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

- ## 2525 – Prehospital Notification
  - Matt Barnick: SFD
    - Consider adding language for alert notification of Double Sequential External Defibrillation (DSED)under Cardiac Arrest. I see that it is requested in the 8031.28 Non-Traumatic Cardiac Arrest policy but adding the language to 2525.07 will make it clear and consistent for the field.
  - SCEMSA: No addition at this time.

- ## 5070 – Hospital Transfer Agreement

- Dylan Hurley: Metro
  - Paramedic Transport: The transferring hospital should provide written orders for patient care
  - Can a sending physician give a paramedic an order outside of protocol without the need for the base hospital? If a paramedic is asked to do something out of their scope, how should that happen? Is base hospital contact needed, or just a written order?
- SCEMSA: Paramedics cannot work out of scope. Patients being transferred will have interventions started – IVF, blood etc. If patients decompensate during transfer EMT-P to follow county protocols. Base hospital consult as usual for patient presentation outside of protocol.

- ## 8020 – Respiratory Distress
  - Dylan Hurley: Metro
    - Heimlich Maneuver (May be attempted three (3) times). If unsuccessful, then "Direct laryngoscopy, remove foreign body with Magill forceps
      - New AHA guidance on choking in conscious adults recommends alternating five back blows followed by five abdominal thrusts, until the object is expelled or the person becomes unresponsive.
      - Should be divided as partial vs complete. Complete should then be divided into conscious vs unconscious.
      - No mention of CPR if unconscious with FBAO; AHA recommends beginning chest compressions in unconscious patients.
      - Add treatment for partial obstruction
  - SCEMSA: OK with adding 5/5 language. Heimlich maneuver (conscious) box. Unconscious – begin chest compressions move to cardiac arrest pathway? Partial obstruction would be covered by 'ALS ONLY' Direct Laryngoscopy box.

If the patient becomes unresponsive, begin CPR immediately but look in the mouth before administering any ventilation. If a foreign-body is visible, remove it. Do not perform blind finger-sweeps in the mouth.

- 8026 – Respiratory Distress
  - Dylan Hurley: Metro
    - Remove the second NIV box after Mag and before Epi.
  - SCEMSA: Assuming this refers to NIV PRIOR to Magnesium. Unclear why this would benefit. Get perspective at meeting. Remove NIV boxes?
- 8030 – Discomfort/Pain of Cardiac Origin
  - Dylan Hurley: Metro
  - Caution: NTG shall not be given to patients who have taken PDE-5 inhibitors [Avanafil, Sildenafil, Tadalafil, Vardenafil, or equivalent] within the last 48 hours.
    - On the respiratory distress protocol, this line is in a big yellow box on the flow chart page. Now it is hidden in the notes section.
    - Add this to the flowchart on the first page, like it is on the respiratory distress
  - SCEMSA: OK to synchronize look of policies.
- 8031 – Non-Traumatic Cardiac Arrest
  - Dr. Mackey – SFD
    - Consider changing resistant VF/VT to "shock-resistant VF/VT"
    - If a second cardiac monitor or AED is available on scene, implement the Double Sequential External Defibrillation (DSED) algorithm.
      - I think you are not meaning two AEDs, correct? All the literature (except SHeldon's in Canada) strongly discourage two AEDs. At least one has to be a defibrillator to make this really work. May need rewording if that's the case.
    - Prior to DSED, providers should verify that the pads are well-adhered and not touching.
      - This should be moved up to number 4, not at the bottom.
    - Resistant: ventricular fibrillation or pulseless ventricular tachycardia that is persistent, after three (3) consecutive defibs, without any transient conversion in response to conventional defibrillation.
      - Consider "change in rhythm"

- SCEMSA: Agree with shock-resistant VF/VT language. We are not meaning two AEDs. If one device is an AED that will be used to deliver the first shock. OK to move well-adhered and not touching pad language up. OK with change in rhythm change.

- Adam Blitz – Metro
  - Thank you for considering adding DSED. I've reviewed several Metro Fire cases involving manual defibrillation for volume and also to delineate patients responding with 3 shocks or less, and for the ones who do not - isolating incessant cases from recurrent cases. Like with classic atrial fib, the one constant is that these figures are irregularly irregular. We see defibrillated patients multiple times a day and then not for two weeks. The first sample reviewed was the 1st quarter of 2026:
    - 197 CPR patients by Metro Fire
    - 44 patients in v-fib/pulseless v-tach (22%)
    - 20 = Recurrent / 14 = Incessant / 10 = n/a (both or converted)
    - 20 of 44 required > 3 defibs (high was 14 shocks)
  - Then I reviewed the most recent complete month, which was July 2026:
    - 56 total CPRs by Metro
    - 11 in v-fb/pulseless v-tach (19%)
    - 1.5 = Recurrent / 5.5 Incessant / 4 = n/a (converted)
    - 4 of 11 required >3 defibs (high was 8 shocks - twice in July)
  - I also spoke with AMR-Napa's Clinical Manager to learn their experience with this. AMR-Napa first began with Double Simultaneous Defib 5 years ago but had to stop. After revamping and changing the S to "Sequential" 2 years ago, they have had better outcomes than the first go-round. They estimate 6 saves in 2 years. Napa County has tenth of the population of Sacramento County and EMS transports are <10% of Sacramento transports. That could translate to 60 patients saved by DSED in the next 2 years in Sacramento.
- SCEMSA: No changes based on comment.

- Dylan Hurley: Metro
  - Change to "If a second cardiac monitor or AED is available on scene, does not interfere with high-quality CPR, and is within manufacturer guidelines, implement the Double Sequential External Defibrillation (DSED) algorithm."
  - Attempting to employ DSED on every resistant ventricular arrest could get in the way of high-quality CPR, such as scene size constraints and active

transport. Adding this allows providers to make the decision if it will impede high-quality CPR.
    - Adding the language for manufacturer guidelines, as Stryker currently has this listed as an off-label use for the LP15.
- SCEMSA: No changes based on comment.

- Cosumnes Fire
    - I support adding DSED as an option for refractory/persistent VF/pulseless VT. I'd also like to ask SCEMSA to consider adding MgSO4 2 gm IV/IO after or in conjunction with amiodarone when VF/pulseless VT is refractory.
    - I recognize that available studies do not show a clear survival benefit from routine MgSO4 in persistent VF/VT arrests. My concern is how the current policy is dependent on the paramedic identifying TdP or polymorphic VT.
    - The likelihood of seeing TdP or polymorphic VT during resuscitation while managing compressions, med prep, and scene coordination is low. Ultimately, the medic will simply see the persistent VF/VT. There is evidence that VF/VT arrests are preceded by TdP or polymorphic VT that deteriorate to VF arrests.
    - I'm suggesting that in addition to high-quality CPR, standard defib, vector changes, DSED, epi, and amio, the option for MgSO4 be an additional treatment for refractory VF/VT.
    - MgSO4 is familiar to SCo medics, is low risk, and will not interrupt compressions or delay defibrillation. Allowing MgSO4 as an adjunct after standard treatment has failed would be a reasonable option for these cases.
- SCEMSA: Do we add consider TdP language for refractory VF/VT. We want medics to be able to recognize TdP and treat accordingly.

8065 – Hemorrhage

- Dylan Hurley: Metro
    - Agreeable with all the changes.
    - Add "Apply a nasal clamp if available" after inserting a cotton pledget.
    - On the non-flowchart version, Section 9 of the BLS in oral hemorrhage
        - "9. For stable patients with epistaxis, encourage vigorous nose blowing to remove clotted blood." Needs to be removed.
- SCEMSA: Disagree. High clot burden in the nose will keep TXA away from bleeding site.

- 8067 – Sepsis
  - Lexy Shoquist: Mercy San Juan
    - I propose that we align the sepsis/ septic shock policy with CMS guidelines to ensure compliance for all acute care facilities in the area.
      - Per CMS Guidelines:
        - 1) "Documentation must be clear that crystalloid fluids were initiated (i.e., date and time of administration is noted)".
        - 2) "It must include the type of fluid, volume, and rate or time over which the fluids are to be given".
        - 3) "The term bolus, wide-open, or open are acceptable for a rate or infusion duration".
        - 4) For Prior to Arrival (EMS): "Documentation of crystalloid fluids administered prior to arrival to the hospital (e.g., ambulance, nursing home) are acceptable if the documentation of fluid administration contains the type, volume, start time, and either a rate, duration, or end time of the fluid infusion. A physician/ APN/PA order for fluids administered prior to arrival is not required."
    - An example of appropriate documentation is: "1000L normal saline bolus started at 09:30"
    - The key word here is "bolus". This word needs to be added somewhere in the EMS documentation for this to be CMS compliant.
    - I suggest updating the EMS documentation requirements to include either the term "bolus" or the specific rate and stop times for fluid administration. Implementing this change will:
      - Ensure continuity of care and improve patient outcomes.
      - Align local documentation with federal CMS legal and medical necessity standards.
      - Improve performance metrics for both agencies and facilities.
      - Protect individual providers through compliant medical charting.
    - Standardizing this documentation will accurately reflect the high quality of care EMS is already providing and ensure that Sacramento County hospitals can maintain federal compliance. I appreciate your serious consideration of this request and its impact on our healthcare systems.
  - SCEMSA: Conversation at MAC. Hospital request versus what is able to be documented in ImageTrend.

- 8805 – Intubation Stomal
  - Dylan Hurley: Metro
    - There needs to be a protocol or language that discusses respiratory distress with a tracheostomy. Many other countries have specific protocols for this, or it is incorporated into another protocol.
    - Currently, there is nothing that guides paramedics in the field on what to do for patients experiencing respiratory distress with a tracheostomy. Things like removing the obturator, inner lumen, etc. are discussed in other protocols, as well as definitions of severity of respiratory distress specific to tracheostomy.
    - Also, what if the patient/caregiver has a replacement/emergency tracheostomy kit?
  - SCEMSA: Group discussion on addition of language – obstructed trach suctioning. Mature v immature dislodged trach – ET tube placement v trach replacement.
- 8833 – Ventricular Assist Device
  - Dylan Hurley: Metro
    - Hyperlink to ICCAC Guides does not work
    - 4 & 5 BLS of the BLS section should be combined on the non-flow chart version
  - SCEMSA: We will look at the hyperlink. Make format change to 4/5.
  - Terry Liddell: Mercy San Juan
    - Hyperlink to ICCAC Guides does not work
    - The 8833 Flowchart reference should also be updated.
  - SCEMSA: Unsure of what the flowchart reference is referring to.
- 9005 – Pediatric Traumatic Cardiac Arrest
  - Dylan Hurley: Metro
    - In the non-flowchart version, there is mention of preventing hypothermia; in the flowchart, there is not.
  - SCEMSA: Hypothermia prevention language can be added to flowchart.