

Sacramento County Emergency Medical Services Agency MAC/OAC Meeting Minutes



Date and Time: December 12, 2025, 9:00am-12:00pm
Location: EMS Conference Room, 9616 Micron Avenue, Suite 940
Sacramento, CA 95827
Facilitator(s): Greg Kann, MD FACEP, SCEMSA Medical Director

Welcome and Approval of Previous Minutes

- A. September meeting minutes reviewed and approved by Brian Morr and Tressa Naik.

MIH Policies

- A. Dr. Kann - The Metro MIH program has been operating for the past five years. It was initially started as a pilot program, but as more MIH programs have been started, we are now going to move the MIH policies from the pilot program to formal SCEMSA policies that will be up for review every two years.

Declared APOT Emergency

- A. Dr. Kann - Discussion on the implementation of a declared APOT emergency being stalled due to staffing changes with the Hospital Counsel. The declared APOT emergency is essentially letting the hospitals know when the system is at low status of only 15 available ambulances. This will hopefully encourage the hospitals to help facilitate getting ambulances back into service. Low system status used to happen multiple times a day and now we are only seeing this 1-2 times a month. We will bring this discussion back to the March MAC meeting and discuss further then.

EMResource

- A. Jeremy Veldstra, UCDMC – Discussion on hospitals reporting their medical and pysch patient hold status every 4 hours so that the acuity of their department can be seen on EMResource, however this is a false indicator of hospital status/capacity. Proposed changes/updates to EMResource so that the hospital status/capacity is more accurate and more widely seen/used. This will help us as a control facility to help distribute patients when needed.

- B. Ben Merin, SCMESA – It would be beneficial for all the hospitals to get together and discuss new ideas/changes to make EMResource a more accurate tool.
 - 1. Set up meetings with the hospital and prehospital liaisons.
- C. Group discussion on the benefits of EMS being able to use EMResource moving forward.

PD# 5050 – Destination – Approved

- A. Vital sign parameters for the TAD policies were updated to avoid patients being denied acceptance into the TAD facilities for vital signs that the facilities deemed to be abnormal. The vital sign parameters for the 5050 policy were updated as well to match the TAD guidelines to avoid any confusion.
 - 1. Action:
 - a. Systolic Blood Pressure ≥ 100 mmHg and ≤ 200 180 mmHg.
 - b. Diastolic Blood Pressure < 120 ≤ 110 mmHg.
- B. Wording was updated to match current wording in PD# 8031 – Non Traumatic Cardiac Arrest
 - 1. Action:
 - a. Any patient with ~~an initial~~ shockable rhythm (Ventricular Tachycardia or Ventricular Fibrillation or shocked by an AED) **at any time** who has a Return of Spontaneous Circulation (ROSC) during any part of the resuscitation and who is transported shall be transported to a STEMI Percutaneous Coronary Intervention (PCI) center.

PD# 5203 – Transport Guidelines – Sobering Center - Approved

- A. Vital sign parameters for the TAD policies were updated to avoid patients being denied acceptance into the TAD facilities for vital signs that the facilities deemed to be abnormal.
 - 1. Action:
 - a. Systolic Blood Pressure ≥ 100 mmHg and ≤ 200 180 mmHg.
 - b. Diastolic Blood Pressure < 120 ≤ 110 mmHg.
 - c. **Has no removable orthotic devices.**
 - d. If there is a history of Diabetes Mellitus, no evidence of Ketoacidosis, and a blood glucose ≥ 60 mg/dl and ≤ 350 300 mg/dl.
 - e. **NOTE:** Isolated mild to moderate hypertension (i.e., SBP ≤ 200 180 mmHg with no associated symptoms such as headache, neurological

changes, chest pain, or shortness of breath) in a patient with a history of hypertension is not a reason to exclude referral to a SC.

PD# 5205 – Transport Guidelines – Mental Health Facility - Approved

- A. Vital sign parameters for the TAD policies were updated to avoid patients being denied acceptance into the TAD facilities for vital signs that the facilities deemed to be abnormal.
 - 1. Action:
 - a. Systolic Blood Pressure ≥ 100 mmHg and ≤ 200 180 mmHg.
 - b. Diastolic Blood Pressure $< 120 \leq 110$ mmHg.
 - c. [Has no removable orthotic devices](#).
 - d. If there is a history of Diabetes Mellitus, no evidence of Ketoacidosis, and a blood glucose ≥ 60 mg/dl and $\leq 350 \leq 300$ mg/dl.
 - e. [Ambulatory, does not require a wheelchair](#).

PD# 2030 – Advanced Life Support Inventories – Approved

- A. Dr. Kann: We spoke with EMSA in regard to adding the AIR-Q as an accepted supra-glottic airway and they approved it for both adult and pediatric patients.
 - 1. Action:
 - a. Supraglottic intubation device (iGel® or [Air-Q®](#)) Infant through adult
- B. Jenna Alexander, SCEMSA: Thermometers are now only required for transporting ALS units and will be optional for non-transporting units. We also added the size 6.5 ET Tube to the required list. It should have always been on the required list but wasn't and we are updating the list to fix that error.
 - 1. Action:
 - a. Thermometer*
 - b. Endotracheal tubes cuffed, 5.0, 5.5, 6.0, [6.5](#), 7.0, 7.5, 8.0
- C. Group discussion on making Buprenorphine a required drug due to the importance of combatting withdrawal symptoms and the benefits seen when used with Narcan. It was agreed upon that each agency would look internally to see when their crews could have used Buprenorphine and come up with a plan on how they could implement Buprenorphine in the future and report back to SCEMSA.

PD# 4050 – Certification – Accreditation Review Process – Approved

- A. Current language will remain in the policy because it comes directly from Title 22.

PD# 8060 – Stroke - Approved

- A. These are tools that can be used in the field to hopefully identify suspected large vessel occlusive strokes that are not candidates for lytic therapy and transporting them to a Thrombectomy Capable Center. We will use CQI to track the data. Policy 2060 – Hospital Services will be updated to include the comprehensive stroke centers.
1. Action:
 - a. Reference policy with the updated edits

PD# 2524 – Extended Ambulance Patient Off-Load Times – Approved

- A. There was a public comment regarding treatment of patients while on wall time. Generally, crews should not initiate treatment (start ivs, give medication/narcotics, etc) while on wall time. They can continue treatment that was started in the field (IV fluids, breathing treatments, etc).

PD# 4150 – EMT Certification Process - Approved**PD# 4510 – EMT Training Program - Approved****PD# 4511 – Advanced EMT Training Program - Approved****PD# 4520 – Paramedic Training Program - Approved****PD# 7600 – Quality Improvement Plan - Approved****PD# 7601 – Quality Improvement Plan - TAG - Approved****PD# 8063 – Nausea – Vomiting - Approved**

- A. Action:
1. For persistent **nausea**/vomiting, may repeat x one (1) for max dose of eight (8) mg.

PD# 8066 – Pain Management -Not Approved

- A. Public comment asked to add Versed when using narcotics. SCEMSA disagrees with this being written in policy and if a medic wants to add

- versed when treating pain, they should contact a base hospital for direction.
- B. Policy to remove any teaching language and add contraindications to drug reference guide.
 - C. Discussion on adding time restraints when giving additional dose of Ketamine. This will be talked about further at the March MAC.

PD# 9013 – Pediatric Shock – Approved

- A. Discussion on adding push dose epinephrine.
 - 1. Action:
 - a. For any signs of shock, attach Normal Saline (NS) and administer fluid challenge of 20 ml/kg if systolic blood pressure less than minimum for age.
 - b. **Push Dose Epinephrine: 1mcg/kg (max single dose 10mcg). May repeat every 2 minutes slow IV/IO push. If continued signs of shock, repeat 20 ml/kg fluid bolus x 1 concurrently.**
 - c. ~~If continued signs of shock continue, repeat 20 ml/kg fluid bolus x 1.~~

PD# 9014 – Pediatric Cardiac Dysrhythmias - Approved

PD# 9017 – Pediatric Trauma - Approved

PD# 9018 – Pediatric Pain Management – Not Approved

- A. Policy to remove any teaching language and add contraindications to drug reference guide.
- B. Discussion on adding time restraints and age/weight requirements when giving Ketamine and Toradol. This will be talked about further at the March MAC.

MCI Plan

- A. MCI Plan will go live May 1, 2026

Roundtable

Next Meeting: March 12, 2026

Adjourn