Sacramento County Emergency Medical Services Agency
MAC/OAC Meeting Minutes – June 2026

Date and Time:	June 11, 2026, 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. March MAC meeting minutes reviewed and approved by Jeremy Veldstra and Bryan Sloane.

PD# 5010 – Paramedic/AEMT to EMT Transfer of Care - Approved

A. Policies 5010 and 5011 have been causing field confusion.
B. Action:
   1. Merge into a single revised 5010 policy effective Nov 1.
   2. 5011 will remain live until Nov 1.
C. Requested removal of 100% QI review requirement.
   1. Action:
      a. Language will be removed from policy.
         ~~i) 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.~~
D. Discussion on medications and conditions approved for ALS to BLS transfer of care.
   1. Zyprexa
      a. Add to list of medications compatible with ALS to BLS downgrade.
   2. Repeat Bronchodilators?
      a. Repeat dosing suggests instability and is <u>not</u> compatible with ALS to BLS downgrade.
   3. Intoxicated Patients:
      a. Existing language (Suspicion for ingestion or overdose <u>and</u> unable to maintain airway) is sufficient.
         i) Stable-airway intoxicated patients may be eligible for BLS transport based on medic judgment.
   4. Vital Sign Criteria:
      a. Group declined to modify VS criteria due to broad use across multiple policies.
   5. AEMT Integration
      a. AEMT language added in preparation for pilot programs.

b. Timeline:
   i) Pilot proposal expected Sept/Dec MAC
   ii) 18 month pilot cycle
   iii) Potential state-level presentations with 2027–2028 implementation

PD# 8062 – Behavioral Crisis – Restraint - Approved

A. Discussion on Zyprexa parameters
B. Action:
   1. If patient is ≥14 and <65, cooperative with a behavioral health presentation and a known history of a psychiatric disorder with acute psychosis, perform the following (in order):
   2. Patient Assessment: assess mental status, heart rate, respiratory rate and if possible, blood pressure.
   3. Administer: 10 mg Olanzapine Oral Disintegrating Tablet (ODT).
   4. Continuously monitor patient (as soon as can reasonably be performed):
      a. ECG monitoring.
      b. Continuous SpO2 monitoring.
      c. Continuous nasal EtCO2 monitoring.
   5. Watch for respiratory compromise.
C. Zyprexa will be required on all transporting ALS units starting Nov 1.

PD# 5056 – MIH - Approved

A. Clarification: SCEMSA does not regulate NP/PA practice. The policy covers the general oversight of the EMS system.
B. Destination list to be broadened to include detox facility, psych clinics and "other" when appropriate.
C. Remove ~~approved~~ terminology where unnecessary.
D. Documentation/reporting format:
   1. To be standardized among MIH programs through TAG.

PD# 6003 – ALS IFT Hospital Requirements – Approved

A. No changes.

PD# 6004 – ALS IFT Agency Requirements – Approved

A. No changes.

PD# 8003 – Seizure – Approved

A. Discussion on updating required medication to include 5mg:1mL versed for correct intranasal route dosing.
   1. Versed (5mg/1mL) added to PD# 2030.

PD# 9002 – Pediatric Allergic Reaction Anaphylaxis – Approved

A. Updated push-dose epinephrine language (removed unnecessary max-dose).
B. Action:
   1. If hypotensive or no improvement, Epinephrine 0.01 mg/ml (10 mcg/ml) – 0.5-2 ml (5-20 mcg) IV/IO every 2-5 minutes. Titrate to a minimum SBP for patient's age, improvement of symptoms. ~~or a total of 0.3 mg is given.~~
C. Clarified AEMT/EMT/Paramedic flowchart formatting. Added EMT auto-injector authorization language.
D. Action:
   1. 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.
   2. Rebound anaphylaxis:
      Patients who have received epinephrine may experience rebound anaphylaxis symptoms after initial improvement. Transport to hospital for further evaluation/monitoring should be strongly encouraged.

PD# 9006 – Pediatric Cardiac Arrest – Approved

A. Clarified that pediatric arrests should be transported after resuscitation attempts; field termination not supported except in obvious death.
B. Providers concerned about interpretation of flowcharts as strict sequence:
C. Action: A general "How to Use Flowcharts" statement will be developed

PD# 9008 – Pediatric Seizures – Approved

A. Updated Midazolam dosing:
   1. Move to 0.2 mg/kg (all routes), max 10 mg, aligned with surrounding counties and evidence.
B. Add ETCO2 monitoring when benzodiazepines are administered.
C. Adult seizure policy to mirror updated pediatric dosing for consistency.

PD# 9013 – Pediatric Hypotension Shock – Approved

A. Updated push-dose epinephrine language to mirror other pediatric policies for consistency.
B. Action:
    1. 0.01mg/mL (10 mcg/mL) – 0.5–2 mL (5–20 mcg) IV/IO every 2–5 minutes. Titrate to minimum SBP for patient's age, improvement of symptoms.
C. Shock policy will remain in effect for pediatrics (unlike adult 8038, which is being Sundowned).

PD# 2210 – EMR Scope of Practice – Approved

A. No changes.

PD# 2501 – Emergency Medical Dispatch Priority Reference System – Approved

A. No changes.

PD# 5001 – Equipment and Supply Shortages – Approved

A. No changes.

PD# 5100 – IFT ALS/CCT Program Requirements – Approved

A. Data will be clarified at next TAG meeting.

PD# 5101 – IFT Medical Control – Approved

A. No changes.

PD# 5102– IFTs – Approved

A. No changes.

PD# 5550 – Bio-Medical Equipment Maintenance – Approved

A. No changes.

PD# 6005 – ATV Utilization – Approved

A. No changes.

PD# 6006 – Blood Infusion – Approved

A. No changes.

PD# 6007 – IV Infusion – Approved

A. No changes.

PD# 8001 – Adult Allergic Reaction Anaphylaxis – Approved

A. Corrected epinephrine dosing typo.
B. Clarified push-dose epinephrine use.
C. Action:
   1. If extremis or no improvement, **Push Dose Epinephrine** 0.01mg/ml (10mcg/ml) 0.5-2ml (5-20mcg) every 2-5 minutes IV/IO. Titrate to SBP > 90. ~~Maximum 0.5mg~~
D. Added rebound anaphylaxis language.
E. Action:
   1. Patients who have received epinephrine may experience rebound anaphylaxis symptoms after initial improvement. Transport to hospital for further evaluation/monitoring should be strongly encouraged.

PD# 8017 – Dystonic Reaction – Approved

A. No changes.

PD# 8018 – Overdose – Not Approved

A. Significant revision planned:
   1. Replace "tricyclics and related compounds" with symptomatic overdose with wide complex QRS.
   2. Recognize that real-world overdoses often involve unknown/mixed agents.
   3. New language will be added for September MAC meeting.

PD# 8038 – Shock – Sundowned

A. Group consensus: Policy is redundant and confusing given other existing shock specific policies.
B. Decision: Will be removed November 1st.

PD# 8065 – Hemorrhage – Not Approved

A. Revisit TXA use for head/neck bleeding and nasal packing.
B. Workgroup will return with structured clinical guidance in September.

PD# 8808 – Vascular Access – Approved

A. No changes.

PD# 8827 – 12 Lead – Approved

A. Remove language regarding serial ECGs.
B. Encourage repeat ECGs when clinical suspicion remains high or change in patient condition.
C. Action:
    1. Repeat ECGs should be performed if there is a change in the patient's status or clinical presentation. ~~Prehospital serial ECGs are not indicated due to the high instance of false alerts.~~
D. Future possible consideration: right-sided/posterior leads (15 lead ECGs).

PD# 8844 – Spinal Motion Restriction – Approved

A. No changes.

PD# 9016 – Pediatric Parameters – Approved

A. No changes.

Roundtable

Next Meeting: September 10, 2026

Adjourn