replace them brand name with a generic term.	-Discuss further at MAC -Potential path: with county MD approval
2002 – Naloxone Leave Behind Program	Kevin Mackey	Policy B. 2. c. Can we change the verbiage to "Opioid Resource Information Sheet"? The DHS one is a mess, very hard to read. I believe each agency has made their own because of it. happy to share ours with the LEMSA if you wish.	-Agreed
2003 – BLS Tiered Response	Kevin Mackey	Policy 5011 has parameters for a call that can be handed off to an EMT including acceptable vital signs parameters. Suggest not trying to describe a "potentially unstable" patient here. You already have acceptable guidelines for vitals. Same policy (5011) refers to the PAT, but this policy goes in to detail. Assuming you agree that moving all of I in 5011 (already submitted as a suggestion), then it would make sense to move the PAT description over to the ALS to BLS policy. This policy then becomes cleaner, all of your parameters are in one place. I hope that makes sense. Recap: move "I in 5011 to 5050. Remove PAT discussion here and add it to 5011. Refer to 5011 in this policy	-Okay to remove vital sign parameters to 2003 with reference to stability criteria in 5011 -Discuss further at the MAC
4050 – Certification Process	Kevin Mackey	Under "Responsibilities of Relevant Employer...", I would like to discuss with the group where everyone places the information from an investigation based on "upon determining the disciplinary action to be taken, the	-Discussion at MAC

		Relevant Employer shall complete and PLACE IN THE PERSONNEL FILE a statement". Does everyone place it in a personnel file? How long does it stay in the file? Are there criteria for removing it from the file? Thank you!	
8042 – Childbirth	Julie Carrington – Cosumnes Fire	It's time to update our obstetric policy. I propose the following: 1. Change the name of the policy to Childbirth and Obstetric Emergencies 2. Keep the protocol addressing a midwife on scene and how the medic can collaborate care with the provider. 3. Add eclampsia care, including Mg++ administration 4. Add post-partum hemorrhage care, including TXA administration.	-Agree with name change -Magnesium added to seizure policy at June MAC, proposing referring to the 8003 seizure policy if patients begins to seize -Agree with postpartum hemorrhage care (possibly bring back to December MAC with proposed changes)
5011 – Paramedic/AEMT to EMT transfer of care	Kevin Mackey	#1: Policy A. 4-8: Is there any way we can get these to mirror the TAD policy vital parameters? They are nearly identical. Would make life A LOT easier! #2: Policy B. 3: Remove the STEMI language, and leave the "Discomfort ..." language. Reason: Chest pain of suspected cardiac origin" also captures NSTEMIs. The AHA is looking to expand their requirements to encompass NSTEMIs (not sure how). We do, however, want chest wall pain or low level trauma chest pain (mechanical) to be BLS. The paramedic will need to choose a path, which will strengthen the system. #3: I. Patient ED Consolidation. Would it be cleaner to move this language into 5050. I know that 5050 is already pretty lengthy, but it might make this policy a little shorter and 5050 to contain everything that involves hospital destination.	-1. Agree with standardizing stability parameters across all policies (TAD,ALS/EMT) -2. Agree with changes -3. Discuss ED consolidation at MAC
2525 – Pre-Hospital Notification	Jeremy Veldstra - UCDMC	Remove "status of response to hospital"-this should have no bearing on how a hospital determines resource need and isn't needed in a patient report Add the following to Trauma alert to align with Stroke and STEMI: "Patient's name, date of birth, or medical record number, if known"	-Comment acknowledged regarding code status, will keep in policy -Agree aligning specialty care reporting

2525 – Pre-Hospital Notification	SFD	Recommend adding language: Whenever possible, STEMI alerts should be communicated (ideally by radio) as soon as possible (ie: prior to initiating transport). Reason: the AHA has noticed our county FMC to intervention times can be long. This is their suggestion to try to lift more of the county up and decrease FMC to intervention times	-Agree, alert should be called once a STEMI EKG is obtained and transmitted to the hospital
2525 – Pre-Hospital Notification	Kevin Mackey	Please clarify, under "Prehospital Notification Format" on page 2, what is meant by "Full set of current and/or previously abnormal vital signs".	-Agree, will list in policy
7508 – SALT	Kevin Mackey	There was talk of implementation November 1, 2025. What is the effective date?	-Going live February 1, 2026 with MCI Plan
8025 – Burns	Kevin Mackey	Thank you for making the changes! Amazing!	
8025 – Burns	Julie Carrington – Cosumnes Fire	Under BLS 5.b. The wording is confusing. Is it necessary to say that if <20 min of CRW isn't achieved, that a worsened injury will occur? Possible solution is to emphasize the importance of CRW in "Policy" above the treatment sections and eliminate 5.b	-Changes were made to 8025 to mirror the agreed upon changes to pedi-burns at June MAC
9007 – Pediatric Diabetic Emergencies	Kevin Mackey	Bottom of new flow chart under "If blood glucose <60 mg/dl, REPEAT". What are we repeating? Suggestion: This is probably where IO access to be obtained. We have already waited 15 minutes. Suggest removing "REPEAT" and "IMPROVING" box below it and go to IO. This would be consistent with the written longer version.	-Flowcharts are being paused right now due to recent ADA guideline updates
9007 – Pediatric Diabetic Emergencies	Julie Carrington – Cosumnes Fire	NS bolus is listed as 20 mg/kg It should be 20 mL / kg	-Change was made
9006 – Pediatric Medical Cardiac Arrest	Kevin Mackey	Under "NOTE" at the bottom of page 1, the statement is made "It is important to spend 20 minutes doing effective CPR to attempt to get ROSC in the field." It goes on to say "If CPR and ALS is performed for 20 minutes with no ROSC, the patient will be transported to the ED." To clarify, the clock starts with ALS? The way it reads could be interpreted to transport every patient, which I know is not the intent. Also, I imagine there is a pediatric TOR policy in the works that will match this when it goes in to effect next year?	-It is the intent that all pediatric patients under CPR will be transported to ED to be pronounced -Add language about adding obvious signs of death -Ask for clarification regarding the vf/vt comment, not sure what you're referring to. -Agree with removing igel language, will refer to as BLS

		Pediatric Asystole and Pediatric VF/VT should all be under this policy. Wy too much to break it out. Suggest a Page 2 for asystole/PEA and a page 3 for VF/VT. Please remove the term "iGel". There is no evidence that iGel is specifically the preferred advanced airway. Change to supraglottic, or something more generic like that. We will know more after the PediPART trial is done.	airway, pending ADA review of flowchart
9006 – Pediatric Medical Cardiac Arrest	Julie Carrington – Cosumnes Fire	On page 2 at the bottom of the flow-chart to the left "For VT/VF unresponsive to defib/epinephrine:..." The last bullet point states "For refectory VF/pulseless VT>>>>>>>>>>>>>>>>" What does >>>>>>>>>>>>>>>>>>>> refer to?	-Likely refers to repeating the vf/vt algorithm -Suggest adding language for refractory vf/vt being transported at 15 minutes to match adult cardiac arrest policy -Also suggest adding language to synchronize max epi dose at 3 total doses
9008 – Pediatric Seizure	Kevin Mackey	On new flowchart: Consider removing everything under the "E" for EMT on the non-seizing side. These patient's aren't monitored in the ED, most don't need IVs (we have IN and IM if needed quickly), and having midazolam on the non-seizing side is confusing. I would also suggest removing any reference to the "Pediatric behavioral Crisis". Again, difficult to figure out in the short prehospital space, and does not really belong here. Finally, both arrows pointing to PD 9007: Diabetic emergencies" need a parameter in there for them to go to that. Is a blood glucose of 215 enough? I get if the blood glucose is 40, that makes sense. Add the parameters on the arrow or in the in the "Blood glucose analysis" box please.	-Flowcharts are being paused right now due to recent ADA guideline updates
9011 – Pediatric Overdose	Kevin Mackey	On the new flow diagram: Under "suspected narcotic overdose", under the EMT, what does "NOT ADMINISTERED TO RESTORE CONSCIOUSNESS" mean? I think I know, but please clarify. I feel like this can be added on the back of the sheet, under PEARLS, and left to the training aspect, that the goal of	-Flowcharts are being paused right now due to recent ADA guideline updates

		naloxone is to restore respiration, not consciousness. Also, IMO, the "Remember" part of the EMT instructions is out of place and not consistent with prior policies. If the policy needs to be instructive on remembering details, that should go in PEARLS, IMO. Finally, why is the Poison Control Center number on this policy? Is it for parents? The PCC is not a base hospital and can not give orders. Suggest removing it.	
9009 – Pediatric Neonatal Resuscitation	Kevin Mackey	On the Instructions on the back of the flow chart, the policy indicates that Neonatal arrest is "predominantly caused by asphyxia". But then goes on to say "maintain a C-A-B resuscitation"? Suggest rewording to say "Focus on effective airway and ventilation watching for chest rise and fall while maintaining 3:1 CPR"	-Flowcharts are being paused right now due to recent ADA guideline updates
9009 – Pediatric Neonatal Resuscitation	Dylan Hurley - Metro	Can we get an approved age of viability?	- Viability is generally defined as 20 weeks
8060 – Stroke	Kevin Keenan	In light of the recent implementation of severe stroke triage using the LAMS score in Yolo County, I recommend that the policy be updated to align with the American Heart Association's consensus recommendations regarding Stroke Urban Transport. https://www.stroke.org/en/professionals/stroke-resource-library/pre-hospitalems	-Further discussion at MAC
8060 – Stroke	Brian Morr	Should SCEMSA change the stroke policy to require transport of certain stroke patients to a comprehensive center, it should be the time closest comprehensive center.	-Further discussion at MAC
8060 – Stroke	Dawn Warner	Time is Brain - patients should be transferred to the closest Comprehensive Facility (regardless of insurance or affiliated system). I would prefer that SCEMSA consider drafting a Stroke screening policy similar to Yolo's... based on pre-hospital stroke score and patient acuity. This policy proposal is basing hospital	-Further discussion at MAC

		triage on last known well and assuming TNK works all the time, which it doesn't.	
8060 – Stroke	Kwan Ng	The patients with stroke outside of thrombolysis timeframe should be transported to closest Comprehensive Stroke Center (CSC) regardless of their insurance status or type. There should be no hesitation to get stroke patients to the closest CSC that will allow them to have access to the fastest and most advanced treatments. Anything less would be a disservice to our community.	-Further discussion at MAC
8060 – Stroke	Jeremy Veldstra – UCDMC	Strongly agree to make the proposed changes for transport to Comprehensive center. Propose that transport is to the closest despite health care system patient is set up with. These patients meet specialty criteria, just as STEMI/Trauma and should follow same destination decision criteria	-Further discussion at MAC
8060 – Stroke	Josh Adams	The change to the policy was talked about for the past few years with the concern for the need for each hospital's stroke alert data before any change. There has not been sharing of any stroke alert data yet and this change seems to be just being proposed because of Yolo changing theirs. Some of the comprehensive stroke centers have longer door to groin time than other systems have Primary stroke center door time to groin puncture at the comprehensive stroke center after transfer. This data needs to be shared before a change in the policy.	-Further discussion at MAC
8060 – Stroke	Dr. Jingjing (Jenny) Chen	I am fully in support of a revised diversion policy for large vessel occlusion patients. However, I would recommend revising the policy to triage any suspected large vessel occlusion patients to a THROMBECTOMY-CAPABLE center instead of only to a comprehensive stroke center. Thrombectomy-capable centers are fully equipped to deliver the full-range of ischemic stroke care that a comprehensive stroke center does. By limiting triage to only the comprehensive stroke centers, EMS could be adding unnecessary time to	-Further discussion at MAC

		transport and delaying critical patient care. Every minute 1.9million neurons are dying in a large-vessel occlusion stroke. Every minute spent diverting to a comprehensive stroke center is a minute lost—and in stroke treatment, time is brain. Delays can mean the difference between recovery and irreversible damage. I highly recommend revising the policy to include diversion for LVO to thrombectomy-capable centers.	