Sacramento County Emergency Medical Services Agency Medical and Operational Advisory Committee Public Comments – June 2026

- ## Acetaminophen
  - Ryan Grady – ProTransport
    - I am writing to provide public comment on the use of acetaminophen (Tylenol) for fever management in the prehospital setting, with specific consideration for interfacility transport (IFT).
    - Fever, by itself, is not the problem. It is a physiologic response and, in many stable patients, does not require routine treatment in the field. Treating every elevated temperature does not improve outcomes and can distract from identifying and managing the underlying cause.
    - That said, there are clear situations where targeted use of acetaminophen makes clinical sense.
    - From an IFT perspective, we frequently encounter patients with known or strongly suspected infections who are being transferred for higher levels of care. These patients often present with ongoing fever, chills, and body aches despite prior evaluation. In this context, judicious antipyretic use can provide meaningful benefit.
    - Reducing fever in these patients can help decrease metabolic demand, improve overall comfort, and potentially reduce tachycardia and physiologic stress during transport. This becomes more relevant during longer transports, where untreated symptoms can worsen patient tolerance and complicate monitoring.
    - There is also a practical component: patients experiencing rigors, discomfort, and generalized malaise are more difficult to manage during transport. Addressing these symptoms can improve cooperation, facilitate care, and create a more stable transport environment.
    - At the same time, it is important that antipyretic use does not occur in isolation. In patients with suspected or confirmed infection, especially those demonstrating signs of systemic illness, attention should be given to adequate fluid status. Ensuring appropriate fluid resuscitation when indicated is a critical part of managing the overall physiologic stress associated with fever, not just lowering the temperature.
  - SCEMSA
    - Public comment on Acetaminophen. This will not change policy.

- ## 2033 – Determination of Death and 8032 – Traumatic Cardiac Arrest
  - Alex Pibl – Metro Fire
    - Language in these documents is conflicting as to which PEA is criteria for determining death in traumatic cardiac arrest.
    - *2033.18: Determination of Death*
      - Traumatic injuries (if appropriate; respect the possibility of a crime scene):
        - Absence of all pulses, and
        - Asystole by monitor in two (2) leads, or
        - Pulseless electrical activity (PEA) with heart rate ≤ 40 bpm.
      - *8032.02: Traumatic Cardiac Arrest*
        - Chest compressions/high-quality CPR for any rhythm other than Wide Complex PEA <40 bpm or Asystole
  - SCEMSA
    - These policies govern two very separate entities. One is a patient with a clearly unsurvivable injury, the second is a traumatic arrest which is witnessed or attended to in a very short time period after arrest. These were also addressed at the March MAC.
- ## 5010 - Transfer of Care Non-Transporting Paramedic to Transporting EMT/Paramedic
  - Matt Barnick – Sacramento City Fire
    - Item H states "All transports where the transfer of care is to an EMT must be reviewed through the Quality Improvement Process at the ambulance provider level."
    - It is my understanding that when a new policy comes out the ask from SCEMSA is a 100% review for 6 months, then an agency can choose a percentage to review. Is that true? I couldn't find a policy on procedure with CQI review process with this particular circumstance. Any guidance would be helpful.
    - My recommendation is for a clear process to be written about how long a policy is desired for review with a beginning date, end date and percentage (if so desired from SCEMSA).
    - I would also recommend language that suggests a portion to be reviewed vs a percentage as each agency varies with capacity, staff and resources.

- SCEMSA
  - There is no standing 6-month review language. When ALS-BLS transfer of care was started in 2023 it was requested that this level of oversight be performed. It is reasonable at this time to relax this requirement. Open discussion on percentage of PCRs to review.
- Brian Morr – Sacramento City Fire
  - Can SCEMSA please clarify:
  - "N. All transports where the transfer of care is to an EMT/A-EMT must be reviewed through the Quality Improvement Process at the ambulance provider level."
  - For Sacramento City Fire this is in excess of 20,000 calls a year which is multiple magnitudes greater than the requirement to audit 3% of total charts as defined in PP-7600.06 Quality Improvement Program.
  - In the past SFD has received communication from SCEMSA that we are not required to CQI audit 100% of ALS to BLS calls.
  - Does this include calls where Paramedic is driving the ambulance to the hospital and the EMT is providing patient care and completing the ePCR?
  - Should Olanzapine be added to 8062.12 Behavioral Crisis/Restraint at this meeting please include it in the list of approved drugs for Paramedic to EMT transfer of care.
  - We asked a group of paramedics and here are some of the responses we got: (We believe that these are all good points for discussion)
    - Do we need to establish parameters? Emphasis should be placed on paramedic liability (and possible resultant consequences) in the situation where a patient is improperly transferred to a BLS crew.
    - No anticipated deterioration during transport is a good way to phrase it. (Reinforces the paramedics responsibility and liability)
    - Do not want to unnecessarily limit ALS to BLS transfers. I currently like being able to start a lock, give IV Zofran, and IV Toradol and still transfer to a BLS company.
    - May we add two doses of Combivent to the list of medications that may be administered prior to handing the patient off to a BLS crew.
    - Certain situations where a paramedic chooses not to treat such as subjective shortness of breath with no vital sign or physical findings could be a safe BLS transport.

- Situations that should not be transferred to a BLS crew could be better defined … for example, symptomatic overdose or predicted symptomatic overdose, etc.
- Under the heading of chest pain, emphasis should be made for people to not be ruling out cardiac just because a 12-lead doesn't scream STEMI and that blood draws and further assessment are necessary. I feel like people shoot a 12-lead and then say it's not cardiac if STEMI doesn't immediately appear. Consideration toward the elderly, diabetics, transplants, and female patients should be made with atypical cardiac presentations. But with that said, I do think some obviously non-cardiac chest pain patients could probably go BLS.
- I think paramedic discretion regarding the care of hypertensive stimulant use patients like methamphetamine or crack could be exercised in determining a BLS patient. (Crews felt that increasing the Systolic range up to 220 and the heart rate up to 120 would be OK in the setting of asymptomatic patients who have not taken their hypertension medications.) (these patients are routinely triaged directly to the waiting room on ED arrival.)
- Paramedics can safely determine an inebriated patient to be BLS.
- Any call that requires ALS care should automatically be ALS, and doesn't need to be spelled out.
- Restrained patients need a paramedic since these can be high-risk calls. (In the 911 scene call environment. Not intended to apply to psych IFTs)
- I like the paramedic discretion to always keep a call.
- If numeric are determined to be necessary for ALS /BLS determination, we felt like good BLS numbers were:
    - Systolic Blood Pressure- 90-220 (asymptomatic)
    - Diastolic Blood Pressure up to 120 (asymptomatic)
    - Heart Rate 120/Min and Sinus Tach (No irregular rhythms like PVCs or Afib, etc)
    - Pulse Ox numbers of 94% RA or 88% for COPD patients was good (or Home O2 Baseline)
    - Skin signs not concerning for shock is good.

- SCEMSA
  - QI review for ALS to BLS transfer can be relaxed to usual QA chart review level.
  - Any instance where patient care was initiated by a paramedic and care was downgraded to BLS falls under this policy.
  - Agree that BLS may transport patients who have been given Zyprexa. Add to Policy C listing.
  - Repeat dosing of inhaled bronchodilators could be a sign of patient deterioration.
  - Inebriated patient. This could be captured by overdose and able to maintain an airway.
  - Stability parameters are set and impact numerous other policies – EMS to waiting, TAD.

5056 – Mobile Integrated Health

- Brian Morr – Sacramento City Fire
  - Multiple Comments:
    - SCEMSA and CAEMSA have no statutory authority to regulate Nurse Practitioners and Physician Assistants.
    - Section F – SCEMSA has no legal authority to regulate the care provided by the NP/PA
    - Section G – SCEMSA has no legal authority to regulate the referral's made by the NP/PA.
    - Section H – MIH providers document in a separate documentation platform, The documentation needs of these providers are not met by utilizing an ePCR platform designed for 911 and IFT ambulance response.
    - Clinic on SCEMSA approved list and Approved behavioral health clinic, where is this list?
- SCEMSA
  - Discussion at meeting.

8001 – Allergic Reaction/Anaphylaxis

- Dylan Hurley – Metro Fire
  - Clarification on "If extremis or no improvement, Epinephrine 1:10,000 titrated in 0.1mg increments slow IV/IO. Maximum 0.5mg"
  - We currently use 1:100,000/Push-Dose Epi for extremis in anaphylaxis. Are we now using 1:10,000 Epi instead?

- I like the new flowchart style, but this one looks a little busy with three columns. Could we consider removing the angioedema column and instead just add the "For patients with localized swelling to the face or tongue with suspicion of bradykinin-induced angioedema, administer 1 gm of IV TXA" to the anaphylaxis column?
- SCEMSA
  - Examples of extremis are given. The starting treatment for patients with anaphylaxis is 1:1000 IM epinephrine. Follow the algorithm with a total of 3 IM doses. If patient continues to deteriorate and needs BP support then push dose epinephrine is appropriate.

8003 – Seizure

- Cosumnes Fire
  - Add in Cross References PD # 8042 Childbirth and Obstetric Emergencies
  - On page 2 → Seizures: → have either the bullet point or the numbering. Not both.
- SCEMSA
  - Fixed.

8018 – Overdose

- Dylan Hurley – Metro Fire
  - "Tricyclic and Related Compounds", Instead of saying related compounds, can we define the main ones that would follow this treatment flow? ie. "Tricyclic Antidepressant, Anticholinergic, Salicylate"
  - For Anticholinergic & Salicylate, add Hyperthermia and Tinnitus and/or total hearing loss to the list of toxicity symptoms
  - Add new medication Calcium Chloride for treatment of Beta Blocker/Calcium Channel Blocker overdose.
  - Suggested Beta Blocker/Calcium Channel Blocker overdose treatment flow.
    - If HR <50 and SBP<90
    - ATROPINE: 1mg IV/IO, repeat q5 min. Max dose 3mg
    - GLUCAGON: 1mg IV/IO over one (1) minute. May give
    - IM if no vascular access. Single dose
    - CALCIUM CHLORIDE 10%: 1gm slow IV/IO over 10 minutes. Single dose.
- SCEMSA
  - Management of anticholinergic ingestion and ASA is very different from TCA and bicarbonate. Point 2 – do not want to incorporate teaching into policies. Calcium Gluconate should be given through peripheral IV in overdose

setting. Chloride extravasation is highly problematic. Glucagon may provide a benefit in beta-blocker overdose but use in Ca channel blocker overdose is not standard practice. Calcium chloride mentioned above. Often extremely difficult to tease apart what the patient took. The recommendations above mix BB and Ca channel blocker therapies together. Role of EMS in management of these difficult patients that often require Toxicology consult in the ED. Give the common meds in the field – Atropine to try to support HR and push dose epi for BP support.

- 8038 – Shock
  - Dylan Hurley – Metro Fire
    - Push-Dose Epinephrine was added for Pediatric Shock. Considering adding Push-Dose Epinephrine for adult shock.
    - In patients with hypotension refractory to fluid bolus, with no evidence of trauma. Consider Push Dose Epinephrine 0.01 mg/ml (10mcg/ml) Dose: 0.5-2 ml (5-20mcg) IV/IO every 2-5 minutes. Titrate to SBP > 90 mmHg
  - SCEMSA
    - Push-dose epi use will be dependent on type of shock. No role in trauma. Cardiogenic shock requires management of root cause – tachy-dysrhythmia. Hypovolemic shock should be managed with fluids. I have concerns about a blanket statement of push-dose pressors reflexively without evaluation of underlying pathophysiology.
  - Cosumnes Fire
    - At the top with Supplemental 02 → it states >, but all other policies indicate greater than OR equal to. Please add the ≥
  - SCEMSA
    - Fixed.
  - Brian Morr- Sacramento City Fire
    - Please consider including a reference to prehospital blood.
  - SCEMSA
    - Pre-hospital blood program on hold currently.
- 8062 - Behavioral Crisis/Restraint
  - Dylan Hurley – Metro Fire
    - Adding Olanzapine to ALS interventions- will this be a required medication or optional? If required, on transporting units only or non-transporting units as well? Is there an implementation plan?

- SCEMSA
  - This is a required medication. November 1 start date.
- Brian Morr – Sacramento City Fire
  - Sac City Fire supports the addition of Olanzapine.
- SCEMSA
  - This has been added to policy.

8065 – Hemorrhage

- Dylan Hurley – Metro Fire
  - Epistaxis:
    - Cardiac monitoring and ETCO2 measurement as available.
    - Vascular access, but do not delay airway management for suspected posterior hemorrhage.
    - Consider intubation for significant hypoxia, dyspnea, or impending airway loss.
    - Apply pressure for 5-10 minutes to the lower 1/3 of the nose.
    - For stable patients with epistaxis not controlled by direct pressure, encourage vigorous nose blowing to remove clotted blood. 500mg Tranexamic acid (TXA) soaked cotton gauze and place in the affected nostril. Apply direct pressure for 5-10 minutes.
    - Section C on page – Need to correct the sentence to reference both the narcotic overdose policy and the diabetic emergencies policy. Only the policy number for diabetic is listed.
- SCEMSA
  - We went through this exhaustively in 2024. Decision was made to ask for Base order for TXA for head and neck bleeding. Unsure of 'ask' about narcotic overdose/diabetic emergencies policy reference?

8827 – 12 Lead ECG

- Matt Burruel – Alpha One
  - There was a recent ECG education session hosted at Metro Fire Headquarters regarding 12 lead and potentially 15 lead ECG interpretation with a suggestion of serial 12 leads. We appreciated the opportunity to participate and found the discussion surrounding ECG interpretation and cardiac care to be extremely valuable and intriguing.
  - Following that session, AlphaOne would like to respectfully request the opportunity to discuss the possibility of future conversations surrounding 15-

lead ECG utilization and the continued development of a more enhanced ECG interpretation culture within Sacramento County EMS systems.
    - Our intent is simply to begin collaborative dialogue and explore potential educational and clinical opportunities that may continue to strengthen patient care throughout the region.
    - Thank you for your continued partnership and leadership.
- SCEMSA
    - This can be brought forward for discussion.

9002 – Pediatric Allergic Reaction/Anaphylaxis

- Cosumnes Fire
    - Should the blue bar indicating Paramedic treatment be extended alongside the green A-EMT treatment in the systemic (Anaphylaxis) branch? Similar to the Localized branch.
- SCEMSA
    - No, will explain at meeting.
- Brian Morr – Sacramento City Fire
    - Please add the following note (copied from Adult policy 8001.21) "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.
    - Sac City Fire supports Cosumnes' request to standardize push does epi language across the 3 protocols.
- SCEMSA
    - OK with adding EMT epi autoinjector language. Agree with any push dose epi language standardization.

9006 – Pediatric Cardiac Arrest

- Dylan Hurley – Metro Fire
    - Epinephrine (1:10,000) .01mg IV/IO
    - Every 3-5 minutes, max total dose 3mg.
        - Change to 0.01mg/kg
    - There is a new flow chart box at the bottom of pages 2 & 3 that talks about discontinuation. The discontinuation would be viewed as after the "20 minutes" and not obvious death, because at the top of page 1, it already

talks about obvious death. I find this kind of confusing because it says to follow Determination of Death to discontinue, but then further down on the protocol, it gives you direction to not discontinue resuscitation.

- SCEMSA
  - Review flow-chart.
- Cosumnes Fire
  - The new policy appears to indicate that the arrest can be terminated on the scene. That is a change in the current policy that requires transport: "If CPR and advanced life support is performed for 20 minutes with no ROSC, the patient will be transported to the ED and not pronounced on scene."
  - I wouldn't have a problem with the change back to pre 2025, but if that is not the intent, then you may consider removing the references to Determination of Death placed at the end of the second page.
  - Should the green A-EMT treatment be included in the AED defibrillation treatment sections?
- SCEMSA
  - Updated.
- Brian Morr – Sacramento City Fire
  - Question, why is advanced airway always after IV/IO Epi?
- SCEMSA
  - Nothing to add.

9008 – Pediatric Seizures

- Dylan Hurley – Metro Fire
  - Clarifying question, is the IM/IN route a single dose only, or can it be repeated until you hit the max of (4mg/6mg)?
- SCEMSA
  - Single dose. Additional dosing requires base contact. Our dosing is very low and could be increased. SFEMSA uses 0.2 mg/kg for IM/IN/IO/IV use. Max 10 mg with any route. Alameda has max 8 mg for IV/IO/IM. IN 10 mg.
- Cosumnes Fire
  - In the Yes branch → Midazolam IV/IM/IN → IN dose has a decimal, but the dose for the IM does not. Please standardize the format one way or the other.
  - Page 1 states to consider PD # 9021, but it is not in the cross-reference list.

- SCEMSA
  - Fixed.

- 9013 – Pediatric Shock
  - Cosumnes Fire
    - Can you clarify the question box → "History, exam and circumstances often suggest (type of shock)"?
  - SCEMSA
    - Fixed.